HHS-CMS-CMCS

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2:00 pm

Coordinator: Welcome and thank you very much for standing by. Participants over the telephone lines are in a listen-only mode until the question and answer session of today's event time allowing. At that time, you may press Star 1 on your touch-tone phone if you have a question.

Today's conference is being recorded. If you have any objections you may disconnect. And I would like to turn it over to your host, Miss Krista Hebert. Thank you, ma'am. You may begin.

Krista Hebert: Hi everyone, and welcome to today's Medicaid and CHIP All State Call. I would like to welcome Anne Marie Costello, the Deputy Director for the Centers for Medicaid and CHIP services, to get us started today. Anne Marie?

Anne Marie Costello: Thanks Krista, and hi everyone. And welcome to today's All State Call. On today's call, we're going to tackle three important topics. First up is Dennis Sendros, from the Center for Program Integrity who will provide a brief overview of the request for information on the Medicare Beneficiary Identifier, or MBI, Lookup tool. CMS is seeking input and information from stakeholders on the use of these tools by Monday, February 17.

Next up, Tess Hines, from our Children and Adult Health Programs Group, will provide an overview of the CMS Informational Bulletin released on

December 20. This CIB outlines the seamless coverage transition between Medicaid and separate CHIP, as well as exercise of enforcement discretion to delay implementation of certain coverage transition requirements.

Last, but not least, Jen Sheer, from our - also from our Children and Adults Health Programs Group, will provide an overview of the State Medicaid Director Letter also issued in December. This SMDL outlines protections for Medicaid beneficiaries against impermissible fraud and abuse sanctions.

Before we get started, I wanted to let you know that we'll be using the Webinar platform to share slides today. If you're not already logged in, I suggest that you do so now so you can see the slides for today's presentation. You can also submit any questions you have into the chat at any time during our presentation. With that, I'm pleased to introduce and turn things over to Dennis Sendros to get us started. Dennis?

Dennis Sendros: Thank you so much, Anne Marie. So I'm going to be talking about a request for information that we, in the Center for Program Integrity, sent out on Medicare Beneficiary Identifier lookup tools. Even though it says Medicare in the title, I promise it does have a relation to state Medicaid agencies.

Let's go to the next slide. So stolen basically MBIs, Medicare Beneficiary Identifiers, are the ID we use to identify a specific Medicare beneficiary. These are called different things across the health care landscape, but they're still - but they're health care IDs, right? I'm sure every state Medicaid agency also has their own health care ID they use to identify their own beneficiaries.

And they are - stolen health care IDs generally, are driving a lot of fraud. We

see them as a major factor in almost all of our major fraud schemes. When a provider submits claims for someone, that they've never interacted with, that - that's stealing their health care ID to do that, right? So if you're seeing DME claims, or lab claims as we are on the Medicare side, and then getting complaints from beneficiaries saying, "I don't know this provider. I never ordered this service. I - this isn't for me," well, that's coming from MBI fraud.

And sometimes these MBIs are stolen through lookup tools. We're calling them MBI lookup tools, but again these are something that exist throughout the healthcare space. CMS runs a few of these tools. And we have data and can monitor our own tools for abuse. But because they're not just run by CMS, they're run by a lot of entities, because, you know, whenever you walk into your doctor's office if you are missing your, you know, Aetna card or whatever, they're able to look up your information with just a little bit of - they're able to look up your ID with just a little bit of information.

CMS for its tools, requires name, and date of birth, and Social Security number, but some external tools require just a name and a date of birth. And even the Social Security number ultimately doesn't, you know, add a lot of security here. Social Security number leaks are also common. And dedicated criminals can leverage those to steal MBI's.

Some third-party tools are run by clearing houses and billing agencies. But some tools are also run by state Medicaid agencies. They've established their own MBI lookup tools to assist in care coordination for dual eligible beneficiaries. And that's good. It leads to good outcomes, right?

But it's also these - the current structure of the system is really a major vector of fraud, and a serious program integrity vulnerability. So we don't - we are looking at - we're trying to learn more about the system. And we're looking at

prohibiting or restricting externally controlled MBI lookup tools. Because again, we can see the data coming in and out of our own tools, but we can't see it coming in and out of those external tools. We can shut down bad actors when we notice them accessing MBIs improperly through our tools, but obviously external tools are not like that.

But we don't know what we don't know. And we recognize that these tools are really a vital part of the healthcare system, and crucial to ensuring that folks get the access to care that they need. So as we consider changes to the system we want to make sure we fully understand how any changes might affect providers, beneficiaries, other stakeholders, and how we can mitigate the effects of those changes.

So next slide, please. We are soliciting comments to inform future decision-making regarding how we can best protect MBIs and Medicare beneficiaries. And if you go to the link on that slide, you will see a whole host of questions in a survey form you can click into to give us feedback.

The questions fall, you know, generally into about four categories. One, we're looking for feedback from organizations that operate an externally controlled MBI lookup tool, which might be your state Medicaid agency. So you might have some feedback for us there.

We're looking for responses from users of MBI lookup tools, both CMS operated and externally controlled. So if you have a listserv that you think the members of that listserv might be users of MBI lookup tools, and you'd be willing to send this to those folks, that would be very helpful to us. And I'm happy to work with you on language that you can send out to your listserv.

We're also looking at the potential benefit or impact of prohibiting or

restricting externally controlled MBI lookup tools. And again, your state Medicaid agencies or providers might have some valuable insight here.

And then lastly, we're looking at safeguards or best practices from inside or outside healthcare that CMS should consider for preventing MBI theft and misuse. And we're doing a lot of data analysis, and we're staying on top of things, but we know can always improve.

So if you have some time before February 17, 2025 which is when the comment deadline is, we would very much appreciate your feedback or your publicizing this on any appropriate channels. Thank you so much for your time. And I'm going to turn this over to Tess.

Tess Hines: Thanks so much, Dennis, and hi everyone. This is Tess Hines, from the Division of State Coverage Programs, which is the division in CMCS that is responsible for CHIP, Connecting Kids to Coverage Cooperative Agreements and the Basic Health Program.

Next slide, please. Earlier today CMCS published a slide deck on our new Eligibility, Enrollment, and Renewal Tools and Resource Page under the Resources for State tab on medicaid.gov. This state resource page contained a new subpage for Medicaid and CHIP seamless transitions where you'll be able to locate the slide deck along with other materials with guidance about coverage transitions. This includes the recently published CMCS Informational Bulletin released on December 20 related to coverage transitions. And the slide deck is meant to act as a counterpart to that Informational Bulletin.

The transition CHIP in the slide deck aims to provide guidance to states for implementing new requirements for coverage transitions that were added

through the Streamlining Medicaid CHIP and BHP Application, Eligibility, Determination, Enrollment, and Renewal Processes Final Rule, which was published on April 2, 2024.

There are three key policy changes related to coverage transitions that were made through the April 2, 2024 final rule that we'll cover in today's presentation, and are the main focus of the Informational Bulletin. We will refer to these three requirements in the guidance as the seamless transitions requirement, the procedural disenrollment and account transfer requirement, and the combined notices requirement.

Each of these requirements apply to all states that operate a separate CHIP regardless of whether a state's separate CHIP and Medicaid programs are administered by the same state agency. And we'll discuss each of these requirements in more detail in the next few slides.

Next slide, please. And just to give a brief overview of the content of this slide deck that we'll cover today, it follows a similar structure as the Transitions Informational Bulletin. So first we'll provide an overview of the three new seamless coverage transitions requirements that were added through the April 2, 2024 final rule. And the remaining slides will outline how the seamless transitions requirement in particular should be operationalized by states.

Next slide, please. Next slide. So this slide describes the seamless transitions requirement, which has an effective date of June 3, 2024. This requirement applies only to children. And it requires Medicaid and CHIP agencies to make determinations of eligibility for MAGI-based Medicaid and separate CHIP on behalf of the other program.

It also requires that Medicaid and CHIP agencies accept determinations of

MAGI-based Medicaid and separate CHIP eligibility made by the other program. Medicaid and CHIP agencies are also required to transition a child's account between programs as appropriate when determined eligible.

Next slide, please. So this slide covers the other two key policy changes from the April 2, 2024 final rules, which are the combined notices and the procedural disenrollment account transfer requirements. First, the combined notices requirement requires Medicaid and CHIP agencies to send combined Medicaid and separate CHIP eligibility notices whenever a child is transitioned between Medicaid and separate CHIP.

Next, the procedural disenrollment account transfer requirement requires Medicaid and CHIP agencies to transfer accounts of individuals who are procedurally disenrolled from Medicaid or separate CHIP to the Marketplace or a basic health program if an individual is assessed as potentially eligible for coverage through either of those programs. And for both of these requirements, CMS is exercising enforcement discretion and will not expect states to demonstrate compliance until June 3, 2026.

We recognize that in order to implement these two requirements, states will likely need to make potentially significant systems changes at a time when states are already processing other complex system modifications. So we will continue to evaluate facts on the ground with regards to these two requirements. And if states experience indicates that additional time might be needed to demonstrate compliance, we'll certainly take that into consideration in developing further policy.

Next slide, please. Next slide. Moving on to operationalizing the seamless transitions requirement, this slide outlines the four options states have to comply with the seamless transitions requirements. And it's important

to note that a state's Medicaid and CHIP agencies must both elect the same option.

The first option is to use a shared eligibility service for making determinations of eligibility for both Medicaid and separate CHIP. Many states already implement this option, and it is the most straightforward to implement since eligibility determinations for both programs are contained within the same system.

The second option is to accept findings related to eligibility criteria made by the other agency. Under this option, states have to align their MAGI-based methodologies and verification procedures in Medicaid and separate CHIP. Therefore, states that elect this option may need to submit Medicaid or CHIP state plan amendments and/or make updates to their MAGI-based verification plans to ensure that Medicaid and separate CHIP are in alignment.

The third option is to delegate authority to the other agency to make final eligibility determination. Under this option, states need to submit a single state agency Medicaid SPA to delegate authority to the states CHIP agency to make determinations of eligibility for Medicaid. State CHIP agencies must also establish procedures to receive accounts sent by the Medicaid agency, notify the Medicaid agency of account receipts, and maintain proper oversight of separate CHIP eligibility determinations made by the Medicaid agency.

The fourth option is to adopt other procedures that would be subject to approval by CMS. And for states that are interested in exploring alternate procedures to comply with the seamless transitions requirement. Feel free to contact CMS for more information and technical assistance.

And for states that elect the second or third options listed on this slide, either

to accept findings related to eligibility criteria made by the other agency or to delegate authority to the other agency to make final eligibility determinations, states will have until June 30, 2025 to submit any necessary state plan amendments to CMS in order to effectuate these options.

Next slide, please. So the next several slides provide visuals for implementing the seamless transitions requirement at each point of the eligibility cycle, first at application, then at renewal, and then during a continuous eligibility period based on changes in circumstances. And we describe all the steps that states will need to take to implement the seamless transitions requirement at each of these stages in the eligibility cycle to transition children from Medicaid to Separate CHIP and from separate CHIP to Medicaid, or to other insurance affordability programs as appropriate.

So this current slide outlines the scenario of when a Medicaid agency receives an application and there is sufficient information contained in the application for the Medicaid agency to determine eligibility. There are three potential outcomes for this scenario.

First, if the Medicaid agency is able to determine that the child is eligible for Medicaid, the agency must send notice of approved eligibility and enroll the child in Medicaid. Second, Box C describes the outcome of if the agency determines that the child is ineligible for Medicaid but is eligible for separate CHIP, then the Medicaid agency must send notice of denial for Medicaid with fair hearing rights and transfer the child's account to the CHIP agency. The CHIP agency must then accept the determination of eligibility made by the Medicaid agency, send notice of approved separate CHIP eligibility, complete any necessary pre-enrollment activities, and enroll the child in separate CHIP.

And then in the third potential outcome described in Box C, if the Medicaid

agency determines that the child is ineligible for both Medicaid and separate CHIP, the Medicaid agency must coordinate with the CHIP agency to ensure that the child receives denial notice and appropriate appeal rights for both programs. The Medicaid agency must also assess the child's eligibility for coverage through the marketplace, or a BHP, and transfer the child's account to the appropriate program if they are assessed as potentially eligible.

Next slide, please. This next slide outlines the scenario of when a Medicaid agency receives an application and more information is needed to determine eligibility beyond what is provided in the application. In this scenario the Medicaid agency must send a request for additional information.

If the family timely responds to the request for additional information, the Medicaid agency must follow the steps outlined in Box 2, on the preview slide, to determine eligibility for the child based on the information provided. If the family does not timely respond to the request for additional information, this would lead to a procedural denial. So in this case the Medicaid agency must send notice of denial for Medicaid with fair hearing rights.

Next slide, please. So this slide, and the following, describes similar scenarios for when a CHIP agency receives an application and outlines the steps that states must take depending on whether sufficient information is contained in the application. And the CHIP agency can make a determination of eligibility or if additional information is required to make that determination. Similar steps apply for the outcomes of these scenarios as what is required to implement the seamless transitions requirement for when a Medicaid agency receives an application as described on the previous slide.

Next slide, please. Next slide. And the next few slides describe scenarios for

implementing the seamless transitions requirement at renewal. The current slide describes the steps states must take when a Medicaid agency is unable to determine a child's continued eligibility for Medicaid on an ex parte basis, sends a renewal form, and the family returns the renewal form or any other requested information or documentation needed to determine eligibility.

And this scenario has three potential outcomes. First, described in Box A, if the Medicaid agency is able to determine the child eligible for Medicaid based on the information in the renewal form, it must send notice of approved Medicaid eligibility and renew Medicaid coverage.

Second, in Box B, if the Medicaid agency determines, based on information provided in the renewal form, that the child is no longer eligible for Medicaid but is eligible for separate CHIP, the Medicaid agency must send an advance Notice of Termination for Medicaid with fair hearing rights, terminate Medicaid eligibility, and transfer the child's account to the CHIP agency. The CHIP agency must then accept the determination of eligibility made by the Medicaid agency, send notice of accrued eligibility, complete any pre-enrollment activities, and enroll the child in separate CHIP.

Under the third potential outcome described in Box 2, if the Medicaid agency determines the child to be ineligible for both Medicaid and separate CHIP, based on information provided in the renewal form, the Medicaid agency must coordinate with the CHIP agency to ensure the child receives advance Notice of Termination from Medicaid, denial of separate CHIP eligibility, and appeal rights for both programs. The Medicaid agency must also terminate the child's Medicaid eligibility, assess the child's eligibility for coverage through the marketplace or BHP, and transfer the child's account to the appropriate program if they are assessed as potentially eligible.

Next slide, please. So this next slide describes the scenario of when a Medicaid agency is unable to renew a child's coverage on an ex parte basis from the renewal form, but then the family does not return the renewal form. And in this scenario, there are two pathways depending on whether ex parte data is sufficient to determine eligibility, despite the family not returning the renewal form, or if the family does not return the renewal form and ex parte data is insufficient to determine eligibility.

For the first pathway described in Box 4, there are two potential outcomes. One, in Box A, if the family does not return their renewal form, but ex parte data is sufficient to determine that the child is ineligible for Medicaid and eligible for separate CHIP the Medicaid agency must send advance Notice of Termination for Medicaid with their hearing rights, terminate Medicaid eligibility, and transfer the child's account to the CHIP agency. The CHIP agency must then accept the determination of eligibility made by the Medicaid agency, send notice of approved separate CHIP eligibility, complete any pre-enrollment activities, and enroll the child in separate CHIP.

The other potential outcome under this pathway is if the Medicaid agency determines the child to be ineligible for both Medicaid and separate CHIP based on ex parte data. If this outcome occurs, the Medicaid agency must coordinate with the CHIP agency to ensure the child receives advance Notice of Termination from Medicaid, denial of separate CHIP eligibility, and appeal rights for both programs. This would lead to a procedural termination and the Medicaid agency must then terminate Medicaid eligibility.

Under the second pathway described in Box 5, if the family does not return the renewal form, and the ex parte data is insufficient to determine eligibility, this would lead to a procedural termination. The Medicaid agency would determine the child ineligible for Medicaid, send advance Notice of

Termination with fair hearing rights, and terminate the child's Medicaid eligibility.

Next slide, please. And this slide, and the one that follows, describe similar scenarios for separate CHIP and for CHIP agencies to implement the seamless transition requirement at renewal when continued eligibility cannot be determined on an ex parte basis.

As with the scenarios included for Medicaid renewals, on the previous two slides, the potential outcomes and steps states must take depend on whether the family returns a renewal form, and then if the ex parte data is sufficient to determine eligibility for a child when the renewal form is not returned.

Next slide, please. Next slide. Moving on to this slide, this covers requirements for states to implement the seamless transitions requirement for children during the continuous eligibility period based on a changing circumstance.

If a state obtains information during a child's Medicaid continuous eligibility period, which indicates that the child is no longer eligible for Medicaid and is eligible for separate CHIP, the state must maintain the child's enrollment in Medicaid for the remainder of the continuous eligibility period and then conduct a full renewal at the end of the child's continuous eligibility period. However, if a state obtains information during a child's separate CHIP continuous eligibility period, which indicates the child is no longer eligible for separate CHIP and is eligible for Medicaid, special considerations would apply.

Next slide, please. So in the case of a child that is determined eligible for MAGI-based Medicaid during a separate CHIP continuous eligibility period

the CHIP agency must determine the child ineligible for separate CHIP and provide advance Notice of Termination with review rights, terminate separate CHIP eligibility, determine the child eligible for Medicaid, and transfer the child's account to the Medicaid agency.

The Medicaid agency must then accept the determination of eligibility made by the CHIP agency, provide notice of approved Medicaid eligibility, and enroll the child in Medicaid. In this scenario, the Medicaid agency has the option to provide the child with its new 12-month CE period as is the effective date of when the child is determined eligible for Medicaid or the state can provide the child with continuous eligibility in Medicaid for the remainder of their original CE period.

Alternatively, if a child is assessed as potentially eligible for Medicaid on a basis other than MAGI during a separate CHIP CE period, the CHIP agency must transition the child's account to the Medicaid agency to make a determination of eligibility on a non-MAGI basis. The CHIP agency must continue to cover the child under the separate CHIP unless and until the agency receives notification that the Medicaid agency has determined the child to be eligible for Medicaid.

Next slide, please. And this slide provides a reminder of long-standing requirements for coordination between all insurance affordability programs including Medicaid, separate CHIP, BHPs, and the Marketplace. These requirements were in place before the April 2, 2024 final rule, and continue to remain in effect.

This includes requirements for each program to assess potential eligibility for other insurance affordability programs and transfer accounts of individuals assessed as potentially eligible to the appropriate program. This also includes

requirements for insurance affordability programs to retain enrollment of individuals found to be potentially eligible for Medicaid on a non-MAGI basis while the Medicaid agency makes a final determination of eligibility for Medicaid.

Next slide, please. This slide outlines strategies that states should to consider to minimize disruptions in coverage for children transitioning between Medicaid and separate CHIP in states that utilize managed care delivery systems. These strategies include contracting with managed care plans that serve both Medicaid and separate CHIP, and allowing children to maintain enrollment in the same plan when they transition between programs. States may also possibly assign children to a plan using a process that preserves existing provider beneficiary relationships when states do not contract with the same managed care plans for both Medicaid and separate CHIP.

Next slide, please. And finally, this slide provides additional considerations for states that charge premiums or enrollment fees in their separate CHIP to effectuate coverage when implementing the seamless transition requirement. States have options to waive premiums or enrollment fees for the first month of coverage or to delay collection of initial premiums and enrollment fees post-enrollment for children transitioning from Medicaid with separate CHIP. It's important to note that once a child is enrolled in separate CHIP, they may not be disenrolled for failing to pay premiums during the continuous eligibility period.

Next slide, please. And for more information please review the transition CID which is also available on medicaid.gov under the new Medicaid and CHIP Seamless Transitions page, and on the Federal Policy Guidance page. And for any questions you can please feel free to contact me directly. My contact information is provided on this slide as well as in the conclusion of the

transition CID.

So thank you all for your time. And I will now hand the call over to Jen Sheer to discuss the State Medicaid Director Letter on protecting Medicaid beneficiaries against impermissible fraud infringement.

Jen Sheer: Thank you, Tess. As Tess said, my name is Jen Sheer. And I'm from the Children and Adult Health Programs Group. Today, I'll be talking about State Medicaid Director Letter Number 24-005, Protecting Medicaid Beneficiaries Against Impermissible Fraud and Abuse Sanctions.

Next slide, please. During the presentation today, we will be focusing on both permissible and impermissible penalties and sanctions for eligibility-related Medicaid beneficiary fraud and abuse.

Next slide. State Medicaid Director's Letter 24-005 was published on December 5, 2024. This letter builds upon FAQ Number 31 from the October 17, 2022 set of unwinding frequently asked questions.

Before we begin, I want to highlight one key takeaway from the SMDL, and today's presentation, and that is that CMS expects state Medicaid agencies to promptly cease the use of any sanctions or penalties for beneficiary fraud and abuse which are inconsistent with this guidance.

As we'll discuss in more detail today, federal law with very limited exceptions does not permit state Medicaid agencies to recoup funds from or lock out from Medicaid coverage a beneficiary who the state determined abused or defrauded the Medicaid program.

Next slide, please. We'll start with a brief background regarding eligibility

determinations fraud and abuse. Next slide. Federal regulations require each state Medicaid agency to operate a fraud and abuse detection and investigation program.

Next slide. Here are a few key definitions for today's presentation. The first is fraud, which is defined in federal regulation as an, intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law. Section 1128(b), of the Social Security Act, sets out a knowing and willful standard for the offending conduct.

Next, what is abuse? The definition for abuse in regulation includes beneficiary practices that result in unnecessary cost to the Medicaid program. It's important to note that errors on the part of the state Medicaid agency do not fall within the scope of the definitions for fraud or abuse.

Finally, earlier in this presentation I mentioned lockouts. While not defined in statute or regulation, the term lockout refers to a situation where a state Medicaid agency bars an individual from applying for and/or receiving Medicaid coverage for a specified length of time and/or makes receipt of Medicaid services contingent upon repayment of funds.

Next slide. States are expected to make timely accurate eligibility determinations and redeterminations in accordance with federal regulations and the state's verification plan. States must have procedures in place to allow beneficiaries to report any changes in circumstances timely that may impact their eligibility.

Next slide. There are a number of resources available on medicaid.gov

regarding eligibility determination and redetermination processes. It's important to note that even in situations where a state suspects a beneficiary of fraud or abuse, when a state receives reliable information indicating that a beneficiary may no longer be eligible for example, from a beneficiary report during an eligibility period or at renewal or from a periodic data match, in these situations the state must treat the information that led to this conclusion as a possible change in circumstances, conduct a redetermination of the beneficiary's eligibility in accordance with federal regulations which includes considering their eligibility on all bases prior to a termination of eligibility.

States must comply with these requirements even if a state determines that the previous determination of eligibility was incorrect or that a change in circumstances resulting ineligibility occurred in the past. Retroactively terminating a beneficiary's coverage back to the date of the inaccurate determination, or a previous change in circumstance, violates the beneficiary's due process right.

Next slide. As a reminder, federal regulations describe the step the state Medicaid agency must take to address instances of potential beneficiary fraud or abuse. This State Medicaid Director's Letter does not alter the existing and long-standing requirements for state Medicaid agencies to refer suspected incidents of beneficiary fraud to an appropriate law enforcement agency or the requirement for the state Medicaid agency to conduct a full investigation.

Next slide. Next slide, please. Krista, are you able to advance the slide? It's still showing the previous one on my screen. Thank you. If you have a scenario, or if a state runs into a scenario, where an action on the part of a beneficiary meets the definition of both fraud and abuse a state Medicaid agency could elect to pursue an in Visa investigation concurrent with a

referral of the potential fraud to law enforcement.

Next slide. We will now move into some of the key topics from the SMDL. The first one is, what are the permissible penalties if it is determined after an appropriate referral to law enforcement that a beneficiary has engaged in fraud?

Next slide. Individuals convicted of fraud, in either state or federal court, would be subject to the penalties imposed by the court. These could include criminal or civil penalties for fraud or liability for civil damages due to fraud, all of which are outside the scope of this guidance. If a state Medicaid agency is concerned that a specific court order or criminal or civil penalty may be inconsistent with federal Medicaid statute and regulation, the agency should consult its legal counsel.

Next slide. Next, we will discuss the permissible sanctions for beneficiary abuse. Next slide. Sanctions for beneficiary abuse may only be applied by a state Medicaid agency to a beneficiary after the completion of a full investigation by the agency that results in a determination that the beneficiary committed abuse. It's important that this investigation not infringe on an involved individual's legal rights. And it must afford impacted individuals due process of law.

It's also important to keep in mind that not all failures to timely report a change in circumstances will meet the definition of abuse, and therefore state Medicaid agencies may not automatically treat every failure to report a change in circumstances timely as abuse.

Next slide. Permissible sanctions for beneficiary abuse include warning letters, fines, and other sanctions that are in the approved state plan. Sanctions

for abuse cannot conflict with other federal statutory or regulatory requirements.

Next slide. Federal regulations state that warning letters can be used as a sanction for beneficiary abuse. Such warning letters may provide notice that continuation of the conduct in question may result in further action. Because this sanction is clearly identified in federal regulations, states do not have to document the use of warning letters in the Medicaid state plan.

Next slide. Federal regulations also allow states to impose other sanctions provided under the state plan therefore, any beneficiary sanctions for abuse, other than a warning letter, must be approved by CMS and documented in the state plan. State Medicaid agencies may impose fines on beneficiaries who commit eligibility abuse as an other sanction.

In order to do so, the circumstances under which fines may be imposed, and the amount of such fines must be documented in an approved Medicaid state plan amendment. These fines must be reasonable in amount, and not be correlated with the value of items and services provided to the beneficiary after the instance of abuse. They cannot equal or exceed the value of items and/or services provided to, or capitation payments made on behalf of, the beneficiary after the instance of abuse.

Next slide. And now we will discuss the impermissible administrative sanctions for Medicaid beneficiaries fraud and abuse. Next slide.

The recoupment of funds, or sometimes called overpayments. The recoupment of funds, which are sometimes colloquially referred to in this context as overpayments, from beneficiaries for the cost of medical assistance provided prior to the effective date of a beneficiary's termination denies the beneficiary

their rights to advance notice of a termination and a fair hearing and is impermissible.

Even voluntary repayment would violate the beneficiary's due process rights. Again, state Medicaid agencies are not permitted to recoup funds from beneficiaries except in circumstances explicitly provided for in federal statute and implementing regulations, which include liens placed on a beneficiary's property prior to the beneficiary's death pursuant to the judgment of a court that Medicaid benefits were incorrectly paid. Next, a state recovery proceeding for correctly paid Medicaid benefits. And finally benefits provided pending the outcome of a fair hearing.

Next slide. Our next impermissible administrative sanction is lockouts. Lockouts prevent an individual from applying for Medicaid, and violate the requirement that states furnish Medicaid benefits to eligible individuals with reasonable promptness and in accordance with their state plans.

There is an exception, Section 1128 Capital D Paragraph A of the act, the Social Security Act, provides the state Medicaid agency the discretion to limit, restrict, or suspend for up to one year Medicaid coverage of an otherwise eligible individual who is convicted of fraud in federal courts. It's important to note that this penalty cannot affect the Medicaid eligibility of any other person regardless of the relationship between the individual and the penalized beneficiary.

Next slide. All right, finally states cannot terminate the eligibility of any beneficiary, including a beneficiary suspected of committing or determined to have committed fraud or abuse, without first conducting a redetermination of eligibility on all basis determining the individual ineligible, and providing advance notice of determination and fair hearing rights.

Next slide. Next slide. As discussed, it's important that a state's fraud and abuse these processes afford individuals due process of law. Individuals must be provided with the opportunity to challenge allegations of fraud or abuse.

Next slide. Next slide. You've also heard me mention that sanctions for abuse other than a warning letter must be documented in a state's Medicaid state plan. So if a state elects to impose administrative sanctions, it must document the proposed sanctions in its state plan and receive CMS approval. For states interested in this option, please contact your state lead for technical assistance. We are available and happy to talk with states as they think through potential sanctions.

Next slide. We have here some resources that may be helpful for states as they think about the guidance in this SMDL. If you have any questions about SMDL 24-005, please send them to medicaidpibeneficiaryprotections@cms.hhs.gov. Thank you all very much for your time. And now I'll pass the mic back to Krista.

Krista Hebert: Hi everyone. Thank you so much for a wonderful presentation today. At this time, we will open things up for an open Q&A, so please feel free to enter your questions into the chat at this time. (Fran), I'm not seeing any questions in the chat at this time, are you?

Coordinator: No, that is correct.

Krista Hebert: Okay, great. We'll give it a minute, and then maybe we'll open the phone lines. But let's see if any questions come in through the chat first. All right, I do see one question here that I'll read out loud now. "If an adult appears ineligible for Medicaid due to income based on an ex parte review, and they

do not return a renewal form, would states transfer the adult to the FFM or state-based exchange?"

Woman: Can you just repeat the question one more time, Krista, just to make sure I referred it correctly?

Krista Hebert: Absolutely. Yes, absolutely. "If an adult appears ineligible for Medicaid due to income based on an ex parte renewal review, and they do not return a renewal form, would states transfer the adult to the FFM or state-based exchange?"

(Sarah): At this point, no for the FFM, state option, state flexibility for an SBM, State-Based Marketplace. That would be a procedural denial for Medicaid. And the assessment, you know, for Marketplace coverage based on the ex parte data is not required at this point for FFM, this is a procedural denial.

Krista Hebert: Thank you, (Sarah). I see one additional question here about whether the slides will be made available after this meeting. Yes, the slides will be posted on medicaid.gov on the All State Call page after the meeting. All right, (Fran), I'm not seeing any other questions in the chat, so can you please provide instructions again for how folks can come off mute if they'd like to verbally ask a question?

Coordinator: Yes. And thank you so much for asking. Now, if you're on the telephone, and you would like to ask a question, please press Star 1. If you muted your phone, please unmute it and record your name clearly when prompted. Your name is needed to introduce your question. Star 1 anytime. One moment please. Well, thank you. I have no questions over the telephone lines.

Krista Hebert: Okay, great. Maybe we'll just give it one or two more minutes and see if

anybody - any questions come through. And then if not, then we'll wrap up early. So I'll be on standby for just another minute or so. All right, we do have another question here in the chat that I'll read now. "Will CMS provide a SPA template for states that would like to take the option to continue the renewal asset exemption flexibility as a permanent change?"

Sarah Dillon: This is relating to the E14 strategy that was made permanent? Can the person clarify? Sorry, this is Sarah Dillon.

Krista Hebert: I'm not seeing a follow-up in the chat, but it does seem that Sarah - I'll all read the question again, "Will CMS provide a SPA template for states that would like to take the option to continue the renewal asset exemption flexibility as a permanent change?" And actually yes, they did just respond that yes, this is related to an E14.

Sarah Dillon: Okay. So there's two asset E14 related E14s that were made permanent. The one that relates to doing sort of if the AVS doesn't return information quickly enough to complete based on an ex, you know, sort of based - doing the ex parte process. So if they complete the renewal and then finish the ABS process after the renewal is complete, that does not require a state plan amendment, but you would want to look at your verification. Your - this is a non-MAGI also, so this is not your MAGI verification plan that's submitted to CMS, but you would want to make sure to have that clearly documented in your policies and procedures.

For the non-MAGI for the strategy where you're going to use a 1902(r)(2) disregard to adopt, you know, to disregard increases in assets, that is a - that state plan page already exists. It's your - it's a more, you know, less restrictive methodologies page. I don't know what that is offhand. I don't think our experts are on this particular phoneline. But you should, in either case, the

best is to reach out to your state lead, and they can get you to the right experts to provide you whatever technical assistance you need to get that paperwork in order.

Krista Hebert: Thanks so much, Sarah. And I'm seeing some things in the chat too. At this time, I'm not seeing any additional questions. (Fran), did we have anybody else come in on your end?

Coordinator: No, nothing over the telephone.

Krista Hebert: Great, well then I think we can wrap up there for today. I just wanted to thank the team today for the discussion. And as a reminder, there will be another All State Call next week - next month rather, on February 18. Of course, if questions come up between calls, feel free to reach out to us, your state leads, or bring your questions to the next call. Thanks again for joining us, and we look forward to chatting next month.

Coordinator: As we are concluded again, thank you so much for your participation. Please go ahead and disconnect at this time.