Centers for Medicare & Medicaid Services
COVID-19 Medicaid & CHIP All State Call
December 15, 2020
4:15 pm ET

Coordinator: Welcome and thank you for standing by. I'd like to inform all parties that your lines have been placed on a listen only mode until the question and answer session of today's conference. To ask a question at that time, please press star 1, unmute your phone, and record your name so you can be introduced for your question. Today's call is also being recorded. If anyone disagrees, you may disconnect at this time.

It is my pleasure now to turn the call over to Ms. (Julie) - I'm sorry, Ms. Jackie Glaze. Thank you. And you may begin.

Jackie Glaze: Thank you. And good afternoon and welcome everyone, to today's all state call. I will now turn to Anne Marie Costello, our Acting Center Director. And she will share highlights for today's discussion. Anne Marie?

Anne Marie Costello: Thanks, Jackie and welcome. And thank you everyone for joining us today. I know we had a change in time but I'm thrilled to see that we have so many people on the line with us today. On today's call, we will continue our discussion from the last few weeks regarding the continuous enrollment provision of the Interim Final Rule. And I will also provide an update on vaccines.

Sarah DeLone, the Director of the Children and Adult Health Programs Group and our subject matter experts, will talk through the answers to a number of additional questions on the continuous enrollment provisions of the Interim Final Rule.

After those FAQs, we'll open up the lines for your general questions. Before we jump into the continuous enrollment question and answer session, I want to talk about the COVID-19 vaccines for a few minutes. As I'm sure you've all seen, over the weekend the FDA authorized emergency use of Pfizer's COVID-19 vaccine and the advisory committee on immunization practices or the ACIP, has recommended the vaccine for those 16 years of age and older.

We have also been able to confirm with our colleagues in CDC, that the Pfizer COVID-19 vaccine for the ages 16 to 19, will not be provided through the Vaccine for Children Program but rather, will be provided through the COVID-19 vaccine program. Therefore, the VFC regional maximum ceilings do not apply.

We encourage states to review their state plans to determine if changes are necessary to their reimbursement methodologies related to vaccines for these individuals. This information will be outlined in an update to our vaccine toolkit that we are hoping to release in the coming days.

In this toolkit update we'll also be providing additional information on Medicaid managed care network adequacy and state plan amendment processes, including ways to expedite vaccine administration reimbursement state plan amendments.

We also provide some information on state flexibilities with respect to payment of vaccine administration, and provide some examples for consideration including an example based on Medicare vaccine administration reimbursement.

As outlined in the updated toolkit, states looking to expeditiously update their reimbursement rates for the COVID-19 vaccine, may submit a Disaster Relief

State Plan Amendment template. However, these approvals will be temporary through the end of the public health emergency. That said, the disaster SPA process can provide states with an early effective date that would otherwise be available through the routine SPA process.

Even if a state takes advantage of the disaster SPA process, the state would need to submit a regular SPA if they want to continue to receive the temporary 6.2 percentage point FMAP increase for as long as possible. This is necessary because a state must provide coverage and payment for COVID-19 vaccine administration for the end of the last quarter of the public health emergency, to receive the increased FMAP for that quarter.

And the disaster relief Medicaid SPAs cannot extend beyond the date of the COVID-19 public health emergency end. Again, we'll provide more information on these changes in the next release of our vaccine toolkit, which we expect to issue shortly. I'd also like to take this opportunity to encourage states to take a close look at their vaccine administration reimbursement rates and consider Medicare's policies and rates for the COVID-19 vaccine.

Medicare payment rates for COVID-19 vaccine administration will be $28.39 to administer single dose vaccines. For a series of two or more doses, the initial dose administration payment rate is $16.94 and $28.39 for the administration of the final dose. These rates will be geographically adjusted and recognize the costs involved in administering the vaccine, including the additional resources involved with required public health reporting, conducting important outreach of patient education and spend an additional time with patients answering any questions that they may have about the vaccine.

States may also want to consider extending those rates to the administration of (PE)s for individuals under age 19. Any states with questions on these changes, are encouraged to reach out to their state leads for more information. With that, I'll turn things over to Sarah DeLone to start our continuous enrollment discussion. Thank you. Sarah?

Sarah DeLone: Thanks, Anne Marie. So today we are going to present a set of questions in a final topic area that we haven't addressed yet on these all state calls, on the Interim Final Rule before opening up the lines to answer any questions you may have on the information presented on today's call, or previous calls or of course, whatever other questions you may have.

So today specifically, Gene Coffey, a Technical Director and our (Age/Body) Disabled Eligibility expert, is going to answer questions regarding the application of the continuous coverage requirement under the Interim Final Rule, to individuals participating in a 1915(c) waiver program, or receiving institutional or other long term, excuse me, long term care services and support.

So Gene, first basic question. Can a state terminate an individual's participation in a 1915(c) waiver during the PHE, consistent with the continuous coverage requirement under the Interim Final Rule?

Gene Coffey: Right. Very good. Thanks, Sarah. This is a very fundamental and very important question. Hi folks. You know, this is Gene Coffey from Medicaid Eligibility. And before I answer this and our other HCBS questions, I just want to quickly note the work my eligibility colleague, (Catherine Birdland) and our (DEHPG) colleague, (Ralph Lallor) contributed to our answers today. And hopefully these answers sill be helpful.

So as Sarah said, our first fundamental question is can a state terminate an individual's participation in a 1915(c) waiver during the PHE? And the answer is yes. Under the Interim Final Rule if a Medicaid beneficiary participating in a 1915(c) waiver is no longer able to participate in the waiver because for example, the individual no longer meets the relevant level of care for the waiver, a state can terminate an individual from the waiver without violating the continuous coverage provision of the F-F-C-R-A or FFCRA.

Of course, a state would have to provide advanced notice of the termination to the individual and an opportunity for a fair hearing. But if the termination is otherwise required under the Medicaid statute and regulations and the state's 1915(c) waiver and the state has complied with all pre-termination procedures, well then a state would not violate the continues coverage provision by terminating the individual waiver participation.

Now because all 1915(c) waiver participants are eligible for Medicaid under the state plan, states claiming FFCRA's enhanced FMAP must ensure that no individuals lose their underlying Medicaid eligibility as a result of a termination from their 1915(c) waiver.

For most Medicaid beneficiaries participating in a C waiver, the waiver termination will not impact their underlying eligibility. However, under Medicaid's rules, a termination from a 1915(c) waiver would ordinarily impact the underlying eligibility of two populations of beneficiaries. Number one, individuals in the eligibility described at 42 CFR 435-217 of our regulations, which we generally refer to as the 217 group, and those medically needy beneficiaries whose financial eligibility is determined under institutional deeming rules because of their eligibility for a 1915(c) waiver.

For these particular individuals, a termination from a waiver would ordinarily impact their underlying Medicare eligibility. However, for states claiming the enhanced FMAP authorized under FFCRA Section 6008(b)(3) and Section 433-400 of the Interim Final Rule, protect the Medicaid eligibility of such beneficiaries.

As states claiming the enhanced FMAP may not terminate the underlying Medicaid eligibility of any validly enrolled beneficiaries through the end of the month in which the PHE ends, with the exception of course, as we've noted many times, of those individuals who move out of their states or voluntarily disenroll.

So states cannot terminate for example, the coverage or as we've just, you know, gone over, the coverage of a 217 group enrollee or a medically needy beneficiary who again, has had his/her eligibility evaluated under institutional rules, where those individuals are terminated from C waivers during the PHE.

Instead again, states must be sure that any action they take stemming from the individual's waiver termination, is consistent with the Interim Final Rule. For example, 217 group enrollees receive full state plan benefits, which is tier one coverage under the IFC.

Thus, consistent with Section 433-400 of the IFC, for a 217 group enrollee who is terminated from a C waiver and is not eligible for any other tier one group coverage under the state plan, a state would have to keep such individual in the 217 group and provide full state plan benefits notwithstanding the fact that the individual is no longer participating in the C waiver itself.

Sarah DeLone: I feel like I should give a little pause for people to digest that. That was a lot. Thanks, Gene.

Gene Coffey: Yes.

Sarah DeLone: So if an individual no longer meets the requirement for a 1915(c) waiver that the individual is participating in, but the individual is eligible for a separate 1915(c) waiver in the state, can the state then move the individual to the second C waiver, even if it offers a different package of services? So somebody doesn't lose their underlying eligibility for Medicaid, but loses eligibility for one waiver and becomes eligibility for another waiver. Can that person be moved?

Gene Coffey: Good. Okay. Another good question and I think the answer here is a little bit shorter and hopefully more straightforward as Sarah suggested, or mentioned maybe, you know, some folks still need some time to digest the first one. I want to emphasize that again, the overall answer to the first question that we began with was yes, states can terminate individuals from 1915(c) waivers where they are no longer eligible for those C waivers.

But, you know, with regard to our second question here, can a state move an individual from one C waiver to another, where the subsequent waiver might not offer the same package and benefits? And again, here the answer is yes. If moving a 1915(c) participant from one 1915(c) waiver to another is consistent with the Medicaid statute and the regulations and the terms of the state's waiver program or programs I should say, a state claiming FFCRA's enhanced FMAP, would not violate the continuous coverage provision under the Interim Final Rule by making such a move.

For example, if an individual is determined to no longer meet the targeting requirements for a 1915(c) waiver the individual is enrolled in, but the individual meets the targeting and other requirements for a separate 1915(c) waiver, the state must move the individual to the latter waiver and doing so would not violate 433-400 of the Interim Final Rule.

As long as the individual continues to have access to the same or better tier of coverage, it does not matter if the individual would not have access to waiver services in the subsequent waiver that the individual could access in his/her original waiver.

Sarah DeLone: That last sentence Gene, that you just said, that last statement seems like the current (level). Right?

Gene Coffey: Yes. Yes.

Sarah DeLone: Yes.

Gene Coffey: No doubt.

Sarah DeLone: Yes. Thanks.

Gene Coffey: Do you want me to read it again?

Sarah DeLone: And hopefully…

Gene Coffey: Do you want me to say that again?

Sarah DeLone: Yes. Yes. Yes. Do it again.

Gene Coffey: Yes. Okay.

Sarah DeLone: Do it again.

Gene Coffey: Right. Right.

Sarah DeLone: Because this applies to question one…

Gene Coffey: That, that…

Sarah DeLone: …and question two.

Gene Coffey: That was your way of suggesting that…

Sarah DeLone: Yes.

Gene Coffey: …I say that again. Yes. I do want to confirm again that as long as the individual continue to have the same or better tier of coverage. Again, tier of coverage is the fundamental underlying requirement for states in shifting an individual at all in terms of eligibility groups or waivers.

As long as the individual continues to have access to the same or better tier of coverage it does not matter if the individual would not have access to waiver services that the individual could access in his/her original waiver.

Sarah DeLone: Perfect. So shifting a little bit now, how about somebody's not losing, you know, not losing eligibility for their waiver program, but can a state eliminate services from an individual's 1915 - from an individual participant's plan of care during the PHE?

Gene Coffey: And again, the answer here is in fact, yes. If a state determines during the public health emergencies that a Medicaid beneficiary participating in a 1915(c) waiver lo longer meets the coverage or functional criteria for a service that's part of the waiver participant's approved plan of care, the state may eliminate the service from the individual's plan of care.

Now of course, as we mentioned before, the state would have to provide the individual the appropriate notice and opportunity for a fair hearing if it wanted to eliminate such services. And further, you know, given the state's obligations under the ADA and (Olmstead), you know, we want to advise states to consider the impact of removing a service from an individual's plan of care based on a changed circumstance that they have on the ability of the waiver participant to be served in the community, rather than an institutional or congregate setting.

However, FFCRA's continuous coverage provision as interpreted by the Interim Final Rule, does not pose a bar to an otherwise permissible reduction in a service from a 1915(c) waiver participant's approved plan of care.

Sarah DeLone: So how about Gene, if an individual receiving nursing facility services or home and community based service, waiver services? If such an individual no longer meets the level of care criteria for the institutional or other LTSS benefit, may the state transfer the individual to an eligibility group for which he/she is eligible?

Gene Coffey: Okay. In this particular circumstance it depends. And hopefully this answer to this question isn't too complicated and, you know, I think we do have some time for states to follow up here if it's not. But first, for Medicaid eligible nursing facility residents, not meeting the state's nursing facility level care

criteria generally does not have a direct and immediate impact on underlying eligibility.

It will certainly affect the individual's coverage for the 19 - or not the 1915, the nursing facility services themselves, but underlying the eligibility generally will not be directly affected or (effected). This is true even for individuals in eligibility groups that require institutionalization as an eligibility factor, such as a group we commonly call the special income level group, which serves individuals in institutions with incomes up to 300% of the SSI federal benefit rate.

As long as the individual remains in the nursing facility he/she will remain eligible for the special income level group and will be entitled to all medically necessary state plan services even though the state would not cover the nursing facility services if the individual no longer meets the requisite level of care criteria.

But if the special income level group enrollee ultimately leaves a nursing home because he/she is determined to no longer meet the relevant level of care, which will most typically be the case if he/she no longer meets the relevant level of care criteria, then the coverage tier rules of the IFC will apply.

And, you know, as the special income level group receives tier one coverage the individual who leaves the nursing facility and goes to the community because he/she no longer meets the level of care criteria, will have to be offered tier one coverage in the community. So, you know, in this example, you know, the individual despite his/her discharge from the facility, must remain enrolled in the special income level group unless there is a separate

eligibility group for which the individual is eligible that offers tier one coverage.

While the state no longer recover nursing facility services for the individual it would be required to provide other state plan services needed by the individual. A similar policy applies to 217 group enrollees in certain medically needy beneficiaries whose underlying Medicaid eligibility is tied to the waiver participation as we've generally already discussed.

I mean for example, if a 217 group enrollee no longer meets the level of care criteria for his/her 1915(c) waiver as explained earlier, the state can terminate the beneficiary from the waiver program. However, if the change in the level of care need for such a beneficiary, results in termination from his/her 1915(c) waiver, the beneficiary must remain enrolled in the 217 group unless there is a separate eligibility group for which the individual is eligible, that offers tier one coverage.

While the state no longer would cover the 1915(c) waiver services for the individual, it would be required to provide other state plan services.

Sarah DeLone: Great. Thanks, Gene. So just as a follow up question to the previous question, if the individual who no longer meets the level of care criteria for institutional coverage or home and community based services, if that individual would not be otherwise eligible for Medicaid and is covered in the special income level group or the 217 group, is the state required to continue to pay for the long term care services it supports?

Gene Coffey: The answer is no. States are not required under FFCRA's continuous coverage provision, to continue to pay for institutional or HCBS services or any other services for which a Medicaid beneficiary is determined to no

longer demonstrate need. You know, this is true regardless of the eligibility group in which the individual may be enrolled.

You know, in the specific example of the special income level group or 217 group enrollee, if the change in the level of care results in the individual leaving the institution or being terminated from the waiver, a state would not continue to cover LTSS for that individual given that the individual no longer meets the relevant level of care criteria.

The state would be required to provide other state plan services needed by the individual, based on the state's medical necessity criteria for those other services. But again, the state is not going to be required to provide coverage for LTSS services that an individual no longer has a demonstrated need for.

Sarah DeLone: And how about the question, a little bit similar to one that I asked you before, but a variation. Can a state eliminate services from an approved 1915(c) waiver during the PHE, so eliminate the service for all of the waiver participants?

Gene Coffey: Right. The answer is yes. A state can amend the terms of an approved 1915(c) waiver to eliminate coverage services without violating FFCRA's continuous coverage provision, you know, as interpreted by the Interim Final Rule. Now a state proposing to do so would have to comply with standard waiver amendment procedures.

And additionally, again, the state would want to consider the ACA (Olmstead) implications of eliminating a service from a 1915(c) waiver. But effective November 2 with the publication of the IFC, FFCRA's continuous coverage provision would not pose a bar to otherwise permissible service reductions in 1915(c) waivers.

Sarah DeLone: And one final question Gene, may a state consistent with FFCRA's continuous coverage requirement, move a beneficiary from fee for service Medicaid coverage under the state plan, to a managed long term services and supports waiver? Also, you know, conversely, can a state do the reverse - move a beneficiary from an MLTSS waiver to fee for service Medicaid coverage?

Gene Coffey: And the final answer here to this, or the answer to this final question here, is yes. A beneficiary may be moved into a managed long term care services and supports waiver if the individual meets their eligibility criteria, provided that the individual's Medicaid eligibility continues within the same or a more robust tier of coverage.

A state could also move a beneficiary from a managed long term services and supports waiver to fee for service coverage provided again, that the coverage remains in the same tier under Section 433-400. For example, both fee for service coverage and then managed long term service and support provide coverage - provide tier one coverage that is met. So that level of coverage would in fact have to be preserved.

Sarah DeLone: Okay. Thanks, Gene. For a second there I thought we were on Who Wants to be a Millionaire when you were giving your final answer.

Gene Coffey: Okay. Yes.

Sarah DeLone: So Jackie, that - that wraps it up for this batch of questions and answers on the Interim Final Rule. So I'm going to turn it back to you to open up the lines.

Jackie Glaze: Great. Thank you, Sarah and Gene. Before we open up the lines for questions that we'll take from you, we do have one question that we would like to

respond to that we received through the chat function last week. And so I'll read off the question and then I'll ask Jessica Stephens to respond.

So the question is the effective date of the IFC is November 2, 2020. However, states would not have had time to implement the changes in the IFC given the need for proper notice and current approved prior authorizations. Is (FFP) available to states for the timeframe between the effective date of the IFC and a date that states can transition beneficiaries to the appropriate coverage group? So Jessica, I'll turn it to you.

Jessica Stephens: Thanks, Jackie. And the answer is yes. (FFP) is available for medical assistance furnished between November 2, 2020, the effective date of the IFC and the date that a state is able to take eligibility actions now permitted under the IFC. So for example, if a state is transitioning beneficiaries to the appropriate coverage group.

States may claim (FFP) at the applicable matching rate including increased - any increased FMAP rate during the PHE, for the group in which the individual is enrolled. For any beneficiaries moved to a new group, states must make appropriate adjustments to claim (FFP) as the applicable match for the new group.

As we said before, failure to take action on a known change in circumstance during the PHE or process delayed changes in circumstances at the end of the PHE, may place the state at risk of (perm) or other eligibility audit findings, for not acting timely, to complete required redeterminations of eligibility.

Jackie Glaze: Thank you. Thanks, Jessica very much. So now we're ready to take any questions that you may have. So if you have questions over the presentation

you heard today or any other general questions. So Operator, we're ready to open up the phone lines at this time.

Coordinator: Thank you. If you'd like to ask a question over the phone, please press star 1. Please ensure your phone is unmuted and record your name to ask a question. Again, that is star 1 to ask a question. And if you wish to withdraw, it is star 2. One moment please, while we wait for questions to come in.

Our first question is from (Renee Marlow). You may go ahead.

(Renee Marlow): Hi everyone. This is (Renee Marlow) with California. And I just had a quick question. Given the series of calls that we have had and a lot of information has been exchanged from CMS on the IFC, I mean on the - yes, on the IFC, is there going to be written guidance that CMS is going to be providing back to the states given all of the information that has been shared based upon all the questions that have come in? And if so, what's the timing of the guidance? Thank you.

Anne Marie Costello: So Jackie, maybe I'll take this one. (Renee), thank you very much for that question. We had a similar question last week. At this point, we do not know what we will put out in written guidance. We're at a point in time where we are not able to push out guidance as quickly as possible in written format. And to that end, that is why we are doing these question and answer sessions during our all state calls.

We are also making the all state call transcripts and audio recordings available on CMS.gov. And we hope to send out a crosswalk of (when) different topics were addressed on the different calls, to make it easier for states to go back and reference the answers that we gave verbally. We're hoping that this will still face immediate needs until we can get some additional guidance out.

(Renee Marlow): And do you know - thanks for that Anne Marie. Do you know when the crosswalk will be available?

Anne Marie Costello: Let me ask and see if anyone on the team - I think very soon. But let me just double check.

(Renee Marlow): Okay. Thanks.

Sarah DeLone: I think that's right, Anne Marie. I think that we - I think we've pulled one together and make it - it should be able to be I think, sent out through the listserv I think is the plan that should be able to happen fairly soon.

Anne Marie Costello: It should go out to the listserv and to everyone who gets this (appointment). So sure, we'll get that out very quickly, (Renee).

(Renee Marlow): Okay. Thanks so much. Thanks, Sarah and thanks, Anne Marie.

Coordinator: The next question comes from (Nancinio Wright). You may go ahead.

(Danielle Lewis Wright): This is (Danielle Lewis Wright) calling from DC. I hope you all can hear me okay. So I have a few questions related to the date in which we are supposed to transition beneficiaries who qualify for another category. And we're just trying to understand how to operationalize it.

So would it be on November 2 or is the expectation, the date in which your state is able to make your system changes, rule changes and needed training to staff? So let's say that's March 1st. Would we be penalized or is that acceptable to you've developed a framework necessary to operationalize these changes?

Sarah DeLone: So this is Sarah. I can take a stab. Hi (Danielle). So, you know, you - you'll, you know, typically if a, you know, if a change in a benefit, you know, in somebody's coverage category, is going to result in any sort of change to their benefits, or maybe an increase in cost sharing will have some impact on them, right, you're going to need to provide the advanced notice that's required under the regulations. Right?

So you can't sort of retroactively change somebody's coverage in a way that, you know, that impacts them. So what the expectation is, that you work, you know, sort of expeditiously, you know, to make the system changes that you need, in order to sort of be able to effectuate those changes.

And you just - you do that in, you know, in as reasonably quickly as you can and right, that's all that we can expect. So you can't sort of retroactively put somebody back to November 2. You can only sort of, you know, correct things moving forward.

And we understand, you know, you can't do that right away. Those states can turn on a dime and magically move everybody to the correct category. So does that help?

(Danielle Lewis Wright): Okay. That's really helpful. And one other question related to leveraging electronic data sources. So let's say there's a change in circumstance due to age, and so you're a childless adult, you're aging out of that category. Is the expectation that we also leverage entrance data sources to verify income and residency or we would just act on that age and maintain the current information we have for those eligibility factors?

Sarah DeLone: Well if you - you may want to take this with you one on one. I mean if you - or if it's in between regular renewals and you have no reason to think that the person's income has changed, you certainly can if it's part, you know, access data source. If you can, just move on the information that you have.

(Danielle Lewis Wright): Okay. That's helpful.

Sarah DeLone: But unless you regularly access data sources anyway, that's the - that's going to be the better course.

(Danielle Lewis Wright): And if we lose…

Sarah DeLone: If you - sorry, somebody else trying to get in. Anne Marie, is that you or Jessica?

Anne Marie Costello: No. No one.

Sarah DeLone: Oh. Yes, so you can, you know, unless you have reason to believe that the person's income is change, like you already are doing regular data matching, then you could just use the income information that you have and move them into the appropriate group.

If they're not eligible for, you know, that other group then, you know, you could reach out to sort of try and get their income information. Because if they say you can move them into the better group, because of course you can't terminate somebody. So that would be your sort of next course of action.

But if there's another group for you to move them into, that's what you should do. Does that make sense?

(Danielle Lewis Wright): That makes sense. And if you move a person into another category, would you automatically give them a 12-month cert period or you just look because at this point we're approaching 12 months from the PHE. So what - if you were transitioning would been - would you have then been another 12-month period? That's another thing we kind of…

Sarah DeLone: No. They stay on their same renewal cycle where you've just done sort of an administrative shift based on the information in your case record and you know the rules to, you know, provide, you don't do renewals more than once every 12 months unless you have an indication of a change, you know, in circumstances.

So this is actually sort of - there is - Jessica, I don't know if you know off the top of your head where this is. It's in 435-916 somewhere which sort of explains what to do when somebody has a change in circumstances. And, you know, how to handle other potential eligibility factors. But the short answer is keeping them on the same renewal cycle. Jessica, do you have anything to add?

Jessica Stephens: I would add that actually this particular scenario is described in a good amount of detail in the informational bulletin that we released last week, about acting on changes in circumstances more generally, and obligations for states to move individuals.

So I think I would agree with everything Sarah said, with one exception, which is that if a state in transitioning the individual to a, you know, through a different eligibility group does have all the information that they need in order to complete an eligibility determination for that group without requesting additional information from the individual, the state has the option to start a new 12-month eligibility period.

In the same way that any change in circumstance allows the state, provides the state an option to provide a new 12-month eligibility period as long as you have all the information needed.

((Crosstalk))

Sarah DeLone: You would actually go out and (ping) the data source, right in order to reverify income in that situation - in - it's taking up that option, right Jessica?

Jessica Stephens: Correct.

Danielle Lewis Wright: Okay. Thank you so much.

Sarah DeLone: Sure. Thanks for the question.

Coordinator: Our next caller is Ms. (Pavlona). Thank you. And you may go ahead.

Ms. (Pavlona): Hello everybody. Thank you for taking my call. I actually - (Renee) from California asked my question. So I would like to withdraw.

Coordinator: Okay. The next question is from (Deanna Hart). You may go ahead.

(Deanna Hart): Hi. This question is I think related to the previous one, but just wanting to confirm. If an individual who prior to November 2 should have moved from one benefit package to another in both tier one packages, but the state didn't move them, in order to receive the enhanced match. Does the state need to go back not retroactively, but does the state need to go back immediately or as soon as possible, to act on those changes and move those individuals into the correct benefit packages?

Or can we wait until the next redetermination date and act on that change then?

Sarah DeLone: So what the regulation, you know, would require is actually not the IFC, right, it would be the Medicaid statute or regulations would require that you make that move as expeditiously as possible, recognizing that, you know, that it may not - you know, two sort of caveats. So we recognize this can be - get complicated to actually effectuate this for everybody, so there needs to be a reasonableness applied to this and what's feasible for states.

That, you know, you - so one is if the change that you didn't, you know, that you didn't effectuate, take in - sort of take that final action, was, you know, sort of maybe six months ago. You don't necessarily know that that's still correct. You might know if it's age, right? You might know. Right? That person is not going to get younger again.

But if it's because income went up and it was six months ago, you don't know whether this person's income is still where it was six months ago or whether it's actually fallen again. So you'd actually need to do a new processing of that.

And then, you know, and then it's just a - and then it's a matter of how quickly and I think states are going to be in different positions depending on how you, you know, how you adjusted your systems to accommodate the initial interpretation of the continuous coverage requirement. Right? You're going to need to make changes.

And like we were saying before, you can't sort of make changes to people retroactively. So you should do that. The policy is that what the sort of the

straight read, you know, put aside sort of the operational challenges that you may have is yes, you should move that person to the new group if that's where they - that's what their current circumstances, you know, warrant even though the change had happened before November 2.

But recognizing that that probably can't happen instantaneously, right? So you just need to work, you know, as diligently as reasonably can be expected to, you know, to process those.

(Deanna Hart): Okay, great. Thank you.

Coordinator: The next call is from (Nicole Silks). You may go ahead.

(Nicole Silks): Hi. I can withdraw my question. It's been answered. Thank you.

Coordinator: All right. Thank you. There are currently no additional questions in the queue. If anyone would like to ask a question, please press star 1, unmute your phone, and record your name to ask a question.

Jackie Glaze: Anne Marie, would you like to wait a few minutes to see if we get additional questions? Or would you like to close out?

Anne Marie Costello: No. Let's wait a second and see. We just called for questions. Let's wait a second…

Jackie Glaze: Okay.

Anne Marie Costello: …to see if anyone has any additional questions.

Coordinator: The next question comes from (Renee Marlow). You may go ahead.

(Renee Marlow): Oh, hi. Thanks again. So this is (Renee) again. So Anne Marie, could you - so at the beginning when you were going over the - some information from the COVID-19 vaccine, you had made a reference to the enhanced FMAP rate. Could you go over that again in terms of what some flexibilities that states have? It sounded as if you said we could, you know, put forward the state plan amendment to continue with the enhanced FMAP. But I would appreciate it if you could cover that again.

Anne Marie Costello: Sure let me just - I'll start and ask my colleagues who are much smarter than me, to jump in here. (Renee), what I was saying was that many states will need to submit state plan amendments to reflect a payment methodology or a reimbursement rate for administration of the COVID-19 vaccine. States can come in now and submit a Medicaid disaster relief SPA template.

And the advantage of that is that states can have an early effective date than if they used the routine SPA process, right, which could be no earlier than the first day of the quarter in which the SPA is submitted. Or I think for payment methodologies, it will (provide) two public notice requirements with the use of routine SPA.

If you come in through the disaster relief Medicaid state plan amendments, we have the ability through the use of 1135 waivers to allow - permit earlier effective dates, modify tribal consultation policies and waive public notice requirements.

But however, the authority for the disaster relief template and when the public health emergency ends. However, to be eligible for continuing to receive the enhanced FMAP, states must need to continue to provide reimbursement for

COVID vaccines through the end of the quarter in which the public health emergency ends.

So you - states will need to come in with the second state plan amendment through the routine SPA process to have a rate methodology in place for - to ensure continuation of the enhanced FMAP. So let me pause there and see if (Jeremy) or (Rory) or Alissa DeBoy want to jump in.

Rory Howe: I think that covers it well, Anne Marie. I don't have anything to add.

Alissa DeBoy: Me neither, Anne Marie. Thank you.

Anne Marie Costello: Okay.

Alissa DeBoy: And to note that this will be noted in our upcoming toolkit. Thanks.

Anne Marie Costello: So (Renee), we know that a lot of states want to get their state plan amendments in place quickly so that's why we're recommending use of the disaster relief SPA template. But over time states will need to come in with a routine SPA just to ensure coverage in the state plan through the end of when they might be eligible for the enhanced FMAP. So hopefully that's helpful to you all.

(Renee): No. It is. Thank you so much.

Coordinator: Our next question comes from (Danielle Wright). You may go ahead.

(Danielle Lewis Wright): Hi everyone. I have a follow up question regarding the guidance for PARIS termination. I just wanted to make sure that we're clear about the expectation of using electronic data sources to verify our (payers) matches.

Historically, we have not done so. Once a person appears on, a beneficiary appears on a PARIS match we would then send out a request for information to verify district residency.

But as we look at the available measures in terms of the language and the guidance, we were just trying to think through does that mean we have to verify through - check in DMV and then if there - if they appear to be a district resident then we would maintain coverage or should we follow in the same process prior to COVID?

So if you could provide clarification that would be helpful.

Jessica Stephens: Sure (Danielle), it's Jessica. And it's the latter. That the - it's not quite the same process as prior to COVID because the - what we're looking at here is whether the - through a PARIS match you identify that an individual is no longer a state resident. So as you indicated, the expectation would be that if you identify an individual on a PARIS match you would first, you know, reach out to the individual to have them confirm district residency.

If the individual does not respond, that is not sufficient information at this point, to determine that they are no longer a resident and terminate their eligibility. We don't describe explicitly which data sources a state would need to check but yes, DMV, checking other information in your state case records to identify whether you have information that would indicate that they may in fact be a state resident.

If you have any information that does, you would not be able to terminate eligibility. In the IFC we also clarify that there'll be an expectation too, to communicate with the other states in which it appears the individual may be enrolled, prior to terminating eligibility.

(Danielle Lewis Wright): Okay.

Jessica Stephens: Does that answer your question?

(Danielle Lewis Wright): Yes. That's helpful.

Jessica Stephens: Sure. And I would just maybe note again, we flagged this a couple of weeks ago, that the exception for - to allow terminations based on a PARIS match for an individual who does not respond to requests for information, is very narrow and it is just for PARIS. So the process that I just described, would not apply in - for another data source for example.

(Danielle Lewis Wright): Understood.

Anne Marie Costello: Yes.

Coordinator: There are no additional questions at this time.

Jackie Glaze: Anne Marie, may I turn to you?

Anne Marie Costello: Sure, Jackie. Sorry. I was having a little bit of phone troubles. So thank you everyone. I want to take this opportunity to thank Sarah DeLone, Gene Coffee, and Jessica Stephens, for their excellent presentations and information. Sarah, I do think sometimes I am getting younger, but we'll see about that.

Sarah DeLone: Only you, Anne Marie. Only you.

Anne Marie Costello: Switching topics, I'd like to announce a temporary staffing change in the Center for Medicaid in CHIP Services. Effective this week, Judith Cash, the Director of the State Demonstrations Group, has moved to our Center Director's Office to temporarily serve as CMCS's Second Deputy Center Director. Teresa DeCaro will lead the State Demonstrations Group temporarily, while Judith is on detail to our Center Director's office.

I'd also want to take this opportunity to thank Alissa DeBoy, the Director of the Disabled and Elderly Health Programs Group, for stepping into the role of the Acting Deputy Center Director in September. Alissa has just completed her detail with our Center Director's office and I know that the Disabled and Elderly Health Programs group is thrilled to have her back.

I also want to thank Melissa Harris, the Deputy Director in DEHPG who served as the group's director during that time. We're excited by these leadership transitions and know that this team is well-positioned to continue working with you and your teams in the coming months.

Looking forward, this will be our final call for 2020. It's hard to believe we've made it through the year already. It has been one heck of a year and we are very, very grateful for the partnership with each and every one of you. We could not do the work that we do if it were not for our partners in the states and the state associations. So we really thank you for everything that we have been able to accomplish together, this year.

I hope that you'll be able to have a happy holiday season and we'll reconvene in early January and we will restart our weekly all state call series again. Of course, as questions come up between these calls, feel free to reach out to us, your state leads, or bring your questions to our next call. Thanks again, for

joining us today and we'll talk to you soon, in January. Take care and have a lovely holiday season.

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

END