

Centers for Medicare & Medicaid Services
COVID-19 Medicaid & CHIP All State Call

January 19, 2021

3:00 pm ET

- Operator: Greetings and welcome to the CMCS All-State Medicaid and CHIP call 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. If at any time during the webinar, you need to reach an operator, please press star zero. As a reminder, this webinar is being recorded on Tuesday, January 19th, 2021. I would now like to turn the webinar 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'd like to turn now to Anne Marie Costello, our Acting Center Director, and she will share highlights for today's discussion. Anne Marie.
- Anne Marie Costello: Thanks, Jackie. And again, welcome to everybody for joining us today. First up today staff from our Disabled and Elderly Health Programs Group and the Financial Management Group will respond to a few unanswered questions from last week's call on our recent state health official letter that provides guidance to states on a new mandatory Medicaid state plan benefit for medication-assisted treatment.
- Anne Marie Costello: Then we'll hear from Shannon Lovejoy and Michelle Wojcicki in our Children and Adults Health Programs Group. Shannon and Michelle will present a more in-depth look at the eligibility and enrollment provisions of the state health official letter CMS released on restoring regular operations after the COVID-19 public health emergency ends.
- Anne Marie Costello: I want to highlight that on Friday, we released two tools to help states plan for return to regular operations, a general planning tool and an eligibility and enrollment focused tool. They are both available on the COVID-19 page on [medicaid.gov](https://www.medicare.gov). After the eligibility and enrollment presentation, we'll open the line for your general questions.
- Anne Marie Costello: Before we begin today's presentation, I want to provide an update on the medication-assisted treatment, or MAT, SHO letter CMS released on December 30th that we discussed last week. The MAT SHO letter outlines requirements for states related to a new mandatory benefit established by Congress for Medicaid. Section 1006(b) of the SUPPORT Act, which was enacted in October of 2018, established a new mandatory state plan benefit for medication-assisted treatment (MAT) under section 1905(a)(29) of the Social Security Act.

Anne Marie Costello: This provision, effective on October 1st, will be in effect through September 30th, 2025. As we previously communicated, states will need to submit a new SPA to cover the new mandatory benefits. Templates for ease of completion have been posted on Medicaid.gov. Because most states have been unable to submit the required MAT benefits SPA, the SHO letter describes how states can request section 1135 waiver authority to modify the regulatory deadlines associated with SPA submission and public notice for coverage and payment SPAs for the new MAT benefit, and also have an October 1st, 2020 SPA effective date.

Anne Marie Costello: The SHO letter indicated that states are to submit section 1135 requests to modify the deadline for the MAT SHO submission of public notice by January 14th, 2021. Recognizing that states may need more time to submit their 1135 waiver request and because the secretary extended the public health emergency until April 20th, 2021, we are extending the due date for the 1135 request. States now have until February 15th to submit their 1135 waiver request to CMS. The SHO letter outlines the details for submitting these 1135 requests and CMS is committed to approving these requests in an expedited manner. The statute also allows for an exception based on provider shortages and a legislative delay, and there's a process to request it. We've updated the date for submission of the exception based on provider shortages and the exception for delay due to legislative cycles, again, until February 15th, 2021. The request must be submitted to the SPA mailbox or portal.

Anne Marie Costello: With that, I'll turn things over to Kirsten Jensen who will kick off the MAT SHO questions and answers left over from our last call. Kirsten.

Kirsten Jensen: Thank you, Anne Marie. And I'll be joined today by John Coster and Jeremy Silanskis, who will also answer some of the remaining questions that we have. The first question we have is, "Should references to MAT and existing state plan pages be removed, or can they be left in if they are offered under existing benefits?"

Kirsten Jensen: We are asking that states move mandatory MAT coverage to the new 1905(a)(29) template. And for states that do already cover these services in their state plan, there are a couple options with how the state can approach that coverage. One is that states can remove the existing coverage because it will be offered in 1905(a)(29). Another option is the state could put sunset language on their existing coverage, so that that coverage does not apply during the five-year period that 1905(a)(29) is in effect. And the third option is that states can put language on the 1905(a)(29) page that in effect makes it the coverage that is being used for MAT for that five-year time period.

Kirsten Jensen: We can work with you to craft language that meets either of those two needs, but we did want to let you know that we had found some flexibility so that it does not necessarily require states to pull coverage out, take down coverage in the state plan that you might already have in place.

- Kirsten Jensen: The next question that we have, there's two that I'm going to turn over to John Coster, and I'll read them, the first one, John, is, "States don't manage drugs in the same manner that is in the MAT guidance. Is there a plan to change the language that states cannot cover a drug that is not a CMS covered outpatient drug?"
- John Coster: Yes. So the statute really makes it clear here that states have to cover all drugs approved under the Food, Drug, and Cosmetic Act, including methadone and all biologicals under Section 351, and we've interpreted that to mean regardless of whether they're covered outpatient drugs or not. We believe that most of these drugs, again, the state's only required to cover methadone buprenorphine, naltrexone, and all forms of them, most of these are covered outpatient drugs. There may be a case where a drug is not a covered outpatient drug for some reason. And in that case, the state would still have to cover it. But our interpretation of congressional intent was that states would have to cover all forms, strength, and dosage forms of these MAT drugs, regardless of whether they were covered outpatient drugs or not.
- Kirsten Jensen: Thank you, John. The next question for you is as new drugs come to market, we cannot refuse to cover a drug whose manufacturer does not participate in the rebate program. And I think the next logical question there is would the state be obligated to cover new drugs as they come to market under the new MAT benefit?
- John Coster: Well, here again, yes, the state would have to cover new drugs to treat opioid dependency, opioid use disorder, if it was approved as a drug or licensed as a biological by the FDA. If it was specifically used to treat opioid use disorder, the state would have to cover it, even if the manufacturer did not participate in a rebate program. I think as we made clear in the SHO, even though a state may not be able to collect section 1927 rebates, it would still be eligible for FFP for that drug and the state can prior authorize that drug, use utilization management techniques, to try to steer beneficiaries to other drugs that were included or are included in the rebate program or that might be most cost effective.
- John Coster: But at the end of the day, if the patient needs a particular drug approved by the FDA or biological that's specifically labeled to treat opioid use disorder, the state would have to cover that drug, even if it was not in the rebate program. But again, you could collect FFP for that particular drug.
- Kirsten Jensen: Great. Thank you, John. And then now over to Jeremy. We have a question about what information needs to be included on the 419(b) page for the new MAT benefit?
- Jeremy Silanskis: Thanks. So that question is a good, little philosophical, and it probably just depends on your current payment structure for other MAT services in your state plan. And we've been working with our general counsel on potential options for states using a variety of scenarios. So your best approach is probably to come in

and work with us directly, so we can give you the TA based on your state plan setup.

Jeremy Silanskis: I would say that what Anne Marie mentioned at the front of all this is really important. You should get your 1135 request in, so that way you have flexibility around public notice. And that's probably the most pressing thing to consider at this point in time, and then to know that the normal state plan requirements apply here. So you'd want to have a comprehensive description of your payment methodology, including how you pay for the variety of services that are offered under this new benefit. And that could look like some cross-referencing to other sections of your state plan, if you're keeping your rates as they are today. It could be that you want to pay differently for this new benefit. It could be that you don't cover services at all under the benefit, and would need to start fresh. So I think we'd want to have that conversation with states directly to meet your needs.

Kirsten Jensen: Great. Thank you, Jeremy. And with that, I'll turn it over to Jackie Glaze to help us through the rest of the agenda for the call today.

Jackie Glaze: Thank you, Kirsten, Jeremy, and John, for your updates. We'll now transition to Shannon Lovejoy, and she will provide information on the unwinding eligibility and enrollment provisions outlined in the recently released SHO letter. Shannon.

Shannon Lovejoy: Thank you, Jackie. Hi, everyone. This is Shannon Lovejoy in the Division of Enrollment Policy and Operations. And a few weeks ago, you heard from some of our colleagues who walked through the state health official letter, or SHO, on restoring regular operations after the public health emergency ends. As Jackie mentioned today, we're going to take a deeper dive in the eligibility and enrollment sections of the SHO. And we'll primarily be focusing on content that you can find in sections six and seven of that letter.

Shannon Lovejoy: So when the public health emergency ends, states will need to work through any backlog of pending eligibility and enrollment actions that were received during the public health emergency and take steps so that they're able to resume routine operations. And when we talk about pending eligibility enrollment actions, we are referring to applications, and for states that selected this option, verifications for individuals who are enrolled during the public health emergency based on self-attested information, redeterminations based on changes in circumstances, and renewals.

Shannon Lovejoy: And while we know that states will have some work to do when the public health emergency ends, CMS strongly encourage states to take steps now to limit the volume of work that they'll have to go through when the public health emergency ends to the extent possible. In particular, it's really important to prioritize processing applications so individuals can get access to coverage sooner, but also to make sure that you're doing what you can to work through any renewals, changes in circumstances, and verifications.

Shannon Lovejoy: So states can take up to four months following the month in which the PHE does end, but there'll be some interim milestones that states will need to meet for processing application. For all other actions, so verifications, changes in circumstances, and renewals, states may take up to six months to complete any backlog of pending actions and resume routine operations. And we'll spend a little bit of time going through these different enrollment areas to fully understand the scope of work the states should be thinking about that will need to be completed.

Shannon Lovejoy: We're really hoping that states are prioritizing application processing during the public health emergency. We know that most people at least have some pending applications that were received during the public health emergency that they will need to address given that applications are received on a rolling basis. So states may take up to two months to complete eligibility determinations for pending MAGI and other non-disability applications after the month of public health emergency ends. States can take up to three months to complete pending eligibility determinations for disability-related applications received during the public health emergency. And then, states can take up to four months to resume timely and accurate determinations of eligibility for all new applications.

Shannon Lovejoy: And when we talk about pending applications, what we're referring to are applications that the Medicaid or CHIP agency received during the public health emergency that are not processed, as well as account transfers the state receives from the exchange during the public health emergency. And as a reminder, applications are considered to be processed when an eligible applicant is enrolled or when an individual is denied coverage, because the state can determine that the individual is eligible.

Shannon Lovejoy: After the four-month timeframe, states are expected to timely process applications consistent with application processing time standards and regulation, so that determinations of eligibility must be completed within 90 days for applications that are based on disability, and 45 days for all other applications.

Shannon Lovejoy: And now, I will turn it over to my colleague, Michelle Wojcicki, who will walk through the verification section. Michelle?

Michelle Wojcicki: Thank you, Shannon. This is Michelle, and I'm going to talk about verifications. So states may elect, as Shannon noted, to enroll applicants based on self-attested information, and then access relevant data sources consistent with their verification plan to verify eligibility criteria for beneficiaries after they enroll. This is what we often refer to as post-enrollment verification. States can make the selection, or may have made the selection already through their state verification plan, or if they wanted to limit it temporarily during the PHE, through the Medicaid and CHIP disaster relief MAGI-based verification plan agenda, in what we've been referring to as their verification agenda.

Michelle Wojcicki: Also, as Shannon noted, just a reminder that to help with some of the backlog work, states should be completing post-enrollment verification processes during

the PHE to the extent possible. As a reminder though, states validly enrolled based on self-attested information may not and be terminated, and states claiming the 6.2 FMAP bump authorized under the FFCRA.

Michelle Wojcicki: And so then, the timelines pertaining to verifications at work is that within six months after the PHE ends, states that enrolled individuals based on self-attested information during the PHE must complete outstanding verifications for those individuals. States may be in different phases of that process, if you will, but some of those actions then may include or would include that full process beginning verifications that the state has not initiated, such as checking the data sources consistent with your state's verification plan or addendums; requesting additional information from beneficiaries as needed, if you didn't have that in the data sources or otherwise available; and then providing advanced notice and terminating coverage for beneficiaries determined ineligible, but are still enrolled.

Michelle Wojcicki: No later than six months after the PHE ends for states that continued to enroll individuals based on self-attested information, so continue to opt to use post-enrollment verification, must complete those verifications of eligibility for all beneficiaries involved within a reasonable timeframe after their initial enrollment. States may not wait to conduct the required verification until the beneficiary's next renewal. And with that, I'll turn it back to Shannon.

Shannon Lovejoy: Thanks, Michelle. So the third area that states will need to address when the public health emergency ends are redeterminations based on identified, so through a pre-eligibility data match or other program information, beneficiary reported or anticipated changes in circumstances. And anticipated changes could include something like an individual who has an upcoming birthday, that means that they're reaching an age milestone for an eligibility group in which they're enrolled. And when we talk about pending changes that were identified, reported, or anticipated during the public health emergency, we're referring to a wide range of changes in terms of anything: changes that the state received, but hasn't contacted the beneficiary to follow up to redetermine eligibility, to redeterminations that the state has gone through the process to complete, found the individual is no longer eligible, but the state was unable to terminate coverage due to the continuous enrollment requirements.

Shannon Lovejoy: The other thing that states should keep in mind is that, we noticed some of you have taken up temporary eligibility groups or have applied new income or resource disregards. And anytime that those are eliminated or sent, that is considered a change in circumstances for any of those individuals, for who this change in state policy might affect their eligibility. So states will often need to think about including these redeterminations in the scope of work that will need to be completed when the public health emergency ends. And then after six months, after the month in which the public health emergency ends, states must promptly act on all newly-identified reported or anticipated changes consistent with federal regulations.

Shannon Lovejoy: And then the last area of the work is renewals. So states must complete pending renewals that were due during the public health emergency, and resume timely and accurate redeterminations of eligibility for renewals within six months, after the month the public health emergency ends. Again, similar to changes, this includes: renewals that the state was unable to initiate, but were due during the public health emergency; renewals that the state did start the process, perhaps started the ex parte process, looking at information, looking to see if eligibility can be renewed based on available information, but the state was not able to send the beneficiary's renewal form; or renewals that resulted in an actual determination of ineligibility, but the state wasn't able to terminate coverage.

Shannon Lovejoy: And after six months, states must meet the requirements in regulation to renew eligibility, once every 12 months and only once every 12 months for MAGI beneficiaries, and at least once every 12 months for non-MAGI beneficiaries. And we know in particular, trying to work through any pending renewals could have impact on states work in the future. And so, CMS is available to provide technical assistance to states that are trying to figure out how to work through their renewal backlog.

Shannon Lovejoy: So the state health official letter, in addition to outlining work that would need to be completed, also talks about how states can better, more efficiently work through their pending backlogs. And one of the best ways that we think that states can help better address the work at the end of the public health emergency is trying to take steps now to prioritize actions, to make sure individuals are able to enroll in coverage, and then, just given the volume of work that will need to be completed, states are really encouraged to process as many pending verifications renewals and redeterminations based on changes in circumstances as possible during the public health emergency to limit the backlog. The more work states are able to do now, especially to complete renewals based on available information, to complete verifications and to act on changes in circumstances, the less states will have to worry about working through when the public health emergency ends.

Shannon Lovejoy: But to help states work through any backlog-appending action, we've outlined a process for states to prioritize work on pending verifications, redeterminations based on changes in circumstances, and renewals using a risk-based approach. And when we talk about a risk-based approach, we mean an approach that prioritizes actions for individuals who are most likely to no longer be eligible for coverage, and an approach that minimizes the extent to which coverage is provided to individuals who no longer meet eligibility criteria. And in this SHO, we outlined four different risk-based approaches for states to address their pending cases, and states may select one of the four risk-based approaches.

Shannon Lovejoy: The first approach outlined in the SHO is a population-based approach. And so under this approach, states would prioritize any pending work, based on prioritizing individuals in groups who are most likely to no longer be eligible. So for example, states could prioritize work for cases for individuals who become categorically ineligible for their group, so they meet an age milestone or an

individual becomes eligible for Medicare and that affects eligibility in their current group. This can also include prioritizing individuals who were determined ineligible for Medicaid during the public health emergency, but who remained enrolled due to the continuous enrollment requirement. Now, when using a population-based approach, we would not expect states to prioritize working through cases for eligibility groups for populations where eligibility tends to be more stable, such as children or former foster care youth, or individuals who are duly-eligible for Medicaid and Medicare.

Shannon Lovejoy: Another approach that states may take is a time-based approach. And under this approach, states would prioritize its cases based on the length of time the action has been pending. So they complete oldest pending actions first, and newer pending actions later. States can also take a hybrid approach, which is a combination of the population and time-based approaches that we just discussed. So for example, a state could choose to start their work using a population-based approach, so prioritizing work for certain populations, and then using a time-based approach for any remaining cases that continue to be open. Or they could split the different types of eligibility enrollment actions and take a different approach for each of those actions. So for example, use a population-based approach to process changes in circumstances, and use a time-based approach to process renewals.

Shannon Lovejoy: And the last approach that states can take is a state-developed approach, which is a state-specific, risk-based approach. The states can use based on what they think might work best for them, so long as their approach prioritizes actions for individuals who are most likely to be no longer eligible or for which there's a greater risk that an ineligible individual may remain enrolled longer.

Shannon Lovejoy: So states may also want to consider, to help make their work a little bit more efficient or to streamline work, to take a look at different authorities and efficiencies that are existing. So states should look to see what flexibilities they implemented during the public health emergency and see if any of those should be maintained, either through the duration of the public health emergency, or extended on a temporary or permanent basis when the public health emergency concludes. States can also choose to adopt other existing authorities that may streamline their eligibility and enrollment processes, such as updating their verification policies or adopting certain state plan authorities, such as express lane eligibility for children. One thing that states should really think about, during the public health emergency and thinking about work that they can do now, is that if the states are taking up different authorities, some of these might require the submission of a state plan amendment. They might require an updated verification plan. And all of this is work that states can begin now, so that they're prepared for when the public health emergency ends.

Shannon Lovejoy: So the last strategy that we wanted to spend a little bit more time on, and we know we've already received several questions about this strategy, is regarding repeat redeterminations for individuals who are determined ineligible during the public health emergency. So in general, states must repeat redeterminations for

individuals who were determined ineligible, but the state is not able to terminate coverage at this point in time, and would do so at a much later point in time. But in the State Health Official letter, we outline a process for which states may avoid repeating redetermination for certain beneficiaries. And so instead, at the end of the public health emergency, the state may have the opportunity to go ahead and send advanced notice of termination and fair hearing rights for beneficiaries without having to repeat the redetermination. But this process may look a little different, depending on if the individual was determined ineligible during the public health emergency, or if the individual failed to respond to a request for information.

Shannon Lovejoy: So for a redetermination that was completed during the public health emergency, so long as that redetermination was completed no more than six months prior to the date of termination for an individual who was found ineligible, and the state provides an initial notice at the time of the determination, so lets the beneficiary know of their eligibility determination that enrollment will end after the month in which the public health emergency ends, and notifies the individual that they can and should report changes in circumstances, then the state can avoid repeating the redetermination and just move to sending the advanced notice of termination, which in this case would be a second notice when the public health emergency ends.

Shannon Lovejoy: For individuals who fail to respond to requests for information, as long as the state sent the renewal forms no more than six months prior to the date of termination, the state can allow beneficiaries to provide information at least through the end of the month which the public health emergency ends. An initial notice is not required, but so long as that initial form was sent no more than six months prior to the date of termination, the state can move to send the advanced notice of termination in fair hearing rights when the public health emergency ends.

Shannon Lovejoy: So to help explain how this process works, we have a couple of examples that we're going to walk through that we hope will help illustrate how a state can avoid repeating the redetermination. So in this example, we have James. And let's say James is due for renewal this month in January. And we found that he is no longer eligible for Medicaid on all bases. So we send James a notice stating that he was determined ineligible, and this enrollment will continue until after the public health emergency ends, and that he can report any changes in circumstances while he remains enrolled.

Shannon Lovejoy: And just for this example, we'll say that the public health emergency ends in April. So James's this case will become one of the pending cases that is a state we need to work through when the public health emergency ends. So let's say we're able to pick up James's case pretty quickly, and we do so in May. So James we notice has not reported any changes since we determined him ineligible in January.

Shannon Lovejoy: So since we are able to move and terminate coverage by the end of May, and this is within six months from the date of his determination in January, we are able to send the required advanced notice in fair hearing rights, without having to redetermine eligibility. If for some reason, let's say we picked up James's case in August, then that is more than six months since we determined that James was no longer eligible. And at that point we would have had to repeat the whole renewal and start the process over again.

Shannon Lovejoy: So here we have another example, and this is a case for an individual who did not return information at renewal. So let's say we have Amelia who is due for renewal in February. This month in January, we initiate Amelia's renewal. We attempt to renew based on available information, but we're not able to do so. So we send a renewal form. Amelia does not return her renewal form before the end of her eligibility period in February, but because we're in the middle of the public health emergency, we take no action. And we allow Amelia to remain enrolled and allow her to return her renewal form, at least through the end of the month in which the public health emergency ends.

Shannon Lovejoy: So again, in this example, we're just going to assume that the public health emergency ends in April. Again, Amelia has still not returned her renewal form. Amelia's case would be one of the cases that are part of the pending work that we need to go through at the end of the public health emergency. In this example, we're able to pick up Amelia's case pretty quickly. We do so in May. We see that she still has not returned her information. Since we are able to terminate Amelia's coverage in May, which is within six months from the date in which her renewal form was sent in January, we are able to just go ahead and send her required minimum 10 days advance notice with fair hearing right and terminate coverage by the end of May for failure to respond. Again, similar as we walked through in the last example, if for some reason we weren't able to pick up Amelia's case till much later, let's just say August, that is more than six months after Amelia's renewal form was sent to her. And instead of just moving to send advanced notice, we would have to start the renewal process all over again. And that may mean sending Amelia a new renewal form.

Shannon Lovejoy: So the last piece that we just wanted to go through really quickly is that as part of all of this work, states should develop a post-COVID eligibility enrollment operational plan to document how the state is going to achieve the timelines we discussed earlier in this presentation. So the four and six months timeline. States should document how they're going to complete their pending work and resume routine operations.

Shannon Lovejoy: To assist states, as Ann Marie mentioned earlier on Friday, CMS released a planning tool that states can either use to reference for the type of issues that they may need to address in their operational plans. Or the tool is also designed so states can just use it to document their plans. States do not need to submit their post-COVID eligibility enrollment plan to CMS for approval, and states are not required to use the tool. States will be asked to submit data to CMS to

demonstrate their progress, but a data submission tool is forthcoming. And we hope to get that out to all of you very soon.

Shannon Lovejoy: And then this is just a summary of everything we walked through in the different timelines. But with that, I believe we are ready to open up the line for questions.

Jackie Glaze: Thank you, Shannon. Thank you, Michelle. And so at this point, we're ready to take your questions. And so we'll start with the chat box. The operator will give you instructions, and then we'll follow by taking questions over the phone. So Frank, I'll turn it to you for the instructions.

Operator: Thank you. If you would like to register a question, please press the one 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 question, please press the one four on your telephone. One moment please, for the first question

Jackie Glaze: We're going to do the chat function first?

Barbara Richards: Great. Thanks, Jackie. And thanks, Shannon. We have a couple questions in the chat around the eligibility and enrollment provisions that Michelle and Shannon just described. The first question is with respect to the timeframe was for addressing newly determined and renewal determinations during the PHE, i.e. the four and the six months. Are those timelines from the end of the federal PHE or the state declared PHE? And what if they don't align?

Shannon Lovejoy: Hi, this is Shannon. So those timelines are from the end of the federal public health emergency. And in part, because that also lines up with the continuous enrollment provision that states maintain coverage through the end of the month in which the public health emergency ends. We do recognize that the end of the public health emergency at the federal level may not necessarily align with the end of a state's public health emergency, but the timelines in this letter are tied to the federal public health emergency.

Ashley Setala: Great, thanks Shannon. So the next question then is if a renewal form is sent to an individual during the PHE that requires the individual to provide additional documentation and the individual fails to respond, the state is not permitted to terminate eligibility. Is the state then allowed to send out another renewal to this individual once the PHE is over, if there has been less than 12 months between the time the packets were sent out?

Shannon Lovejoy: This is Shannon again. States can send out the packet again. And as we just walked through towards the end of this discussion, there are steps that states would need to take in order to avoid having to resend that information out. So for some individuals, states will have no choice even if they wanted to avoid repeating the redetermination process. There'll be some circumstances where the

state has to go through the renewal process again, or the redetermination process, which might include sending a new renewal form. But certainly if the state is wanting to work through renewals and start the process over again, they can do so. In some cases, they must do so.

Barbara Richards: Great. Thanks, Shannon. We have another question for our colleagues in CAHPG. CMS's expectations that states process more than a year's worth of eligibility determinations in either four months for six months, may be difficult for many states to accomplish, especially for those states working with legacy systems or those implementing new systems. Are there penalties if states can't comply with the recommended timeframes? First question, and then will CMS offer any waivers as was done under the ACA, if they need more flexibility to be compliant?

Jessica Stephens: This is Jessica Stephens. I'll take that one. So the expectation is that states that are unable to meet the timelines that are outlined in the SHO will be expected to provide a plan and timeline. And we would likely request corrective action from those states. I think we recognize that some of these timelines are ambitious, which really underscores the importance of states being able to begin the work now and do a lot of the planning that we're talking about at the moment. And why we're available for technical assistance to help states meet the timelines that we have in place.

Jessica Stephens: That said, of course, we recognize that as states continue to think about this, they'll have additional questions. And our goal is to be able to connect states with each other to figure out what the challenges are and where there are additional flexibilities, if appropriate, to provide. But at this point, I'm not sure what specific ACA related waivers you're thinking about, but there are a number of existing flexibilities available to states that we're happy to explore with individual states right now.

Ashley Setala: Great. Thanks, Jessica. The next question then is to clarify the timeframes listed, i.e. six months, post-PHE. Does that mean the states may still get the temporary enhanced FMAP through the six months post-PHE?

Sarah deLone: Jess, maybe I can jump in. So the increased FMAP, the 6.2 percentage point increased FMAP has four conditions. It's really not tied per se to this unwinding period. One of them is the continuous enrollment requirement. And that, as Shannon said, is the reason why this catch up on these eligibility actions is told from the end of the month in which the PHE ends, because that's the end of the continuous enrollment requirement. At 6008(b)(3) of the FFCRA for states that are claiming the 6.2 percentage point FMAP increase.

Sarah deLone: The other three conditions all must be met. They all last, and they relate to premiums, coverage and cost sharing, exemption for COVID testing, treatment services and the maintenance of effort of, no more restrictive eligibility standards, methodologies, procedures. Those are 6008(b) 1, 2, and 4. Those conditions all go through the end of the quarter in which the PHE ends. And that

I believe, and FMG, please jump in, correct me if I'm wrong. That is also when the 6.2 percentage point FMAP increase under FFCRA expires. So hopefully that answers the question.

Barbara Richards: Great, thanks Sarah. We have another question for our colleagues in CAHPG. By the time the PHE ends, everyone will need to complete a renewal. Can states skip the change of circumstance processing and just complete a renewal?

Shannon Lovejoy: This is Shannon. So the SHO does outline some different ways that states can align their work and really focuses on when to prioritize or deprioritize certain work. So for an individual who has a renewal that is due during the six month period of time that states are expected to work through any of their pending actions and resume routine operations. As long as the renewal is due within that six month period of time, the state can wait to process any changes in circumstances when they're doing that renewal. If the renewal was due beyond the six month window, obviously waiting until the renewal would not line up with the timeframes that states are provided to catch up. And in that case, a state would need to work through the changes in circumstances.

Ashley Setala: Okay. Thanks, Shannon. The next question is please explain how CMS defines pending for application. States changed rules in March 2020 to accept attestation of eligibility factors for applications. Are states now supposed to go through all of the applications from the past 10 months and verify both non-financial and financial factors?

Jessica Stephens: This is Jessica. I'll start with this one and allow Michelle to add if there's anything. I think this is in reference likely to a state that has taken up the option for post-enrollment verification during the public health emergency. And they want to distinguish the work that might be required to do that from the work that would be potentially required to process an application. If a state has taken up that option to enroll based on self-attestation and verify post-enrollment, consistent with requirements.

Jessica Stephens: For example, for income, the state would still need to do the post enrollment verification, so check data sources, reach out as needed, all after enrollment. Much of that work can be done during the public health emergency, especially the checking of the data sources. In that situation though, that application, or at that point, that beneficiary would not be considered to have a pending application because the state would have determined eligibility based on self-attested information. A pending application would be an application that the state has not processed, meaning that the individual has not been provided with a determination of eligibility or ineligibility.

Jessica Stephens: There are cases where state enroll an individual based on certain self-attested information where allowed under statute and regulations. For example, states that have taken up the option to enroll an individual based on self-attested residency. In those cases, there's no additional work to be done. The states have completed the eligibility determination based on that information and other data sources as

appropriate. That application would be considered to be complete, but Michelle, anything to add to that?

Michelle Wojcicki: Just to say that in previous COVID-19 FAQ's we've published, there's a series on verification where we provide some additional details regarding post enrollment verification and, as Jessica mentioned, note which area that a state may choose to use self-attested information and in what areas an individual needs to check data sources, particularly financial data sources that the state determines useful. We are also available to work with the state. I know that enrollment verification is new for many states, and so we're able to work through particular questions you may have as you look to implement the temporary options you've elected under your addendum.

Barbara Richards: Thanks, Jessica and Michelle. We have another question also for our colleagues in Children and Adults Health Programs (CAHPG). For closures after the PHE and the flexibility to disenroll ineligible members without a second request, can you review how to count out the six months? To close a person whom the state has previously reached out to in the six months prior is it closure within six months from when the agency last sent their request or notice? I'm happy to repeat that, too.

Shannon Lovejoy: Yes. I think I got the question. This is Shannon again. I'm just going back to the slide. It depends a little bit on whether the individual was determined ineligible or if they fail to respond. It is a within six months period of time and within six months from when the state would be able to terminate their coverage. For individuals who are determined ineligible, it is within six months that the redetermination of ineligibility needed to occur within six months of when an individual would be able to be terminated if the state were to move forward and act on it.

Shannon Lovejoy: For an individual who fails to respond to a request for information, it's six months from when the form was sent. Hopefully that helps clarify that for that individual. I can walk through real quickly. The form one might be the trickiest, so for the example that we walked through with Amelia's renewal form, her renewal was due in February, but her form was sent in January. As long as the state was within six months of that January date then they can move to send the advanced notice of termination. In example for May, the state could actually move to terminate coverage in May. While providing the required minimum 10 days advanced notice, the state can move forward with Amelia's case without repeating her renewal, but if, for example, the state was delayed until August, in this example, then the state would have to repeat the renewal.

Jackie Glaze: Thank you, Shannon. Let's check the phone lines at this point to see if we have any calls. Operator, can you begin queuing up the phone calls and we'll see if we have any there?

Operator: There are no questions at this time, but as a reminder to register a question, please press the one four on your telephone.

- Jackie Glaze: Okay. As we're waiting, I'll turn it back to you, Barb and Ashley, if you want to ask another question.
- Ashley Setala: Sure. We've got a question for CAHPG, but not on the SHO content today. It is related to the recent legislation that was passed. It says, I received a comment today from an advocate that the Consolidated Appropriations Act of 2021 extends the moratorium on terminating Medicaid through December 31st, 2021. Is this true?
- Sarah deLone: I think we'll have to take back. I don't want to say definitively no, but I think we need to take that back. We'll just leave that as an unanswered and we will loop back next week with an answer to the question.
- Barbara Richards: Thanks, Sarah. We also have another question for CAHPG, non-unwinding SHO letter. Will the supplemental unemployment payments (\$300 per week), will that be treated the same way as the original FPUC from the CARES Act?" Sarah Specter, are you on?
- Sarah Specter: I am on, but this is Sarah. I don't know that I have that right at the tip of my tongue. I think we are working on making sure that we nail that answer. It is very much at the very top of our minds as well and I've been planning to do a response to make sure we get that out to states very promptly.
- Sarah deLone: I think we can say very generally that there's several sort of types of assistance that were previously included in the CARES Act that has been extended. Generally the same treatment of those sources of income with respect to either MAGI, non-MAGI individuals that was the case, which is reflected in our FAQ's for the original legislation, continue to apply. There's a new source of funding and a new type of assistance that's available. With that we need to nail down and confirm the guidance on. What our plan is, to just be very clear, what's your extensions of the previous legislation that was available with the CARES Act in which is new and what applies. But high level, the previous types of assistance that have been extended with this legislation are treated the same way.
- Jackie Glaze: Let's check the phone line. Do we have calls at this point?
- Operator: We do have a question from Pat Curtis. Please proceed.
- Pat Curtis: Yes, this is Pat Curtis for Illinois, and I have two questions. The first relates to the redetermination issue and I'm trying to sort out in my mind the issue of within six months of the end of the PHE and after, but the intent here is to maintain as much as possible the initial redetermination date for that particular person. Is that fair? I mean, that's one of the other things we have to look at. Can you speak to that? Can you speak to the guidance for when the state changes the redetermination date for a client and when we maintain it as the same date pre-PHE? That was my first question.

- Pat Curtis: The second question is really, I think, for Jessica and that's on the chart on the SHO letter. I don't see a listing for concurrence, the emails that states send. They weren't a part of the waiver. It wasn't a disaster SPA. It wasn't the verification plan. They just sent emails for changes. Is there an end date for those concurrence requests? That's my two-part question.
- Jessica Stephens: Thanks, Pat. I'm going to attempt to the answer both, but my colleagues will chime in here with more detail, especially on the first question.
- Pat Curtis: Sure.
- Jessica Stephens: The first question about the intent is not necessarily to have states keep the same initial renewal dates. In fact, I think, in some cases it may not be possible, well, depending on how states are conducting renewals at this moment. We do outline in the SHO a few options to help states ensure that after the work that is done, after the end of the public health emergency, you don't end up with, I'm going to say, gluts of renewals in any given month to help space out the renewal periods, the eligibility periods and renewal dates for beneficiaries. Even though you may be conducting all of the renewals within the six month period, there is some flexibility and more to come on how to ensure that that doesn't create significant peaks and valleys in the volume of renewals to be conducted. I'm going to pause for a second to see if that answered your first question.
- Pat Curtis: It does. I'm sure other people...I'm trying to sort it out in my head as to how we can best ensure that we don't cluster these reviews into one big bump, like in a couple months of the year. I just think we have to think through that question, but thank you, Jessica. I think you gave us some guidance. Thank you.
- Jessica Stephens: Sure. I think it's one of the areas where we plan to and expect to be able to spend a good amount of time working with states individually and more broadly on some options available to states there.
- Pat Curtis: Okay.
- Jessica Stephens: With respect to the concurrences, I think it depends a little bit on the state. We issued concurrences to a number of states, and for Illinois, I don't have that in front of me, but I think for most of the items they were linked to the end of the public health emergency, which has not occurred, but I would note that even with the concurrences that we provided that recognize the challenges that states were facing at the time that we issued the concurrences, really, we strongly recommend that they do all that is possible to do right now to reduce the amount of work that needs to be done later.
- Jackie Glaze: Thank you, Jessica. I want to thank everyone for the questions today and thank all of our presenters for the excellent presentations and the information they've shared with us. Looking forward, we will meet with you all again next Tuesday, January the 26th. CDC staff will be with us to discuss the vaccines. If you do have questions in advance of our conversation with CDC next week, you can

submit your questions to medicaidcovid19@cms.hhs.gov. Again, that's Medicaidcovid19@cms.hhs.gov. Please submit those questions by the end of the day, this Thursday, January the 21st. Of course, if you have any questions before the next call, please reach out to us, your state leads, or bring the questions next week. Thank you again for joining us today and hope everyone has a good afternoon. Thank you.

Operator:

That does conclude the webinar for today. We thank you for your participation and ask that you please disconnect your line. Have a great day, everyone.