HHS-CMS-CMCS
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Coordinator: Good afternoon and thank you for standing by. Your line has been placed on a listen-only mode until the question-and-answer session of today's conference. At that time, you may press star followed by the number 1 to ask a question. Please unmute your phones and state your name when prompted.

Today's conference is being recorded. If you have any objections, you may disconnect at this time.

It is now my pleasure to turn the call over to Krista Hebert. Thank you. You may begin.

Krista Hebert: Good afternoon and welcome everyone to today's All-State Call-In Webinar. I will now turn to Anne Marie Costello, Deputy Director of the Medicaid and CHIP, for opening remark. Anne Marie?

Anne Marie Costello: Thanks Krista. And hi, everyone, and welcome to today's All-State Call. On today's call, we'll be providing information on two important topics.

First, Emily King from our Children and Adults Health Programs Group will provide a brief overview of the premiums and continuous eligibility FAQs released on October 27.

Then, Anna Bonelli from our Financial Management Group and Abby Kahn, from - and also from the Children and Adult Health Programs Group, will

provide an important overview on an interim final rule entitled, CMS Enforcement of State Compliance With Reporting and Federal Medicaid Renewal Requirements Under Section 1902(tt) of the Social Security Act that was released yesterday, December 4.

This presentation will describe how CMS will implement the new enforcement authorities provided under the Consolidated Appropriations Act.

Before we get started, I wanted to let folks know that we'll be using the Webinar platform to share slides today. If you are not already logged in, I suggest 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 the presentation.

With that, I'm pleased to turn things over to Emily King to provide an update on the premiums and continuous eligibility FAQs. Emily?

Emily King: Thanks, Anne Marie. Hi everyone, I'm Emily King from the Children and Adult Health Programs Group at CMCS, and I'm here today to talk about the FAQs we posted on October 27, related to continuous eligibility, or CE, and nonpayment of premiums.

And these FAQs follow the state health official letter we released on September 29, which provided guidance to states on mandatory CE for all kids in Medicaid and CHIP beginning on January 1, 2024. And in that September show, we were silent on the question of whether states could terminate CHIP coverage during the CE period if the family does not pay premiums in CHIP.

Current regs say that states can't terminate Medicaid coverage during a CE period due to nonpayment of premiums, so this is really just a CHIP question.

And the answer we posted in late October is no. That states cannot terminate CHIP coverage during a CE period if the family does not pay premiums. I'd encourage you all to take a look at the FAQs for a more detailed explanation of our rationale.

The FAQs also address a related question which many states have had, which is around the availability of federal financial participation, or FFP, for unpaid premiums. Due to existing Medicaid and CHIP regs, FFP is not available for unpaid premiums covered by the state or any other entities such as managed care entities.

We know that these two answers just scratched the surface of your questions, and many of you have submitted important follow-up questions for us on the implication of nonpayment premiums at renewal, blackouts, and things of that nature. And we are working really hard on those and hope to have answers for you soon. So if you have submitted a question already, know that we are working on it, and we promise if we have not forgotten about you.

So with that, I will turn it over to Anna and Abby.

Anna Bonelli: Great. Hi. Next slide, please. Hi, I'm Anna Bonelli, and I'm going to talk about our new rule that was released yesterday on the new reporting requirements and enforcement authority.

One point of clarification, this is an interim final rule with comments. We call it an IFC, which means it's effective starting tomorrow. There'll be no proposed rule, so it's already, you know, effective tomorrow. So anyone who's interested can comment during the 60-day comment period, and you can find more information on how to comment on the Federal Register web page.

Okay. So let's get into the material a little bit. This gets a little technical, so please stay with me, and there will be plenty of time for questions at the end. So as most of you know, since March 2020, as a condition of receiving an increased federal matching rate, states have been required to maintain enrollment of nearly all Medicaid enrollees.

Now that the continuous coverage requirement has expired, states have restarted full Medicaid and CHIP eligibility renewals, and this process has commonly been referred to as unwinding. So I think we are all familiar with this.

As most of you know, the Consolidated Appropriations Act for 2023 was passed almost a year ago. It made many changes to the requirements related to unwinding, but for our discussion today, we are only going to focus on the new reporting requirements and enforcement authorities that that CAA added in Section 1902(tt) of the Social Security Act. Next slide, please.

So the rule we released yesterday has several parts. I'm going to focus on the data reporting and the possible penalties for noncompliance with these new data reporting requirements, and Abby will focus on other parts.

So under Section 435.927, states must report certain data. Now, all the data elements themselves are listed in the appendix in the slideshow on the very last slide. So I'm not going to spell out, you know, each of the data points that states need to report. But the required data all relate to renewals, transitions to other types of healthcare coverage from Medicaid and CHIP, and other operational information.

States can maintain compliance with these new requirements by submitting the required monthly data on time and according to specifications that are outlined in guidance that has already been issued. Data must be complete and

of sufficient quality, which is defined in the rule. And there are some exceptions to these requirements, and I will talk about that a little bit later.

The rule requiring states to report these data only applies to the month between April 1, 2023, and June 30, 2024. So states have already been reporting - excuse me, submitting the required data for months. In fact, long before April 1, for most data points, states have already been submitting. The new rule does not change the reporting requirements that states have already been adhering to.

And in fact, CMS has already been compiling and reporting these data on our web site for months. These data increase transparency about eligibility redeterminations during this critical unwinding period. Next slide, please.

Now, if a state fails to comply with the reporting requirements, the CAA requires CMS to impose a penalty on states. So between the same months that I mentioned on the last slide, that's April 1, 2023, and June 30, 2024, between those months, if the state fails to comply, CMS will reduce the states federal medical assistance percentage, this is the FMAP. So essentially, this is the monetary penalty that we're talking about.

The amount of the penalty varies depending on how many different quarters the state is noncompliant. So if a state fails to report in one month, CMS will reduce that states FMAP for the entire quarter. The amount of the reduction is a quarter of a percentage point.

If a state fails to comply in two different quarters, or the second quarter, the penalty will rise to 1/2 percentage point. The maximum penalty is 1 percentage point. So a couple of clarifications just to make this super clear.

States incur the penalty if they are noncompliant for a single month in a quarter. So the penalty will apply to the entire quarter, even if the state only misses one month during that quarter. And another clarification, the FMAP that we're talking about in this discussion is the FMAP at 1905(b) of the Social Security Act, which is basically often referred to as, like, the default FMAP. It's the most commonly referred to FMAP. Just to help you understand what's going on here. Next slide, please.

Now, CMS recognizes that states can encounter all kinds of circumstances throughout the year. There are hurricanes and cyberattacks, et cetera, that affect states' ability to submit data on time or to use the specific data portal that's designated for submitting certain data. In such circumstances, CMS may approve alternative timelines and/or processes if a state is making a good faith effort to submit the required data.

So again - so in order for CMS to approve an alternative timeline or a submission process, the state would need to make a good faith effort by requesting an alternative timeline or process and receive approval from CMS, and by ultimately submitting the data to CMS in a manner and in a time that allows CMS to make our obligation to report the data publicly - excuse me, to meet our obligation.

So the bottom line is, when a state finds that they are confronting unusual circumstances, please reach out to us as soon as possible. Many of you have contacts at CMS, but the easiest way to get in touch with us is to email cmsonlinesupport@cms.hhs.gov. So now I'm going to turn it over to Abby to talk about other enforcement authorities. Abby?

Abby Kahn: Thanks Anna. Next slide, please. As Anna mentioned, CMS has been working with states for years to prepare for the end of the Medicaid Continuous

Enrollment Condition under the FFCRA and the Return to Normal Enrollment and Eligibility Operations.

We remain committed to continuing the partnership with states that has been so successful to date and appreciate the collaboration that has resulted in many states implementing mitigation to minimize harm to beneficiaries.

Our goal remains to ensure all states are compliant with reporting and federal redetermination requirements and to minimize unauthorized loss of coverage during unwinding. And this rule gives CMS new tools authorized under the CAA to achieve that goal.

In the event CMS identifies a violation of reporting or federal redetermination requirements, and if a state fails to agree on an acceptable mitigation strategy, this rule implements our new statutory authority to require a state to submit a corrective action plan or a CAP.

So for purposes of this rule, what we mean by federal redetermination requirements is all the Medicaid requirements applicable to eligibility redeterminations outlined in Section 435.916, including any alternative processes and procedures approved by CMS under, for example, Section 1902(e)(14) or Section 6008(f)(2)(A) of the FFCRA.

If the state fails, then, to either timely submit or implement an approved CAP, CMS may require a state to suspend some or all procedural disenrollment, impose daily civil money penalties, or both. Next slide, please.

So if we find ourselves in the position to take corrective action, CMS will always send a written notice of noncompliance to a state when requiring a CAP. The notice will include key information, including a description of the violation of reporting or redetermination requirements that led to the

requirement of a CAP, instructions on how and by when to submit a CAP, as well as an explanation of subsequent enforcement actions CMS may take if the state fails to meet the CAP requirements, including suspension of procedural disenrollments and CMPs. Next slide, please.

To meet the CAP requirements and avoid further enforcement action, a state must submit a CAP that is timely, it must include the required content to be approvable, and the state must implement the CAP timely. So to be approved, the states CAP must include the following content.

It must identify immediate actions the state will take to mitigate harm to beneficiaries, which could include reinstating beneficiaries or voluntarily suspending some or all procedural disenrollments until an appropriate mitigation strategy can be implemented.

It must list steps for the state to come into compliance with reporting or redetermination requirements in the longer term. And it must specify dates and milestones by which the state will achieve the steps outlined in the CAP. And it must outline a plan for the state to communicate the steps in the CAP to CMS, state staff, and beneficiaries. Next slide, please.

As I said, to meet the CAP requirements, a states CAP must be both approvable and submitted and implemented timely. To be approvable, the CAP must include the content discussed just on the previous slide. And it must outline steps for the state to eliminate or minimize beneficiary harm as expeditiously as possible.

And it must present a plan that would achieve full compliance within a reasonable timeframe. And in evaluating what's reasonable, we would consider any need for systems changes, the creation of new policies and procedures, staff training, et cetera.

To be timely, the CAP must be submitted within 14 days of the date on the notice. CMS will approve or disapprove the CAP within 21 days of submission of the CAP by the state.

And lastly, the state must begin implementation within 14 days of CMS's approval. This means seeking the immediate actions identified in the - by the state to mitigate harm or risk of harm while the state implements the rest of the CAP.

And if the CAP is submitted timely, approved, and implemented timely, then the state will be in compliance with the CAP requirements, and CMS will not take further enforcement action. After a CAP is implemented, CMS will continue monitoring that the state fulfills the steps in the CAP. Next slide, please.

However, if the state either doesn't submit or implement the CAP according to the deadlines just mentioned, or the CAP doesn't include the required content, or the steps in the CAP do not seem reasonable to fix the underlying issue leading to the noncompliance with the reporting or redetermination requirement, or CMS approves the CAP, but the state does not begin promptly implementing it, or the state starts implementing but subsequently fails to meet key milestones in the CAP. These are all reasons why CMS may determine that the state is out of compliance with the CAP requirements, and we may further - take further enforcement action, including requiring the state to suspend procedural disenrollment, pay CMPs, or both.

Again, CMS will always send the state a written notice prior to taking enforcement action. The notice will outline which enforcement action CMS is taking, the relevant deadlines by which the state must take action, instructions

for submitting payment of CMPs, if applicable, and appeal rights available to the state.

And if CMS requires the state to suspend procedural disenrollment, the notice will indicate whether it must suspend all or just some of the disenrollment. And this depends on the impact of the underlying violation that led to the request for the CAP.

If the impact is determined to be broad, then CMS will require the state to suspend all procedural disenrollment. If the impact is narrow, then we'll just require the state to suspend some procedural disenrollment.

So for example, if the state is unable to conduct ex parte renewals for only beneficiaries in long-term care, then CMS would require the state to suspend procedural disenrollment of only beneficiaries in long-term care.

If CMS imposes CMPs, the notice will also indicate the initial amount as well as instructions for remitting payment.

So here, the statute gave CMS discretion to charge up to $100,000 a day in civil money penalties. We apply this discretion in the rule by starting with a smaller daily penalty at $25,000 a day and increasing the amount monthly before reaching the maximum allowable penalty amount.

If a state has not come into compliance with the CAP requirements by the 60th day, the daily amount will reach the maximum of $100,000 a day.

Again, these enforcement actions are taken not in direct response to the underlying reporting or redetermination violation, but rather when the state has failed to timely submit or implement an approved CAP.

So for CMS to lift these enforcement actions, the state must come into compliance with the CAP requirements. So that means it must submit, start, or resume implementing an approved CAP.

Once the CAP violation is remedied, CMS will retroactively lift the CMPs as of the date the state submitted the approvable CAP. Next slide, please.

As I mentioned earlier, the statute gave CMS some discretion in when and how to take these enforcement actions. In the rule, we've interpreted that discretion to mean that CMS will consider whether certain mitigating circumstances exist before requiring a CAP and before requiring a state to suspend procedural disenrollments or impose CMPs.

CMS recognizes that sometimes events are outside the states control, and not all violations have the same risk of harm to beneficiaries. Therefore, we will consider certain factors in deciding whether to require a CAP, a suspension of procedural disenrollments, or CMPs.

First, in deciding whether to require a CAP, CMS will consider whether there was an emergency or other extraordinary circumstances that prevented the state from meeting the reporting or redetermination requirements. If there was, we may delay or not require a CAP.

Second, for redetermination violations only, we'll consider whether the noncompliance caused harm or presents a significant risk of harm to beneficiaries. If not, we may delay or not require a CAP.

Third, for reporting violations only, we'll consider whether the state can easily and quickly fix the issue without a CAP. If yes, we may delay or not require a CAP. Next slide, please.

Once we're at the point where we've already required a CAP, but the state fails to meet the CAP requirements, then we will consider a different set of mitigating circumstances before taking further enforcement action.

First, we'll again consider whether there was an emergency or other extraordinary circumstances that prevented the state from meeting the CAP requirements. If yes, we'll still require the suspension of procedural disenrollment, but we may delay or not impose CMPs.

Second, for reporting violations only, we'll consider whether the violation impedes our ability to monitor procedural disenrollment. If not, we'll still impose CMPs without delay, but we will delay by one month, requiring the state to suspend procedural disenrollment. Next slide, please.

States that disagree with CMS's decision to reduce their FMAP due to a reporting violation may appeal under existing appeal processes or disallowances. States that disagree with the requirement to suspend procedural disenrollment or the imposition of CMPs may appeal CMS's decision to the HHS Departmental Appeals Board. However, states do not have a right to appeal CMS's decision to require a CAP.

For appeals of suspensions and CMPs, states may appeal to the board within 30 days of the enforcement notice. CMPs will continue to accumulate until a decision is rendered. If the board overturns CMS's decision and the state wins the appeal, then the CMPs will be lifted retroactively.

On the other hand, if the board upholds CMS's decision, then the state must pay the CMPs. Next slide, please.

If the state disagrees with the Board's decision, it may request a reconsideration by the CMS administrator within 15 days. If the administrator

decides in the states favor, CMPs will be lifted retroactively. The CMS administrator's decision is the final agency action.

And for the next slide, I'm going to transition it back to Anna.

Anna Bonelli: Great. Thanks, Abby. Okay. So this slide walks through the process of possible enforcement actions that CMS might take under different circumstances. This slide focuses on the reporting requirements, okay? So only violations of the reporting requirements.

And then the following slide, Abby will come back and talk about a different flowchart on renewal requirements.

Okay. So first, a little overview of the flow here because I know it's complicated. Green boxes show questions about decisions that CMS has to make, so these are followed by arrows to either more questions or to blue boxes. Blue boxes show the end results, okay? So hang in there.

Starting in the upper left corner with the green box, CMS will determine if a state has submitted all the required data. If not, CMS is required to impose an FMAP reduction, as I discussed earlier in the presentation. And this is shown in the second column in the top blue box. Once the state receives the FMAP penalty, CMS needs to decide if a CAP is necessary. So now I'm moving down that second column.

And then we will evaluate if the state submits the CAP or - and this is later in the process, if the state is implementing the terms of the CAP. If not, we move into the third column.

We try to make sure that there are no extraordinary circumstances, this is something that Abby talked about. If there are, CMS will delay or forego

CMPs, and we will make sure to only immediately suspend procedural disenrollment if we need that data that's missing for oversight of procedural disenrollment.

Okay. So if there are no hurricanes, et cetera, extraordinary circumstances, then again, and here I'm looking at that fourth column, lower green box. We will evaluate the missing data. And if we find that the states missing data impedes CMS's oversight of procedural disenrollment, and CMS will require the state to suspend procedural disenrollments right away.

If not, CMS will delay a suspension for a month, but either way, CMS will impose CMPs. And you can see that in the lower two blue boxes in the rightmost column.

Finally, this process goes back to the second column, if necessary, and sort of, you know, restarts because - or if necessary, if the state didn't submit or implement the CAP.

Okay. I know that's a lot. But Abby's slide is a little bit simpler, okay? So Abby, you're up.

Abby Kahn: Thank you. So this slide illustrates how the different decision points outlined in the rule can play out in practice when a state is in violation of federal redetermination requirements. So similar to the prior slide, this process starts in the upper left corner with the red box indicating a states violation of federal redetermination requirements.

So first, moving to the right, in the pre-compliance period, the state and CMS work together to bring the state into compliance with all Medicaid redetermination requirements. If the state is willing to adopt mitigation, then there is no further compliance action.

However, if the state is not willing or able to adopt an acceptable mitigation strategy to address the underlying violation, then we move to the next decision point shown in the flow chart, which is whether to require a CAP or not.

So first, we ask if mitigating circumstances apply. If mitigating circumstances apply, like there's no harm to beneficiaries or there was extraordinary circumstances that apply, CMS will take no further action for the time being. As the asterisk in the big blue box at the top of the middle of the slide indicates, we may take action later if the state still doesn't mitigate the problem.

However, if no mitigating circumstances apply, then CMS will require the state to submit a CAP.

The second decision point is reached if the state fails to meet the CAP requirement, at which point CMS will immediately require suspension of some or all procedural disenrollment.

Then - again, in the big green box, sort of in the middle to the right on the bottom, we will consider whether any mitigating circumstances apply in deciding whether CMS will also impose CMPs. So if there are mitigating circumstances, CMS may delay or not impose CMPs.

However, if no mitigating circumstances apply, then we will impose CMPs at the same time that we require the suspension of procedural disenrollment according to the schedule listed in the blue box on the far right bottom.

And again, it's important to note that this is a cyclical process, and CMS will continue to monitor state compliance. For that reason, we have an arrow at the bottom of the chart indicating that once the state submits a CAP, the

monitoring process begins again, and CMS reserves the right to impose further penalties if the state falls out of compliance with the CAP requirements.

So at this point, I will turn it back to the moderator.

Anne Marie Costello: Fantastic. Thank you everyone for your wonderful presentations today. At this point, we will be turning things to face for open question Q&A. At this point, if anyone has a question, they can enter it into the chat function and I will read it aloud.

And at this point, I am seeing one question in chat, so I'll just go ahead and get started as folks enter their questions. This question is unrelated to the slides, but does CMS anticipate that the NPRM clarifying eligibility for a qualified health plan through an exchange, advanced payments on the premium tax credit, cost-sharing reductions, and basic health program, and for some Medicaid and CHIP health insurance programs, the DACA NPRM, which was published on 04-26-23. Will these be finalized, or perhaps a portion of them be finalized? If so, can CMS provide an anticipated timeframe for finalization?

So I'm not sure if we have anyone on the call today to help answer this question. If not, then we can certainly take it back, but I will turn things over to my colleagues in case there is someone. All right. So I will take note of this question and circle back, and we can provide a response offline.

I see another question here in the chat. Can you please provide the link for the slide deck again, please? Yes. The slides will be posted on medicaid.gov very shortly after the presentation.

At this point, I'm not seeing any additional questions in the chat. So just a reminder if folks have any questions, they can post them in the chat.

(Michelle), since I'm not seeing any additional questions in the chat, perhaps we can open the phone lines to see if anyone would like to verbally ask a question.

Coordinator: Thank you. At this time, if you would like to ask a question, you may press star 1. Please unmute your phones and state your first and last name when prompted. Again, that is star 1 to ask a question and star 2 to withdraw your question. One moment, please. Again, that is star 1 if you would like to ask a question. At this time, I am showing no questions.

Anne Marie Costello: All right. We can just give folks another minute or so.

Coordinator: One moment, please. Caller, you may go ahead. You didn't - nobody stated their name. I apologize. Caller, your line is open. Can you please state your first and last name?

(Jacqueline Myers): (Jacqueline Myers).

Coordinator: Thank you.

(Jacqueline Myers): Sorry, I was on mute. Didn't realize it.

Anne Marie Costello: (Jacqueline), your line is open.

(Jacqueline Myers): Oh, sorry. So the question is - I joined late, I'm sorry. So has there been letters sent out that people are on corrective action plan for their reporting?

Anna Bonelli: Hi. It's Anna Bonelli. Thanks for joining. No. There have been no letters sent out issuing a requirement for states to develop a correction action - corrective action plan as a result of not reporting. So far, states have been reporting the required data and CMS has been issuing that data publicly.

(Jacqueline Myers): Okay. Since I'm sort of new to this, is this just you codify?

Anna Bonelli: Yes. So, you know, as I said, the Consolidated Appropriations Act passed about a year ago, we've issued guidance to explain what the reporting requirements are, and this will further codify the reporting requirements that we have already issued.

(Jacqueline Myers): Okay. Thank you. Sorry, my policy person had me jump on. I'm just the data person, and I thought we were doing what we're supposed to be doing, so thank you.

Anna Bonelli: Sure. Glad to have you.

Coordinator: And once again, that is star 1 if you do have any questions or comments.

Anne Marie Costello: And as a reminder, you can also place your comments in the chat function. I'm not seeing any additional questions as of right now, but it is still open.

Coordinator: And at this time, I am showing no further questions on my end.

Anne Marie Costello: Okay (Michelle), I think since we're not receiving any questions, we can go ahead and wrap up early today. Thank you so much everyone, for joining our call today.

Coordinator: And thank you. This concludes today's conference call. You may go ahead and disconnect at this time.

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