Centers for Medicare & Medicaid Services
Medicaid and CHIP All State Call
November 30, 2021

3:00 pm ET

Coordinator: And thank you for standing by. All participants are in listen-only mode until the question-and-answer session of today's conference. To ask the question at that time please press Star 1, unmute your phone and record your name. Today's conference is also being recorded. If you disagree you may disconnect at this time. It is now my pleasure to turn the call over to your host, Miss Jackie Glaze. Thank you, and you may begin.

Jackie Glaze: Good afternoon and welcome everyone to today's All State Call and Webinar. I'll now turn to Anne Marie Costello, our Deputy Center Director, and she will provide opening remarks. Anne Marie?

Anne Marie Costello: Thanks Jackie and hi everyone. We have a couple of topics to cover on today's call. First up Shannon Lovejoy from our Children and Adults Health Programs Group will provide an overview of the new tools released last week which will help states consider and adopt strategies to maintain continuity of coverage for eligible individuals once the 12 month COVID-19 unwinding period begins.

We refer to this tool as the punch list. And our punch list includes operational and policy strategies that states may adopt in several areas.

After Shannon's presentation Jessica Stephens from Our Children Adult Health Programs Group and John Giles from our Disabled and Elderly Health Programs Group will provide an overview of key strategies states may use to engage managed care plans to prepare for a return to regular eligibility and enrollment operations.

States have requested guidance on how they can work with the managed care partners to support and widen efforts including receiving updated contact information from the plans. We hope today's presentation answers many of the questions states have raised.

After this presentation we'll open the lines for your questions. We'll use the Webinar for both presentations today. So if you're not logged into the Webinar platform I suggest you do so now.

Before we jump into today's presentation I wanted to provide a couple of announcements. First, on Tuesday November 23 CMS released two items providing information on SPA and 1915 waiver processing.

First, via a Medicaid update email CMCS distributed and updated CMS 179 Form to be used for all Medicaid and CHIP SPAs submitted on or after December 1, 2021. The changes to the form itself are minor and really recognize the recent CMS reorganization.

However, it does include more details and specific instructions for the Forms CMS 179. We hope this will make it easier for states to accurately complete the 179 Form.

Also last Tuesday we released a CMCS informational bulletin setting up a new submission process for all Medicaid state plan amendments and CHIP SPAs and 1915 waivers that are not already submitted to an electronic platform.

Effective February 1, 2022 these actions currently submitted via email by states will be submitted through an online submission portal. This will help

ensure that they are received and processed by CMS in a timely manner. We'll provide additional details on the 179 Form and submission portal in an upcoming call.

Second, as we are fast approaching the end of the year we'd like to remind states about submitting a state plan amendment to comply with the newly added provider and driver transportation requirements made by Section 209 of the Consolidated Appropriations Act. The effective date of the SPA should be on or before December 27, 2021 and would need to be submitted by December 31 2021.

For more information on this SPA please refer to the informational bulletin Medicaid coverage of certain medical transportation under the Consolidated Appropriations Act of 2021 which we issued on July 12 earlier this year or contact your state leads.

With that I'll turn things over to Shannon to start her presentation. Shannon?

Shannon Lovejoy: Thank you Anne Marie. Hi everyone. We are thrilled to be able to talk to you today about how to improve continuity of coverage for eligible individuals and share a number of the strategies that we've included in this new tool that was released last week.

We know that states are going to have an unprecedented amount of work to address once states begin their unwinding period and begin to restore routine operations. And we've been working very closely with states and other stakeholders to ensure that, you know, states are completing renewals of eligibility, that they're doing so in a way that, you know, promotes continuity of coverage for eligible individuals as well as ensures that those individuals who become eligible for other programs are able to smoothly transition over.

And as part of this we have been encouraging states to review their processes and determine which strategies might be best to adopt to address some of the areas of risk that a state may have in order to maintain continuity of coverage as well as, you know, strategies that could create administrative efficiencies for states.

And of course with this we've also encouraged states to look at the authorities that they've adopted during the public health emergency and determine what should be maintained during the unwinding period. And states should take steps as soon as possible, including now, to submit state plan amendments, update verification plans or even just modify internal documents and policies to make sure that they're taking advantage of these strategies and that they have a plan in place once they begin their unwinding period.

Next slide please. So with that last week we released what, you know, Anne Marie mentioned we call the punch list but officially the document is called Strategies States and US Territory can adopt to maintain coverage of eligible individuals as they return to normal operations. And really what this tool is is a comprehensive list of a variety of strategies that states can adopt to really ensure continuity of coverage, streamline their operations and return to normal operations in an orderly manner.

While we view that these strategies are very critical at this point in time as states begin their unwinding period we do want to note that many of these are strategies that states can adopt at any point in time and are not related only in the context of the public health emergency.

Next slide please. And so the strategies that are listed in this tool are really broken out into seven key areas strengthening renewal processes, updating

mailing addresses to minimize returned mail, improving consumer outreach, communication and assistance, promoting seamless coverage transition, improving coverage retention, addressing potential strains on the eligibility and enrollment workforce and enhancing oversight of eligibility and enrollment operations.

And then within each of these key areas the punch list is really designed as a checklist of strategies so states can go through and see what maybe they've already adopted in other strategies that might be helpful to address risk in these key areas.

And we know that we've provided states with a lot of strategies in this tool and so you will find that once you go into the document you will see that some of these strategies are stared. And these are strategies that we've highlighted for states that might provide the most, you know, bang for your buck and maybe the most efficient to adopt if you're not able to, you know, take up every strategy on the list.

And for the rest of the presentation I'm going to walk through different examples of the strategies in each of these key areas. So I wanted mention that really, you know, this deck only covers a snapshot of the strategies that are listed in the tool and the tool has a much larger comprehensive list of strategies that states can refer to.

Next slide please. So the first key area that's the punch list addresses is related to strengthening the renewal process. You know, we know that even before the public health emergency many individuals lose coverage at renewal in large part to procedural and administrative reasons.

And it's more important than ever that states really look at strategies that allow renewals to be completed preferably on a, you know, ex parte basis if possible or based on the available information. And that states are able to really facilitate the ability for individuals to provide information when it's needed to complete the renewal process.

So we know that increasing the ex parte renewal rates is especially important because the more individuals whose eligibility can be renewed based on available information, you know, means that not only are states able to maintain coverage for eligible individuals but it limits the amount of requests for information that go out to individuals and limits the number of procedural denials the state may have but it also reduces the amount of work that a state may have to do later to process additional information.

So some strategies that states can take to improve their parte rates include things such as expanding the number and types of data sources that are used at renewal or doing things such as, you know, looking at your verification policies and assessing adjusting perhaps your reasonable compatibility threshold for income and really looking at how, you know, data is being used during the ex parte process.

Of course we know that not every individual can be renewed based off of available information. And so this is really a great opportunity for states to, you know, not only look at strategies but really look to make sure that their renewal processes are consistent with federal requirements.

And so this includes ensuring that individuals can submit their renewal forms and any requested information through old modalities so phone, mail, online and in person as well as making sure that renewal forms are pre-populated for individuals enrolled in a MAGI basis. And of course states can also, you

know, adopt that option for non-MAGI individuals and pre-populate renewal forms to minimize beneficiary burden for that population as well.

Next slide please . So the next key theme in the tool is related to strategy states can take to update mailing addresses and ultimately minimize returned mail in order to promote continuity of coverage. You know, the public health emergency has, you know, interrupted I think routine communications that states have had with their beneficiaries and so as a result states may have a lot of outdated contact information for their enrollees and this could lead to an increase in returned mail or a general lack of response as states are completing renewals during the unwinding period.

And so states can adopt a number of ways to just prevent returned mail from ever coming in to make sure that they're taking a variety of approaches to help get updated contact information. So states can adopt strategies such as engaging community based organizations, or application assisters and providers to help conduct outreach and remind beneficiaries to provide updated contact information.

States can also, you know, rely on a variety of modalities to communicate with individuals to send reminders to update contact information. And of course one of the key things is to make sure that individuals when they do need to submit updated contact information are able to do so through a variety of modalities that best meets their needs so including mail, telephone and online.

Next slide please. The next key area of the tool relates to improving consumer outreach, communication and assistance. You know, even if the state takes a number of strategies to streamline the renewal process and has updated contact information they may still not get the response that they need if the

communications really aren't in, you know, simple language and, you know, accessible to individuals.

And there is a ton of strategies that states can take to address the different types of outreach and communication provided to individuals to make sure that they can get better responses from beneficiaries. So this can include things such as improving eligibility notices by really reviewing the notices that you're sending and making sure that communication is updated to include plain language and that important key eligibility information is clearly explained in your notices such as information on the appeals process.

States can also engage in pretty intensive outreach during this period and using multiple modalities to remind individuals of any changes that may be occurring in their coverage or about any requirements or needed information to complete the renewal process to help individuals maintain their coverage. And of course communications must be accessible to individuals who have limited English proficiency or living with disabilities.

And so states should really make sure that they have key documents in a variety of formats for individuals, you know, making sure that there's translations of these documents into multiple languages or that states have provided oral interpretation for some individuals. And then states can also make sure that, you know, especially for individuals living with disabilities that they have a variety of formats for this information such as making sure that written materials are in large print or braille, or making sure that there's access to things such as sign language interpretation.

Next slide please. So we know that with the number of people that have been enrolled that some individual circumstances have changed and not everyone will still remain eligible for Medicaid or CHIP after the public health

emergency ends but many individuals will be eligible for other forms of coverage and will need to make a seamless transition to the new coverage program. And there are a number of strategies that states can really take to facilitate this seamless coverage transition.

So not only should states, you know, adopt strategies to make sure that accounts are seamlessly transferred over to the marketplace but that when they're sending these account transfers over that they're obtaining and including robust contact information. You know, this would also help facilitate additional outreach from the marketplace so that they can also easily reach these individuals post-transition. And of course states can also look at their notices to ensure that they're explaining to individuals the account transfer process and some basic information about applying for enrolling for example on a qualified health plan coverage with financial assistance.

Next slide please. And so there - we've talked a little bit about, you know, some different, you know, operational type strategies but there are a number of, you know, policy strategies that states can take to resume normal operations that are really some of the standard options that states have had that really improve coverage retention. And these are strategies that states can look to adopt on a temporary basis during the unwinding period or really adopt in the long term to improve overall coverage retention rates in their programs.

And so these strategies include things such as adopting 12 months continuous eligibility which for children can be done through a state plan amendment, you know, for adults that can be done through 1115 authority. States can also look to provide 12 months of postpartum coverage which is a new state plan option that will be available to states beginning of April 2022.

And states can also take other, you know, steps to make changes to how they, you know, for example conduct periodic data matching to really promote continuity of coverage and help streamline workflow during the unwinding period. States can also, you know, leverage managed care plans. And the next presentation will really go into more discussion on how states can better work with managed care plans that will cover many of the strategies that are discussed in the punch list as well.

Next slide please. So states also can take a number of strategies to address eligibility and enrollment workforce issues. So even if the process is streamlined for individuals we recognize that states still have an unprecedented amount of work that will need to be completed during the unwinding period and this amount of work is really going to place a heavy burden on your existing workforce.

And so there's strategies that states can take to really just manage the workflow and capacity. So this could include redistributing work across state, regional or county staff.

States that also have eligibility enrollment process in multiple offices can really look at an overflow workforce strategy such that if one office is, you know, maybe getting overwhelmed with an influx of work they can figure out how to transfer some of that work to a centralized unit or another office that has available capacity to help address some of the workflow.

And of course it's also important to provide training and guidance to states. You know, we've heard from a number of states already that, you know, some of them have pretty new eligibility enrollment workforce who really have not had a lot of experience processing the full renewal process that includes

terminating coverage for ineligible individuals and so training and guidance will be needed.

But training and guidance will also be needed even if you have a very well seasoned workforce especially if you're looking to adopt many of these strategies that we've talked about today or changing other policies because the staff will need to be updated on these changes in order to actually effectively implement the strategies that you're putting in place. And of course that also includes updating any eligibility and enrollment manuals or other resources that your workforce relies on.

Next slide please. And the last key area that's addressed in the tool is related to the oversight of eligibility and enrollment operations. So even if you're putting in strategies to really streamline the renewal process, and streamline your workflow and address your enrollment or your workforce capacity, you know, in a robust oversight of the actions that are being taken will help states course correct as well as identify emerging issues.

And so some of the strategies states can take to improve their oversight is to, you know, develop a centralized team that tracks emerging issues and identifies needed solutions. States can also take strategies to, you know, put into place different tracking and management tools or reports especially given, you know, the increased amount of workflow there could be some new resources that states can develop to help keep track of the work and make sure that the state is addressing any issues to prevent inappropriate coverage losses.

So with that, we really hope that you all are able to use this resource and really get a sense of all the different strategies that you can take to help promote continuity of coverage. I will now turn it back over to Jackie for our next presentation.

Jackie Glaze: Thank you Shannon. Next, Jessica Stephens and John Giles will discuss the strategies that states may use to engage the managed care plans with returning to normal operations. So I'll turn it now to you, Jessica.

Jessica Stephens: Thanks Jackie. And John and I really are excited to share with you some of the work that we've been thinking about, about the role of managed care organizations and the role that they can play and the work that states are thinking about with respect to unwinding.

As Shannon mentioned states will have a lot of work to do when they - as they return to normal operations and particularly around renewals. And the work that states can do to collaborate with managed care organizations is one of several tools, like those in the punch list, that states can employ to prevent losses in coverage.

Next slide please. So as we've talked about it may be - it may have been a long time since some states have conducted renewals for certain individuals. And that means a number of things including potentially missing contact information along with additional work that states will need to do to ensure that as they complete renewals and redeterminations when they return to normal operations that they prevent inappropriate coverage lass.

Additionally, there may be confusion on the part of individuals about what they need to do about next steps and the timelines to take specific actions including completing renewal forms or transitioning to other coverage in the event that they are ineligible for Medicaid or CHIP. And close collaboration between states and managed care plans really is one of the key ways in which states can promote continuity of coverage.

And I think this is a good follow-up to the discussion that we just had about the punch list because the strategies that we'll be talking about in more detail in just a moment really cut across many of the areas in the punch list and are actually included in the punch list. Specifically managed care plans can support states to promote continuity of coverage by helping individuals complete the renewal process, minimize churning due to losses in coverage for procedural or administrative reasons. And thirdly, facilitating transition from Medicaid or CHIP to the marketplace where appropriate.

I think it's important to note though that, you know, we've laid out these strategies as permissible and consistent with federal policies but as states look to potentially implement some of these you should consider whether there are any state specific laws or contract provisions that either present barriers or that may need modification in order to implement.

Next slide please. There are four specific strategies that we want to highlight as part of this presentation on the role of managed care plans. First, is partnering with plans to obtain and update contact information which we know is something that many states are thinking about.

Second, which we know some states are already doing, involve sharing renewal files with plans so that the plans can help conduct outreach and provide support to individuals. Third, is enabling plans to conduct outreach to individuals who've recently lost coverage for procedural reasons so for not responding to requests for documentation, for example.

And the last is permitting plans to assist individuals to transition and enroll in marketplace coverage if they're ineligible for Medicaid and CHIP. I'll briefly talk about the first two and then pass it over to John.

Next slide please. So the first one again has to do with partnering with plans to update contact information. And as we mentioned there's very - a likelihood that many individuals may have moved or that they may have updated contact information that will be needed for states to ensure that they complete the - that they're able to complete the renewal process for individuals.

States can accept for managed plans updated enrollee contact information that includes mailing addresses, phone numbers, email addresses. And that Medicaid and CHIP agencies may treat the information as reliable and update the beneficiary record with new contact information from the health plan.

So there are a number of considerations. First, is that we understand that health plans may receive updated contact information from a number of different places.

States should ensure that in receiving information from managed care plans that they only receive information that is received either directly to the plan from the - and provided by, sorry, directly provided to the plan by the individual and not a third party or other source. That may include information directly provided to the plan or that the plan has verified with the individual prior to passing it along to the Medicaid agency.

Secondly, in terms of process, when updated information is received from the managed care plans states would still need to send a notice to the address on file and provide the individual with an opportunity to respond and verify the accuracy of the new contact information. So if an individual responded for example and said, "No I actually haven't moved the state should use that information."

Next slide please. States are also encouraged to contact the beneficiaries through other modalities that Shannon talked about recognizing that those may be modalities that an individual may be more likely to respond such as by phone, electronic notice, email, text message. And to the extent that a state is able to send information to the new address as well as the address on file we encourage states to do that.

What is important to note though is that if a beneficiary does not respond to verify the accuracy of the contact information received by the plan from the individual the state has the ability to accept that information as the updated address for example in the beneficiary record. So again the state needs to reach out to the individual to give an opportunity to dispute the accuracy but if an individual does not respond the state has the ability to accept that as the updated information.

It's important to note though recognizing that there are no states with integrated eligibility systems that there are implications for individuals who are enrolled in both Medicaid and SNAP for example because first if they are within the same agency or they're co-located SNAP can accept Medicaid updated address without further verification.

We know this is an area where states have had questions but in those scenarios if the address is updated for Medicaid, in the way that I just described, it can be updated for SNAP as long as it's not unclear or questionable which, you know, are SNAP specific terms.

But it's also important to note as you work with colleagues in the SNAP side in the state that there are implications for individuals who are enrolled in both programs as well because the state, after updating the address, will need to

collect information from the individual to recalculate benefits and solicit updated shelters - shelter costs and those affect the person's SNAP eligibility.

Next slide please. Strategy two is a strategy that we know a number of states have already implemented and were doing prior to the public health emergency. And that is to have states provide monthly or regular files to plans for beneficiaries who are coming up for the renewal process.

And it's a process that states can also use not only when individuals are beginning the renewal process but specifically through the subset of individuals who have yet to submit the renewal form or additional information and may otherwise lose coverage.

Specifically when working on this process where a state has it implemented already it would be important to just identify where there are system or operational challenges that you might need to think through including sending the information over to the plan. And also working with plans to ensure that they are able to use additional modalities such as phone, text, whatever innovative approaches to contact - to conduct outreach to beneficiaries and help them complete the renewal process.

Next slide please. Certainly there will be individuals who are found to be ineligible of lose coverage for procedural reasons and strategy three and four address those. John, can I pass to you?

John Giles: Yes, thank you Jessica. So under strategy three the approach would be that states would provide their managed care plans with a monthly termination file to enable plans to conduct outreach to individuals who have been terminated from Medicaid for procedural reasons, as an example for not returning their renewal form timely.

And under this particular strategy there are a number of considerations for states to think about. Once terminated a consumer is not considered a plan member. And the Federal Marketing Regulations may apply in that instance.

As you already know under the marketing rule managed care plans generally cannot seek to influence enrollment in conjunction with the sell or offering of any private insurance, and that does exclude qualified health plans. And managed care plans cannot generally directly or indirectly engage in door to door, telephone, email, texting or other cold call marketing activities. And those requirements can be found at 42 CFR 438.104 as referenced here on this slide.

However, we do think that general outreach that is performed by a managed care plan on behalf of a state would not necessarily be considered marketing under the federal rules. And we think that states and managed care plans could carefully balance this strategy with marketing requirements by examining any state specific laws or contract requirements.

Now under this particular strategy we think it would be important for states to think about how they may need to expedite the review of outreach messaging that can be used by managed care plans for this particular purpose or another thing that we think states could think through is maybe using standardized messaging that could be used across their managed care plans for this purpose.

Next slide please. So under strategy four this is really about transitioning individuals to marketplace coverage when you know that Medicaid eligibility can't be retained. So under this approach states would utilize their managed care plans but also offer a qualified health plan to share information with

those enrollees who are determined ineligible for Medicaid and could assist in the transfer of those individuals to marketplace coverage.

So a couple of considerations on this slide. Medicaid managed care regulations do not prohibit a managed care plan from providing information related to a QHP to enrollees who could potentially enroll in that QHP due to a loss of eligibility or to potential enrollees who may consider the benefits of selecting the managed care plan that has a related qualified health plan in the event of future eligibility changes.

This was actually an intentional policy change that we made in the managed care regulations in 2016 as part of the Medicaid Managed Care Rules. And again is codified in that marketing section.

There are no regulation governing insurers who offer qualified health plans through exchanges that prohibit this type of outreach. Managed care plans providing information about the Qualified Health Plan, including helping them to enroll in that Qualified Health Plan, is not considered marketing. As long as states permit managed care plans to provide the Qualified Health Plan information it is not necessarily limited to only those who are terminated.

Managed care plans may reach out to individuals before they lose Medicaid or CHIP coverage to allow them to apply for marketplace coverage in advance and to avoid any gaps in coverage. So, for example, someone whose Medicaid coverage will end at the end of July and is notified before that date could apply, attest to the coverage loss and have marketplace coverage starting August 1 to avoid any gaps in that individuals coverage.

Again, just as many of these strategies, and as Jessica mentioned several times also in her part of the presentation, states and managed care plans will need to

carefully review their contracts to ensure clarity on these issues and to consider whether any state specific laws or contract requirements would prevent any of these strategies. And I think with that I believe I am turning back to Jackie Glaze to facilitate questions.

Jackie Glaze: Thank you. Thank you, John and thank you Jessica. As John indicated we're ready to take your questions now so we'll begin by using the chat function so you can begin submitting your questions now. And then we'll follow by taking questions over the phone.

So I'll turn now to you (Ashley) because I do see a few questions already.

Ashley Setala: Thanks Jackie. Yes, and our first question says, "Things like adding additional or electronic data sources or altering reasonable compatibility rules can be a time consuming process from development to testing. Have there been any updates to timelines regarding the end of the PHE to see if putting these changes in before the end of the PHE is viable from a timeline perspective?"

Jessica Stephens: This is Jessica. I will - and I'll invite others to respond as well. Unfortunately we do not have any updates on the end of the PHE except the latest extension through, I believe it was mid-January, but others can correct me.

And we're also aware of potential changes that I know states are considering around legislative changes with respect to the state's processes for unwinding. If any state though, you know, interested in considering one of these options and is concerned about timing we're certainly happy to have a conversation about ways to potentially implement or other strategies that you might consider in the event that you're unable to make systems or other operational changes in the timeframe in which you're seeking to do so.

Ashley Setala: Okay, thanks Jessica. The next question says, "Has CMS provided guidance or communication regarding a permanent disregard for certain PHE payments? If so is there a list of PHE payments that CMS is disregarding as income or resource permanently? This could change or eliminate a states need for a SPA to disregard PHE stimulus payments?"

Sarah DeLone: So this Sarah DeLone and I'll jump in. I don't know if other colleagues from the Division of Medicaid Eligibility Policy are in.

I mean CMS doesn't per se have the authority to sort of disregard different, you know, PHE related payments. But they're certainly with each of the, you know, the stimulus payments, unemployment bump there's from the different sources of funding.

There was, you know, there is under federal law there sort of is the handling of those. So maybe if there is, I don't think we have pulled together in one resource location sort of all the different payments but we could take that back and see if that's something we think we could pull together easily to provide you.

Alternatively also suggest that you reach out through your state lead if there's specific types of payments that you're having a - that you have a question about. But to the extent to which a given payment is not, you know, is counted either under the, you know, the SSI rules for disabled for certain non-MAGI populations or is taxable for purposes of, you know, your MAGI related groups.

It's not something that CMS would have the ability to say, you know, across the board don't have that income. You could obviously adopt to disregard yourself for an SSI related group.

Ashley Setala: Okay, thanks Sarah. The next question says, "After the emergency period ends are states able to react to reported changes without first sending the member of pre-populated renewal form? Our state checks all available electronic data sources prior to sending the member a pre-term notice that is not pre-populated to redetermine eligibility for individuals who are ineligible for their current category of coverage based on a reported change."

Shannon Lovejoy: Hi. This is Shannon. So even now when an individual is due for renewal or if a state had an individual who a renewal could not be completed during the public health emergency is picking the case back up.

The individual, you know, will need to have another renewal completed. And when the state's doing a full renewal, you know, they must check available data sources to first try to see if they can renew eligibility on an ex parte basis and if at that point they can't, you know, the renewal form must be pre-populated for MAGI beneficiaries. And there are not exceptions to that.

You know, of course if there's an individual who's in the middle of their eligibility period a state can request information, you know, based off of an identified change in circumstance. But that's only for those types of redeterminations for an individual who's within their 12 month eligibility period.

Ashley Setala: Okay, thank you Shannon. The next question says, "Is the same process as the one outlined for managed care allowed for returned mail with forwarding addresses provided by USPS?"

Shannon Lovejoy: No, not at this moment. I'll note that we are - that the policy that we've just - the policy or process that we just laid out is specific to managed care plans for

the moment. Though we understand that this is a question that a number of states do have and we are exploring with colleagues to determine whether there might be additional flexibility with that example but for now, no.

Ashley Setala: Okay. then we have a question for our Disabled and Elderly Health Programs Group colleagues around Section 9817. And it says, "A question related to the guidance discussed on the November 23 call regarding ARP Section 9817 and MOE. Does CMS consider a change in the modality of the service to be a violation of MOE? For example, if an eligibility assessment or service were temporarily permitted to be provided remotely is a state MOE at risk if they end the remote delivery of assessments or services?"

Ralph Lollar: This is (Ralph). And I can take that if you'd like (Alissa)?

Ashley Setala: Sure, thanks (Ralph).

Ralph Lollar: The change in modality, as long as the service is delivered, generally is not a violation of MOE. If the modality required a different or abbreviated format for the assessment tool or form of an assessment tool that may create problems for this state.

If individuals are going from, for instance, remote assessment to full in person assessment and the in person assessment uses a different assessment tool there may be concerns. Absent that same assessment tool delivered in person versus delivered remotely there should not be a conflict or a problem with the MOE.

Ashley Setala: Okay, thanks Ralph. Then the next question says. "If a beneficiary reports their address or phone number change directly to the MCO and the information is shared with the agency why are states still required to send out another notice to confirm the information change? Our system is designed to

capture the updated address and send communications to that address. If the notice must be sent to the old address staff will need to manually send the notice which can be administratively burdensome."

Jessica Stephens: Yes. And that policy comes from the requirement and regulations that information that is received from a third party, which in this case also is from, you know, a managed care organization, must - that an individual must have the opportunity to respond and verify the accuracy or dispute the accuracy of the information prior to the state accepting it. I think where this policy provides additional flexibility that does not - it does not currently exist, for example in the USPS case that we just talked about, is that if an individual does not respond the state would have the ability to consider that as verified.

With respect to the question about how the state system is currently programmed I think that is something that we might be able to work with the state on in a follow-up conversation if you wouldn't mind reaching out and can figure out a way so that you're able to continue using this strategy perhaps in not as manual of fashion.

Jackie Glaze: Thank you Jessica. Operator, we're ready to transition to the phone lines. Would you please provide instructions and then open up the phone lines please?

Coordinator: Thank you. If you'd like to ask a question over the phone please press Star 1. Please ensure your phone in unmuted and record your name to ask a question. Again, that is Star 1 to ask your question. If you need to withdraw Star 2. One moment while we wait for any questions to come in. Our first question comes from (Danielle). You may go ahead.

(Danielle): Hi everyone. This is (Danielle) from DC. Question about the use of updating addresses from our managed care plan. Do we have to add language in our verification plan stating that we're using this approach or is there any type of tool that you are looking for states to complete so for future your auditing purposes that it's archived in terms of the strategies that we're planning to implement?

Jessica Stephens: So, hi (Danielle). For this particular strategy no. The - no update to a verification plan is needed though if using this for an individual right, receiving information it would be important to ensure that the state documents in the case file because in effect it is a change in - a kind of change in circumstance that should be reflected in the case file.

And certainly we encourage states to use the punch list as well as a way of maybe more internally documenting the strategies that the state is taking up. But there's no formal submission to CMS that is needed to use that strategy.

(Danielle): All right, great. Thank you very much.

Coordinator: Our next question comes from (Pat), and I believe it's (Curtis). You may go ahead. (Pat), are you there yet? You want to unmute your phone please. We're going to go to the next one.

(Pat Curtis): Hi, this is (Pat). I'm sorry my - I couldn't get the mute button to work. Can you hear me now?

Coordinator: Yes, we can. Thank you.

(Pat Curtis): Okay, thank you and I apologize. This is (Pat Curtis) from Illinois. My question relates to the guidance you provided, and I can certainly understand

to increase or expand the use of ex parte sources to make the renewals more streamlined and less burdensome on the individual customer.

However, I am not clear, and maybe I misunderstood, how involved does CMS need to be in the state selection or designation of additional es parte sources? And the reason I ask that is on a MAGI verification plan currently, we are asked which electronic sources do you currently use for functions like application, income, citizenship and which your electronic sources you use?

So I'm asking as states seek, and we are looking, you know, as much as we can to electronic sources that we can link up our systems to to increase es parte, but how involved does CMS need to be in approving those sources or is it just up to the state?

Jessica Stephens: Hey (Pat). There is - it is up to the states and there's flexibility there. Though as you note the change would need to be reflected and updated in the MAGI verification plan submitted to CMS and in whatever verification plans you have within the state for non-MAGI.

We're also available as - for technical assistance and conversations about sort of use of various data sources. And when you submit the verification plan change often we may ask questions that may be helpful to the state to think about how you're using particular data sources.

If you're intending to add something like federal tax information and connect through the federal data services hub certainly there are other conversations that we would need to have including our colleagues at CCIIO since in order to connect, there's testing and are there things like that but for the most part for most sources it really is just a change to your verification plans.

(Pat Curtis): Thank you. I appreciate that.

Coordinator: At this time there are no additional questions. If anyone wishes to ask a question yet please press Star 1, unmute your phone and record your name.

Jackie Glaze: Well then we'll transition back to the chat function. (Ashley), I see a couple more questions.

Ashley Setala: Yes, it looks like we have one more that's come in. And it says. "Can states without managed care plans such as Connecticut who uses an ASO model accept updated addresses from the ASO in the same way as MCOs?"

Jessica Stephens: That is a good question. I think we'll want to take that question back. And it sounds like it came from Connecticut probably and reconnect with Connecticut individual - along with any other states that they maybe share that a little more broadly. Thanks.

Ashley Setala: Okay. And then I guess it looks like we have one final question that says, "Is CMS and the administration still committed to giving states 60 days notice to the end of the PHE?"

Jessica Stephens: So I'll note that the commitment to provide 60 days notice actually came from HHS from the then acting secretary. And it is our understanding that that is still the plan to provide states with a minimum 60 days notice. But certainly if we hear additional information we - that you all don't hear we will share with you as soon as possible.

Jackie Glaze: Thank you Jessica. We'll go back and check to see if we have any additional questions for the phone lines. Operator, can you once again provide instructions and check to see if we have any questions?

Coordinator: Yes. And at this time there are no additional questions. But if you would like to ask a question please press Star 1, unmute your phone and record your name. One moment while we wait to see if any additional questions come in. At this time there are no additional questions.

Jackie Glaze: Thank you. And I'm not seeing any new questions through the chat function so I think we'll give everyone a couple of minutes back. So in closing I'd like to thank the team for their presentations today. Looking forward the topics on the invitation for our next call will be forthcoming.

If you do have questions between calls feel free to reach out to us, your state leads or bring the questions to the next call. If you'd like to pre-submit a call, a question for the open Q&A portion of our next All State Call you can email it to medicaidcovid19@cms.hhs.gov by 1:00 pm Eastern Time of the day of the call. So we thank you all for joining us today and hope everyone has a good afternoon. Thank you.

Coordinator: That concludes today's conference. Thank you all for participating. You may now disconnect. Speakers please stand by.

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