

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

November 5, 2020

3:00 pm ET

- Operator: Greetings, and welcome to the CMCS All State Medicaid and CHIP Call and Webinar. During the presentation, all participants will be in a listen-only mode. Afterwards, we will conduct a question and answer session. At that time, if you wish to ask a question, please press star, followed by 1, on your telephone. You may also ask a question by using the chat box in the bottom left of your screen. If at any time during the conference you need to reach an operator, please press star zero. As a reminder, this conference is being recorded Thursday, November 5th, 2020. I would now like to turn the call over to Jackie Glaze. Please go ahead, ma'am.
- Jackie Glaze: Thank you. Good afternoon everyone, and welcome to today's All State Call and Webinar. I'll turn now to Anne Marie Costello, our acting center director, and she will share highlights for today's discussion. Anne Marie.
- Anne Marie Costello: Thank you. We moved our call this week to ensure that the call did not conflict with the Election Day holiday that many state governments observe. Thanks for being flexible with your schedules this week. Today's call will focus on the Vaccine Toolkit the team has released on October 28th. We will also continue our discussion from last week regarding the continuous enrollment provisions of the interim final rule.
- Anne Marie Costello: The Vaccine Toolkit information on vaccine coverage, payments, and administration under Medicaid CHIP and the Basic Health program. The Toolkit is designed to assist state and territorial policymakers to identify the issues that need to be considered and addressed in order to provide coverage and reimbursement for vaccine administration in Medicaid, CHIP, and the Basic Health Program (BHP). Kirsten Jensen, the director of our division of Benefits and Coverage and the Disabled and Elderly Health Programs group will present on the toolkit.
- Anne Marie Costello: Following that, Sarah deLone, the Director of the Children and Adults Health Programs group, along with a number of our subject matter experts, will talk through the answers to a number of state questions on the new interim final rule provisions related to maintaining Medicaid enrollment during the public health emergency. We did not have enough time to cover all of the questions during the Q&A portion of last week's call. We appreciate your interest and engagement in this policy.
- Anne Marie Costello: After those FAQs, we'll open up the lines for your questions on Vaccine Toolkit and the IFC and any other general questions you may have. I will note that we will use slides for today's Vaccine Toolkit presentation. If you're not logged into

the webinar, I recommend that you do so now. The slides will be posted on Medicaid.gov by the end of the day. With that, I'll turn things over to Kirsten Jensen to start our Vaccine Toolkit presentation. Kirsten.

Kirsten Jensen: Thank you, Anne Marie. I'm excited to be here today to talk about the Vaccine Toolkit. It's an important conversation for us to have at this point in time. It will be a living document. As we know we are working in very fluid situations at the moment, and as more information becomes available, we will update the toolkit as is necessary. We already have one update in the works and guidance put out about the Public Readiness and Emergency Preparedness (PREP) Act last week, and we will be updating the Vaccine Toolkit with that information shortly.

Kirsten Jensen: The objectives of the toolkit are really to help states plan for the vaccine and vaccine administration and the territories to plan for the vaccine and vaccine administration in their respective areas. We did design this toolkit to be expansive to discuss the Medicaid program but also the Children's Health Insurance Program and the Basic Health Program. In addition to just the conversation around the vaccine and vaccine administration, this toolkit also discusses a number of other issues around clinical and operational considerations for states such as vaccine storage, priority for vaccine distribution, and pharmacy and provider agreements. That is all outlined in the toolkit.

Kirsten Jensen: Because CMS anticipates that the initial supply of COVID-19 vaccine will be federally purchased, the toolkit's primarily focused on vaccine administration. Again, we can update over time if things change. At the moment, the initial supply will be federally purchased. As always, CMS remains available to provide technical assistance to states as you plan and prepare, and to the territories as well. We encourage the conversation and will assist as we move forward through this process. Next slide please.

Kirsten Jensen: As you know, the Families First Coronavirus Response Act (FFCRA) allows for a 6.2% point increase in FMAP during the public health emergency through the end of the quarter in which the PHE ends. As part of receiving that enhanced match, states and territories should provide COVID-19 testing services and treatments, including vaccines and vaccine administration, specialized equipment, and therapies without cost-sharing to most Medicaid beneficiaries. For Medicaid beneficiaries who are in limited benefit eligibility groups or are covered under existing Section 1115 demonstrations that receive a very narrow range of benefits, these requirements of FFCRA do not apply. These requirements also do not apply to CHIP or the Basic Health Program.

Kirsten Jensen: The vaccine coverage is provided in both of these programs. For CHIP, states must cover advisory committee on immunization practices, or ACIP, recommended vaccines and their administration for children. For the Basic Health Plan, during the course of the PHE, plans must provide coverage for and must not impose any cost-sharing for the COVID vaccine, regardless of whether the vaccine is delivered in or out of network, by an in-network or out of network provider. Sorry. Next slide please.

Kirsten Jensen: After the PHE, what does coverage for vaccine administration look like? There are several populations in Medicaid that will be required to receive a vaccine. That includes children under the age of 21, eligible for EPSDT, any populations who receive coverage through alternative benefit plans, and adults in states where the state has elected to receive the 1% point FMAP increase through 4106 of the Affordable Care Act. States do have the option to cover vaccines and their administration for other Medicaid eligibility groups. We cover other today outside of COVID-19.

Kirsten Jensen: States cover vaccines and vaccine administration throughout their, in areas, certain areas of their program. In CHIP, vaccine coverage will be the same during and after the public health emergency. States cover the ACIP recommended vaccines at no cost-sharing. Similarly with BHP, states must continue to provide enrollees with the COVID-19 vaccine with no cost-sharing after the PHE is over. Next slide please.

Kirsten Jensen: In terms of vaccine administration rates, in Medicaid states have flexibility in establishing rates. Rates are set by the states, as you know, and may be found in the state agency fee schedule by benefit category. States may set vaccine administration codes or pay providers through a rate for an office visit. For facility services, such as hospitals or nursing facilities or FQHCs, vaccine administration is usually included within the facility rate. But states could choose to pay an additional rate for the vaccine administration. States may also choose to pay a vaccine administration fee at or below the Vaccines for Children program, regional rate for children through age 18. Again, there's flexibility here for states for how you pay for the vaccine administration, and our colleagues in the Financial Management Group will be available to provide technical assistance there.

Kirsten Jensen: For the CHIP and the Basic Health Program, separate CHIP programs determine rates and manners of reimbursement for vaccine administration. States have discretion in determining vaccine administration rates for the BHP program as well. We included information here about Medicare reimbursement. States are encouraged to consider these rates when determining their reimbursement rates as the rates that Medicare has established include reimbursement for additional resources that might be involved in reporting or in outreach and patient education and making sure that there's additional time available for providers to answer any questions that patients may have or beneficiaries may have about the vaccine. Next slide please.

Kirsten Jensen: Just to say one more thing on the Medicare piece, there is a very nice section in the toolkit that provides lots of very detailed information about what Medicare is reimbursing for the vaccine administration.

Kirsten Jensen: For states that operate and territories that operate in managed care, you may include the vaccine administration coverage in the contracts and capitation rates, or you may carve it out and pay for the vaccine administration under the Fee for Service Program. Just as a note, during the COVID-19 public health emergency,

Medicaid alternative benefit plans must not impose any cost-sharing for the COVID vaccine, and the vaccine must be provided either in network or out of network. The Medicaid alternative benefit plans are very much tied to the marketplace plans, and this is a particular requirement.

Kirsten Jensen: To ensure that the beneficiaries who are enrolled in managed care plans have easy and prompt access to the vaccine, states are strongly encouraged to consider whether any contractual requirements for credentialing and network contracting should be amended. In addition, states are strongly encouraged to amend their managed care contracts to suspend any limits on out of network coverage for managed care enrollees to specifically improve access to COVID-19 vaccines. That is one of the things that states really need to focus on, is making sure that coverage is available broadly to the Medicaid beneficiaries. Next slide please.

Kirsten Jensen: In terms of Medicaid and CHIP and state plan amendments, and Basic Health Program blueprints, we've provided some charts in the toolkit to help states navigate what needs to be submitted to CMS. I won't walk through each cell here, but essentially, there are only very certain circumstances when states would need to submit state plan amendments to us, and so if it's not otherwise covered in your plan from a coverage perspective in Medicaid, the state might need to submit a SPA, and on the reimbursement side, you'd only need to submit a state plan amendment if you're paying something different from what you otherwise pay now for vaccine administration. In addition for children covered under Medicaid, under EPSDT we do not require a submission, but some states do elect to delineate coverage for children in their state plan. CHIP and BHP do not require SPAs. Next slide please.

Kirsten Jensen: States may use, during the period of the public health emergency, disaster relief SPAs. Most states are familiar with these. We have been processing them for quite a few months now, and so certainly you may use that. If the state would like to make more permanent changes, then we would look to our regular state plan process and submitting any coverage or reimbursement changes necessary. Next slide please.

Kirsten Jensen: In terms of coding and reporting, the American Medical Association will be issuing a separate CPT code for each vaccine. That should be very helpful in terms of being able to guide providers on what codes to use to ensure that states and CMS can properly track the distribution of the COVID-19 vaccine and administration. States should ensure that providers use the standard procedure codes. One of the things we do suggest in the toolkit is that there be strong provider outreach to make sure that they understand what they need to do in terms of billing. States will also need to send the codes to CMS using the normal T-MSIS submission process. If the coding specifics become available, CMS will provide more detailed guidance to states. Next slide please.

Kirsten Jensen: We receive a lot of questions about provider enrollment, both during and after the public health emergency. In terms of the flexibilities during the public health emergencies, the Medicare administrative contractors will share contact

information and/or the enrollment website for each state Medicaid program with newly enrolling providers, so that newly enrolling providers know where to go to become an enrolled provider with Medicaid. If a state doesn't have an approved 1135 waiver for provider in screening enrollment, the state may request that waiver, which will allow you to temporarily enroll providers and waive certain requirements. We've processed a lot of those waivers over the last few months.

Kirsten Jensen: After the public health emergency, CMS data exchange system will be utilized to share data on all existing and newly enrolled providers that will be administering the COVID-19 vaccine in Medicare, and that hopefully will facilitate information to the state Medicaid agencies. In order for states to reimburse for the vaccine administration, providers must enroll, and they must periodically revalidate their enrollment in Medicaid and CHIP. Medicaid and CHIP managed care network providers are also required to be enrolled with the state Medicaid and CHIP programs. States have the authority to temporarily enroll providers using provider screening that is performed by other state agencies, state Medicaid agencies or Medicare. Next slide please.

Kirsten Jensen: In terms of provider and beneficiary education and outreach, the toolkit has quite a list of suggestions and things to think about. Some of the highlights are that states should start thinking about developing a COVID-19 vaccine education and outreach strategy to ensure that both beneficiaries and providers are aware of the availability of the vaccine and administrative match is available for both Medicaid and CHIP for these activities. Education is very important in helping beneficiaries understand where to go to get their vaccine and how to get more information. States are encouraged to coordinate their efforts with state and local health departments and partner with stakeholders to promote coordinated messaging and get that outreach to the Medicaid beneficiaries so that they know when the vaccine is available, where it will be available, and what they need to do.

Kirsten Jensen: States may want to incorporate any ready to use materials from existing national campaigns, such as those prepared by CDC and the Connecting Kids to Coverage national campaign. Those are just a few highlights. The toolkit is very comprehensive and I encourage you to read it and, again, ask CMS any questions that you might have. But I think at this point, next slide please, I'll be turning it back over to Jackie Glaze to open up a question and answer period.

Jackie Glaze: Thank you, Kirsten, for your very helpful information. As Kirsten indicated, we'd like to take your questions now. We will start by using the chat function. I do see a few questions there now, so you can begin entering your questions at this point. Then we will move to take in a few questions over the phone line. We'll be looking for your questions at this point.

Ashley Setala: And, Jackie, it looks like we have a couple of questions on the Vaccine Toolkit that have come in so far. The first one is, "Will there be a separate code or modifier identified for administration of a COVID-19 vaccine to differentiate COVID-19 from other vaccines?"

Julie: Ashley, it's Julie. You want me to take that one?

Ashley Setala: Sure. Go for it.

Kirsten Jensen: Yes, please.

Julie: Sure thing, Kirsten. Yes, we do anticipate that the AMA is going to create CPT codes and probably separate CPT codes for each particular brand of vaccine, and so we will, as part of the outreach to providers that Kirsten mentioned in her presentation, want you to make sure that they are aware of those codes, and use those codes when they're sending in their claims to either the state or the managed care plan, and that those codes are what come in to T-MSIS as well.

Barbara Richards: Great. Thanks, Julie. We've got another vaccine question. Question is, "If state uses the vaccine for coverage programs for Medicaid children, can a state also receive FFP for vaccines provided to children outside of the VFC program for non-participating providers?" If you want me to read that again, I'm happy to.

Kirsten Jensen: Yes, please.

Barbara Richards: "If a state uses the VFC program for Medicaid children, can a state also receive FFP for vaccines provided to children outside of the VFC program for non-participating providers?"

Kirsten Jensen: Do we happen to have Mary Beth Hance on the phone today?

Anne Marie Costello: And I probably would start by saying, and Amy Lutzky you should confirm, that there currently is not a vaccine in testing for children, right? The issue is the VFC program will be a later on issue. But Mary Beth, you should jump in.

Mary Beth Hance: Thanks, Anne Marie. Just to continue. This is Mary Beth Hance from the Family and Children's Health Programs group. Children and Adults Health Program group, I apologize. Just to continue where Anne Marie was going, specific to the COVID-19 vaccines, CDC will make a determination as to whether those vaccines will be included in the Vaccines for Children program once there is an approved vaccine, and when that vaccine is recommended. For now, if your question is specific to COVID, that's not really a question that we're in a position to answer because, again, CDC will make that determination as to whether that's included in the Vaccines for Children program.

Amy Lutzky: This is Amy Lutzky, the only thing I would add to that because I think the question had also flagged an inquiry about FFP for non-participating providers. Not clear whether or not they mean non-participating in Vaccines for Children or non-participating in Medicaid and CHIP, but to receive FFP for the administration of the vaccine, that provider would need to be enrolled in Medicaid and CHIP.

Ashley Setala: Okay, great. Another question on the Vaccine Toolkit. "Please elaborate on the definition of initial when referring to the vaccines paid for by the federal government."

Mary Beth Hance: Jeff Wu, can you step in here?

Jeff Wu: I'm sorry, could you repeat the question?

Ashley Setala: Sure. It is, "Please elaborate on the definition of initial when referring to the vaccines paid for by the federal government."

Jeff Wu: Ah, okay. I think what this question is getting at is essentially how long is the federal government going to be paying for supplies of the vaccine? I.e., at what point might a state or managed care organization find itself in the position of also having to purchase a supply of vaccine in addition to paying the administration fee? If that is what the question is getting at, the answer is that the federal government has procured at this point hundreds of millions of doses of each of the leading vaccine candidates, and has in its contracts with each of those companies, purchase options to purchase many hundreds of millions more doses.

Jeff Wu: The intent here is for the federal government to cover this... I use the word initial again, but what I mean here is this national vaccination campaign. At some point, the federal government would step out of that role, but what's envisioned here is that would not occur until we've been through the full national campaign. If the vaccine, for example, is found to have effectiveness for eight years or whatever, say, eight years from now we'll be in a very different place, and I don't think there would be the expectation the federal government will be paying for supply.

Jeff Wu: But the intent here not is that in a couple of months come February or something, suddenly all of the states and payers are out there trying to negotiate contracts with the drug companies. Is that responsive to the question?

Mary Beth Hance: I think that should be helpful, Jeff. Thanks. Ashley, we can take the next question.

Jackie Glaze: I think we're ready now to take the questions over the phone line. We have a few minutes for that. Operator, can you provide instructions to the audience?

Operator: Sure. If you'd like to ask a question over the phone, you may do so by pressing star followed by 1 on your telephone keypad. We'll pause for just a moment to compile the roster. And there are no questions over the phone lines.

Jackie Glaze: Thank you very much. We do have time at the end of our session to take additional questions, but at this time we'd now like to move to Sarah deLone. She will walk through some of the FAQs related to the maintenance of provisions of the IFC. So, Sarah.

- Sarah deLone: Ah, yeah. Thanks Jackie. Just to level set, our goal in this portion of today's call is to answer the questions that came in through the chat on last week's All State call relating to the interim final rule that we didn't get to. I want to acknowledge that some of you have submitted additional questions since the last week's call. We have received those, and they will be addressed, but not during this segment of the call today. We also, we had a few questions that weren't answered that related to actions states need to take after the PHE, the public health emergency, is over.
- Sarah deLone: We appreciate your interest in receiving guidance on what states need to do once the PHE ends and the continuous coverage requirements for claiming the FMAP increase, which is addressed in the interim final rule once that requirement no longer applies. We are working on guidance, which will be forthcoming, and we'll be in a better position to discuss these issues once that guidance is released.
- Sarah deLone: There were also a few questions from last week that did not relate to the interim final rule, and we wanted to address these first. Melissa Harris, this first one is for you, relates to Appendix K. "If the effective dates of an Appendix K approval is January 27, 2020 to January 26, 2021, will the state be able to submit an additional Appendix K with effective date starting in January 2021 and going later on, or is the maximum duration for an Appendix K waiver one year?"
- Melissa Harris: Thanks for that. This is Melissa. I imagine that there are 50 states interested in this topic. Our prior policy to date for Appendix K has been that they have a maximum lifespan of 12 months, which has been perfectly adequate before now. While a lot of the states were not in a formal period of public health emergency until March of last year, many states retroactively applied some of their Appendix K flexibilities back to earlier months. January, February of 2020, which means their coverage is coming up.
- Melissa Harris: We've had that question posed to us by many states and the state associations about is there any flexibility to extend an Appendix K beyond 12 months? We hope to have some formal answers for you in the coming days. We know that this is a time-sensitive issue, and I don't have anything late breaking right now, but we will get some information out to all the states as soon as we can because we know it's nationally applicable. Thanks.
- Sarah deLone: Thanks, Melissa. We also received a question asking if it is possible that the public health emergency will end before a COVID vaccine is available. I think we wish we could all predict, but we here at CMCS are not really in a position to give you a good guesstimate as to when either the vaccines will first be available or when the PHE will end. Unfortunately, the question is we're not able to answer.
- Sarah deLone: Now let's turn to two of our senior policy experts, Stephanie Bell and Gene Coffey, to help answer various questions on the continuous coverage maintenance of effort requirement, which was included in the interim final rule,

recently published. Stephanie, to you first, can you explain when the IFC became effective?

Stephanie Bell: Sure. The IFC became effective on Monday, November 2nd, when it was posted to the Federal Register website. We're expecting it to be published in the Federal Register tomorrow, and then the comment period will close on January 4th, 2021.

Sarah deLone: So it is effective now.

Stephanie Bell: Right.

Sarah deLone: Is it effective prospectively, or does it go backwards in time?

Stephanie Bell: Prospectively only. Up until Monday, the prior interpretation from the FAQs was in effect, continued to be in effect.

Sarah deLone: States should not be retroactively applying... Anything that has changed with the IFC should not be retroactive.

Stephanie Bell: Yes. Thank you.

Sarah deLone: Gene, a question for you. Thanks, Steph. Gene, a question for you. Can a state choose to maintain its current level of continuous coverage? That is continue in accordance with the previous guidance in the FAQs and not lower the threshold for moving people to other benefit levels in order to qualify for the enhanced FMAP? Does the final rule set out opportunities for state flexibility, or is it a mandate?

Gene Coffey: They're very good. Thanks, Sarah. This is Gene Coffey from the Division of Medicaid Eligibility Policy. The rule sets out some flexibilities for states, but ultimately the IFC establishes mostly expectations that we are going to have of states with regard to individuals who have obtained Medicaid eligibility and whether it was because they were eligible on the first day of it or subsequently obtained eligibility.

Gene Coffey: Where their circumstance changed, either because they no longer meet the eligibility requirements for the group in which they were originally enrolled, or they have an income increase, excuse me, such that their cost-sharing might change, or their post-eligibility treatment of income liability might change, or they experience any change in their condition, such that they may no longer be eligible for coverage of a particular benefit because they no longer meet the medical necessity criteria. We generally expect that the states are going to act upon those changes.

Gene Coffey: We have set some limits as to what states might be able to do. Where, for example, an individual no longer meets the eligibility requirements fundamentally for the group in which he or she were enrolled. For example, if an individual is enrolled in the adult group and turns 65, the state would, if it is able

to, the state would have to reevaluate, redetermine the individual's eligibility, and only transfer the individual to a separate group if there is a separate group for [inaudible] and which provide a minimum essential coverage. There is that limitation.

Gene Coffey: But again, ultimately where there are changes that affect an individual's underlying Medicaid eligibility for his or her group or coverage for a particular benefit or the scope of assistance relating, as I mentioned, through PETI or cautionary, PETI being Post-Eligibility Train of Income. The idea behind the IFC was not to offer states new flexibility around reacting to those changes, but rather to establish that the state [inaudible] already in the Medicaid statute and regulations to address those particular changes will no longer, prospective from the point of the effective date of the IFC, be considered to be inconsistent with 6008(b)(3) of the Family First Law.

Sarah deLone: Thanks, Gene. Basically, 6008(b)(3), regardless of the interpretation, you should be... Medicaid rules apply, and if the 6008(b)(3) rule and now interpreted in the interim final rule puts a brake on that, doing what the Medicaid rules typically would require you to do would violate the continuous coverage requirement, that's when you stop. If, in the course of your ordinary business, you would move a person from one group to another, and if they stay in that same tier, you are required to do that. If your rules would ordinarily require you to increase somebody's patient liability using the PETI rules, there's nothing in doing that that would violate the rule that's set out in the IFC. You would need to increase that patient liability.

Sarah deLone: Stephanie, does the presumptive eligibility, the rules that explain that people enrolled during the presumptive eligibility period are not considered validly enrolled for purposes of the interim final rule? Does that apply only to presumptive eligibility determined by a qualified entity, or does it also refer to somebody determined presumptively eligible by the state agency itself?

Stephanie Bell: Good question. States have the option to designate themselves as a qualified entity for purposes of making presumptive eligibility determinations. If the state has done that, it's in the PE section of the state plan with the other qualified entities, and some states have done it through a disaster SPA. Then yes, the state would be the qualified entity for this purpose, and the individual determined presumptively eligible by the state would not be considered validly enrolled for this purpose. I would note, though, that if the person had submitted a full application, they remain presumptively eligible until the state makes a determination of eligibility or ineligibility.

Sarah deLone: Great. Thanks, Steph. Gene, if somebody is receiving coverage in a Medicare savings program buy-in only group, and that person becomes eligible for full Medicaid coverage, but they lose eligibility in the buy-in group because they are eligible for a group that has a higher income standard than the buy-in group. Can the buy-in coverage, the Medicare premiums and cost-sharing that they receive, be terminated?

- Gene Coffey: Yes. Not only can it be terminated, but it should be. Where the individual is originally eligible in a Medicare savings program group, and I'm thinking of the QMB group, the SLMB group, the qualifying individuals group. If an individual is eligible under one of those groups but becomes ineligible, but is eligible for a separate eligibility group [inaudible] that provides minimum essential coverage, the individual should be transferred to that other group. Again, it is not something that states would have the discretion to do in that situation. It is something that we would expect the state to do.
- Sarah deLone: Great example of the previous question. Stephanie, with respect to the cost-sharing policy, does this include premiums? If a state waives all premiums, can the state start charging premiums again?
- Stephanie Bell: No. First thing I want to say is the 6008(b)(3) is not the condition to focus on when considering whether a beneficiary can be charged premiums. When we talk about cost sharing with respect to this rule, we are referring to the side that's copayments, co-insurance, and deductibles. The new interpretation of 6008(b)(3) in the IFC does allow states to make changes to cost sharing.
- Stephanie Bell: For example, increasing a copayment for eyeglasses from \$1 to \$2. But with respect to premiums, section 6008(b)(2), so (b)(3) is the one that the IFC really focuses on. (b)(2) requires states to maintain premiums at the same or a lower level as they were assessed on January 1st, 2020 with respect to an individual. In a state that waives all premiums, all beneficiaries that have had their premiums waived would continue to be exempt from premiums until the end of the quarter in which the PHE ends.
- Sarah deLone: Super. Thanks, Steph. Gene, does the new rule apply to beneficiaries who age out from the children's group into the adult group?
- Gene Coffey: Yes it does. Yes. An individual who is eligible in the state mandatory group serving children who, because of age, ages out... Of course that would be the case, of that particular group, but is eligible for these health groups, should be transitioned to the adult group. We note that, obviously while the individual is in the mandatory kids group, the individual would be entitled to EPSDT, and if transferred to the adult group where the individual is under the age of 21, the individual would still be entitled to EPSDT.
- Gene Coffey: But again, if the individual is too old for the mandatory kid's group in a particular state but is eligible for the adult group, or theoretically any other group under the state plan that, again, provides minimum essential coverage, the person should be transitioned to that subsequent group.
- Sarah deLone: Thanks. I want to be mindful of time, and we have several more questions to get through, so I'm going to ask you guys to do your best to be as succinct as you possibly can. I know it's hard to answer these questions succinctly, but if you can so we can leave time for additional questions to come in. Stephanie, with regard to the policy relating to the PARIS match, that only members can be terminated

if there's a PARIS match that indicates potential non-state residency and the state's not able to verify that, and the person does not respond to a request from the state to demonstrate that they still are, in fact, a resident of that state. Does that apply only to PARIS, or can that be applied in other situations, such as when the state receives return mail with an out of state address?

Stephanie Bell: It's really hard for an eligibility person to give a short answer, right?

Sarah deLone: It is.

Stephanie Bell: With respect to this particular policy, it is limited to PARIS matches. There is an exception in the FFCRA and the IFC for individuals who are no longer residents of the state. If the state can affirmatively confirm that a beneficiary is no longer a resident of that state and is in fact a resident of another state, that individual's eligibility would be terminated under this exception. But it's important to keep in mind that especially during the pandemic, many Americans are temporarily moving around, and may be located in a different state but have no intention of staying in that state, and in effect would be considered temporarily absent under the state's policy. This particular exception is limited to PARIS.

Sarah deLone: Thanks. Gene, if an institutionalized individual no longer meets nursing facility level of care, may the state deny Medicaid for this level of care, provided that they still would be eligible for community Medicaid?

Gene Coffey: Another good question. The fact is that if an individual is in an institution, such as a nursing facility, and no longer meets the medical necessity level of care standard the state applies for purposes of coverage for the benefit, the state should no longer provide coverage for that particular benefit. Now in the case of somebody who's in a nursing facility who is determined to no longer meet the coverage requirement and has Medicaid payment for the services stop, there is obviously going to be a very good chance that the individual is going to be exiting the nursing facility.

Gene Coffey: Now of course there are many restrictions under the federal law in terms of the circumstances under which a nursing facility can kick somebody out, but if it were to happen, if the individual no longer... Well, again, the first rule, and I know I'm supposed to be brief. I'm trying to. But again, the first rule is that if the individual no longer meets the coverage requirement, the coverage should stop.

Gene Coffey: In this example, the individual ends up leaving the facility as a result, and there is no other eligibility group for which the individual meets the eligibility requirement, and the individual's original group, probably the special income level group provided MAC, which the special income level group does, the individual would have to be kept in the special income level group. I understand that the individual in this example is no longer even in an institution, but under the IFC, where an individual loses eligibility from one group that provided minimum essential coverage and is not eligible for any other group covered

under the state plan that also provides MAC, the individual has to be kept in the original group.

Sarah deLone: Okay. You guys are doing well. I know it's a challenge for us eligibility nerds, but I appreciate the effort. Stephanie, how does the maintenance of effort provision we've been discussing impact premium assistance programs for individuals who are enrolled, for example, in an employer sponsored insurance for which the state Medicaid agency pays the premiums? Can individuals be terminated from such premium assistance programs?

Stephanie Bell: There's no exception to the MOE for individuals in premium assistance, which means that if the person is eligible for full Medicaid benefits and is no longer eligible for that employer sponsored insurance, the state would need to start furnishing the full benefit package that would be available to any other person in the group or demo which that person's eligible for.

Stephanie Bell: If they are in a state diffusing 1115 expenditure authority to provide just premium and cost-sharing supports to individuals who have ESI, and that person then loses access to their employer sponsored insurance, the state wouldn't terminate the beneficiary's eligibility, but they would stop paying the ESI premiums. If the individual regains access to ESI, that premium and cost-sharing support could be started back up again since they would still be enrolled in the demo. The state can't terminate them, they would have to maintain them in that status until the end of the month in which the PHE ends.

Sarah deLone: Helpful. Thanks. I want to acknowledge that we got a question from Massachusetts, actually, which is a little bit of a variation on that theme involving somebody who becomes eligible for Medicare. We're going to need more information, and so we are reaching out to provide one on one TA to Massachusetts on that question that they asked.

Sarah deLone: Gene, we have one question that's come in that related to the transfers of assets rules. How are states to apply transfer of assets penalty, the penalty period, under the IFC?

Gene Coffey: Mm-hmm (affirmative). Very good. Thank you. We understand that this particular question is of acute interest on the part of many states. First, from certainly, certainly from this point forward, where a new individual is applying for Medicaid and is institutionalized and has made asset transfers in his or her lookback period, uncompensated ones that are not otherwise exempt, you should be applying the penalties against the individual's institutional services.

Gene Coffey: If there are any individuals who attained Medicaid coverage during the PHE and who were determined to have made up asset transfers during their lookback periods, but you did not apply the penalty because we had not confirmed that it was permissible to do so, you should also apply penalties against those individuals equal to the number of months the individual should be penalized. In

other words, there should not be a reduction in the number of months between the onset of the PHE and our publication of the IFC.

Gene Coffey: Additionally, if any institutionalized individual applied during the PHE and you did not determine whether the individual made any transfers because of administrative challenges, or again because we had not confirmed that the application to transfer group was permissible, you should determine whether such individuals made any asset transfers during their lookback period, and again apply a penalty in full against the individual's institutional coverage.

Gene Coffey: There are one or two scenarios that I have not addressed, which we are still grappling with on the CMS end. I'm guessing at some point our state partners are probably going to want to receive something in writing related to what I've just laid out, but ultimately, I at least hope that with regard to the hypotheticals or the scenarios that I just laid out that it's clear. The starting point, of course, again is that transfer rules should be applied moving forward, and that where states delayed the application of them because we had not clarified that the application of the penalty was permissible, they should apply those penalties in full.

Jackie Glaze: Thank you, Gene and Stephanie and Sarah. Really appreciate the information you've shared. I want to move on now to give the audience a few minutes to ask a few questions. At this time, we will move on to the questions through the chat box and take a few questions, and then we'll open up the phone line. Do we have some questions at this point, Ashley?

Ashley Setala: Yes. The first question is a clarification to one of the FAQs that was just discussed. "Can you clarify that if a person ages out of a children's group eligible for EPSDT and transitions to an adult benefit category that meets minimum essential coverage (MEC), that the individual must continue to receive the EPSDT benefit?"

Gene Coffey: Yes. This is Gene Coffey again. I can confirm that, so long as the individual is under the age of 21, which in all likelihood the individual is going to be. Now there may have been... Maybe there's a scenario under which an individual who aged out of the state's children's group was over the age of 21, maybe turned 22 in a state that granted coverage up to or kids up to 21, who becomes eligible, who is eligible for the adult group. But let me just deal with that scenario. Stephanie and Sarah, let me know if you have anything to add.

Gene Coffey: If, for example, in May or June when, again, our original reading of (b)(3) was applicable, an individual was 21 in the state in which the children's group vaccine age was up to 21. Where the individual became 21, we basically instructed that the individual should have his or her Medicaid coverage, which included EPSDT, while the individual was in the kid's group maintained. But now, however, if an individual is in the state's kids group where coverage is provided to kids up to the age of 21, and the individual turns 21, and he or she is eligible for the adult group in the state, the state should transition the individual to the adult group, and

EPSDT would no longer be available to that person because the individual is now over the age of 21.

Sarah deLone: So the critical question is, has the person turned 21 or not? If they've turned 21, no EPSDT. If they're under 21, they still are entitled to EPSDT, regardless of whether they're in the adult group or the children's group.

Barbara Richards: Great. Thanks, Sarah.

Gene Coffey: Sarah said it more quickly than me. Thanks, Sarah.

Barbara Richards: Thanks, Sarah and Gene. We have another question from the chat, and the question is, "Will federal funding still be available for benefits provided to persons who are not validly enrolled?"

Sarah deLone: So-

Sarah deLone: If a state discovers that they have somebody who's not validly enrolled, the expectation is that they will take... First you have to provide advanced notice. Those rights still apply. The state would be expected to take the actions that it needs to take. You figure out there's been somebody who is not validly enrolled, say the state made an error, the person actually did not meet the eligibility requirements due to state error, and then you provide the advanced notice of termination and fair hearing rights. That would be the expectation, and during that period of time to comply with those requirements. Certainly, FFP is available.

Ashley Setala: Okay, great. The next question then is, "Qualified health plans offered through the exchange provide minimum essential coverage. We have a state-based exchange and share an eligibility IT system. Can a state terminate Medicaid for enrollees receiving tier 1 minimum essential coverage who become ineligible for Medicaid during the PHE and who are determined eligible for enrollment in a qualified health plan with or without advanced premium tax credits?"

Sarah deLone: No because it's not Medicaid. You still have to be enrolled in Medicaid to satisfy the 6008(b)(3), continuous coverage requirement. Transferring a beneficiary to the marketplace or transferring them to a separate CHIP program would not satisfy the requirements.

Jackie Glaze: Since we just have another minute or two, let's move to the phone lines. Operator, can you open up the phone lines at this point?

Operator: Sure. At this time, if you'd like to ask a question, please press star then the number 1 on your telephone. If your question has been answered and you wish to remove yourself from the queue, press the pound key. One moment for your first question. And there are no questions over the phone line.

Jackie Glaze: Okay. In closing, I would like to thank Kirsten, Sarah, Gene, and Stephanie, and also Jeff Wu for their presentations and information that they shared today. It's been very helpful, and we know that we'll get additional questions from all of you. But looking forward, we will be canceling next week's call as many of you will be attending the Annual National Association of the Medicaid Directors Conference, so we will reconvene in two weeks on November, the 17th. We will be sending out an invitation with the topic so that you can plan for the next call.

Jackie Glaze: If you do have questions in the meantime, please reach out to us. You can reach out to your state leads or any of us, and we'll be more than happy to assist you. We thank you again for your participation and joining us today, and we hope that everyone has a great afternoon. Thank you all.

Operator: Ladies and gentlemen, this does conclude today's conference call. Thank you for your participation. You may now disconnect. Speakers, please remain on the line.