HHS-CMS-CMCS
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Coordinator: Welcome, and thank you for standing by. At this time, all participants are in a listen-only mode. During the Q&A session, if you'd like to ask a question, you may press Star 1 on your phone. Today's call is being recorded. If you have any objections, please disconnect at this time. I'll now turn the call over to Krista Hebert. Thank you. You may begin.

Krista Vrabel-Hebert: Hi everyone, and welcome to today's All-State Call. I am Krista Vrabel-Hebert, the Deputy Director for the Division of State Coverage Programs. And I will be kicking off today's call. On today's call Brandon Smith, from the Division of Benefits and Coverage, Jerome Lee, from the Division of High Tech and MMIS; Melissa McChesney, from the Division of Medicaid Eligibility Policy; and Josh Bougie, from the Division of State Coverage Program, will provide an overview review of the Medicaid and CHIP interoperability requirements as part of the Advancing Interoperability and Improving Prior Authorization Processes final rule. This final rule was released in February of 2024.

This final rule emphasizes the need to improve health information exchanges to achieve appropriate and necessary access to health records for patients, healthcare providers, and payers. This final rule also focuses on efforts to improve prior authorization processes through policies and technologies to help ensure patients remain at the center of their own care. This rule enhances

certain policies from the 2020 CMS Interoperability and Patient Access Final Rule, and adds several new provisions to increase data sharing and reduce overall payer, healthcare provider, and patient burden through improvements to prior authorization practices and data exchange practices.

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 on I suggest you do so now so that you can see slides for the presentation. You can submit any questions you have into the chat at any time during our presentation.

Before we get started, on the main presentation for today, Sarah Harshman, from the Division of Benefits and Coverage, will provide a brief verbal update on the clinic regulations finalized as part of the 2025 Outpatient Prospective Payment System Final Rule, as well as the HHS extension of the COVID-19 PREP Act. I will now turn things to Sarah to provide those updates. Sarah?

Sarah Harshman: Great. Thank you, Krista, and hello everyone. Just a couple announcements to begin today's call. First, as a reminder, CMS finalized a proposal to add exceptions to the Medicaid Clinic Benefit Four Walls requirement as part of the calendar year 2025 Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule. Prior to this action, the clinic services regulation only included an exception to the Four Walls requirement for individuals who are unhoused.

As a result of this final rule, states will be able to receive federal funding for clinic services provided outside the four walls of certain types of clinic. CMS finalized an exception for Indian Health Service, or IHS, and clinical, or tribal clinics, at a new 42 CFR 44090(c) and optional exceptions for behavioral

health clinics and clinics located in rural areas at new 42 CFR 44090(d) and (e), respectively.

In the final rule, CMS also finalized that states that adopt the exceptions for clinics located in rural areas can choose a definition of rural based on either, one, a definition adopted and used by a federal governmental agency for programmatic purposes, or two, a definition adopted by a state governmental agency with a role in setting state rural health policy. This final rule is effective January 1, 2025.

The exception for IHS Tribal clinics will be a mandatory component of the Medicaid Clinic Services benefit. States that enroll IHS Tribal facilities, as providers of clinic services, will need to submit a Medicaid state plan amendment attesting to coverage of IHS Tribal clinic services outside of the four walls by March 31, 2025.

States that choose to adopt the optional exception for behavioral health clinics will need to submit a SPA and describe the types of behavioral health clinics such exceptions applies to. The states that choose to adopt the optional exception for clinics located in rural areas will need to submit a SPA and describe in the SPA the definition of rural they adopt. In addition, states will need to attest in the SPA that the definition of rural they adopted best captures the population of rural individuals that meets more of the four criteria that mirror the needs and barriers to access experienced by individuals who are unhoused that we described in the final rule.

States can choose to elect one or both optional exceptions at any point on or after January 1, and must submit SPAs during the applicable quarter they want to effectuate coverage. If a state chooses to elect one or both optional exceptions with a January 1, 2025 effective date, then only one SPA is

necessary to elect the optional exceptions and attest to coverage of IHS Tribal clinic services outside of the four walls. CMS is currently developing a SPA template to help assist states with SPA submissions. And that is coming soon.

And we can go to the next slide. For my second announcement, on December 11, 2024 the Secretary of HHS extended the HHS COVID-19 PREP Act authorization of certain providers including pharmacies, pharmacists, pharmacy interns, and pharmacy technicians to administer COVID-19 vaccines, seasonal influenza vaccines, and COVID-19 tests to individuals age 3 and over through December 31, 2029.

As a reminder, the HHS PREP Act declarations can impact state Medicaid and CHIP programs because such declarations might identify certain practitioners as covered persons authorized to administer certain vaccines. These HHS PREP Act authorizations preempt conflicting state scope of practice, or licensure laws, and thus have Medicaid payment implications. This is due to the Medicaid free choice of provider requirement.

Specifically, when a state covers a vaccination for a beneficiary and a practitioner, such as a pharmacist or pharmacy technician, is authorized to administer the COVID-19 vaccine under an HHS PREP Act declaration. The state Medicaid program would be required to provide a pathway to paying that practitioner for the covered vaccine administration when provided in accordance with the provisions of the PREP Act declaration. This is true even when a state wouldn't typically recognize that provider as a provider of vaccinations.

States must still meet all other applicable federal requirements for covering the applicable benefit, such as reimbursing only those providers that are enrolled as Medicaid providers and covering vaccinations for only eligible

individuals. In light of the extension, we encourage states to review their state plan pages to ensure that they are aligned with the extension of the COVID-19 PREP Act.

For more information you can see the toolkit titled, Coverage and Payment of Vaccines and Vaccine Administration Under Medicaid, the Children's Health Insurance Program and Basic Health Program on medicaid.gov. And with that, I'll now turn it over to Brandon Smith to begin our interoperability presentation. Brandon, if you're talking you might be on mute.

Brandon Smith: Thank you, Sarah. I'm Brandon Smith from our benefits - from our Medicaid Benefits and Health Programs Group. And I'll be co-presenting a Medicaid and CHIP focused overview of the interoperability requirements alongside Joshua Bougie and Melissa McChesney from our Children and Adults Health Programs Group and Jerome Lee from our Data Systems Group.

In the later segments of the presentation we may have an opportunity to hear from several other voices that were instrumental in the policy development and reg writing of these interoperability requirements. Some of the names that immediately come to mind are Amy Gentile, from our Managed Care Group, Kirsten Jensen and Sarah Harshman, my bosses, from our Medicaid Benefits and Health Programs Group, whom I likely just named first, Jennifer Shear, from our Children and Adult Health Programs Group, and of course, Lorraine Doo and David Koppel, from our Office of Healthcare Experience and Interoperability.

Next slide, please. EMS interoperability requirements were first introduced through a May 2020 publication titled, Interoperability and Patient Access Final Rule. And because the February 2024 publication built on top of that

foundation set, we'll start with a quick overview of the May 2020 requirements.

Next slide, please. That May 2020 final rule framed three main systems requirements for implementation and maintenance by state Medicaid and CHIP agencies operating fee-for-service programs, for Medicaid-managed care plans, and for CHIP managed care entities. The first was the Patient Access Application Programming Interface, or API, that today, or will soon allow - that today allows, or will soon allow patients to access their claims and encounter information and other specified clinical information.

The second, was the Provider Directory API, requiring impacted payers to better enable care planning and care coordination by making participating provider information publicly available through an API. And the third, was the payer-to-payer data exchange requiring the same payers to exchange clinical data at a patient's request.

Next slide, please. And that brings us back to 2044. Not quite present day, but earlier this year we enhanced interoperability requirements through the publication of the Advancing Interoperability and Improving Prior Authorization Processes Final Rule.

Next slide, please. So before jumping into those interoperability requirements stemming from the February final rule, it can be helpful to kind of run through some of the key terms used throughout the rule, and that are important in the context of policies and compliance steps. The first term is, of course, an Application Programming Interface or API which is a set of tools published by one software developer that allows other developers to know how to and to request or exchange information.

The February rule frequently uses the term prior authorization throughout. And Prior Auth, or PA for short, refers to the approval process required by payers prior to a provider furnishing care. And the rule just defines that it's made up of two parts. The first part being the request part, which flows from the provider to the payer, or the approver. And the second part being the decision part made by the impacted payer.

The federal rule also uses the term items and services when discussing prior authorization policies. And the term, as applied to the policies, does not include drugs of any kind. And a term we've already used in this presentation is, Medicaid and CHIP payer, or that you will hear throughout the presentation will be Medicaid and CHIP payer.

And that generally refers to state Medicaid and CHIP agencies operating fee-for-service programs, Medicaid managed care plans, and CHIP managed care entities. And finally, the last key term would be the Fast Healthcare Interoperability Resources, or FHIR, which is the technical standards and requirements that the APIs described throughout should conform to.

Next slide, please. So on February 8, of this year, we published CMS-0057-F again, titled Advancing Interoperability and Improving Prior Authorization Processes Final Rule. And that final rule really builds upon the system's requirements in the May 2020 Patient Access Final Rule.

And we achieved that primarily by buttressing the patient - we achieved that by primarily buttressing the Patient Access API with additional information. We also introduced requirements for impacted payers to develop three new APIs. And those three new APIs are the Provider Access API, the Payer-to-Payer API and the Prior Authorization API.

Next slide, please. So where is the May 2020 final rule left off requiring that these APIs are sourced for claims and encounter data primarily. The February 2024 rule requires that patients have access to even more of their data beyond the claims and encounter data, and information that's relevant to their care.

So the Patient Access API from May 2020 is buttressed by including prior authorization information within the health information suite that these APIs have to host. And that - and beginning January 1, 2027 for Medicaid and CHIP fee-for-service, and by the rating period beginning on or after January 1, 2027 for Medicaid and CHIP managed care, the APIs must host information about prior authorization in addition to the claims and encounters data and clinical information I mentioned for the May 2020 requirements. Additionally, starting in 2026 Medicaid and CHIP impacted payers are required to report annual metrics to CMS about Patient Access API usage.

Next slide, please. So the first of the new APIs required is the Provider Access API. And beginning January 1, 2027 for Medicaid and CHIP fee-for-service programs, unless granted an extension or an exemption, which will be discussed in greater detail in the coming slides. And by the rating period beginning on or after January 1, 2027 for Medicaid and CHIP managed care payers, payers must implement and maintain an API supporting data exchanges between payer programs and providers.

As far as the data being exchanged it's essentially the same content as in the Patient Access API that includes claims and encounter data, and the prior authorization information. And additionally, given the sensitive nature of health information, Medicaid and CHIP payers must authenticate the identity of the provider that requests access and establish an attribution process to assign beneficiaries to that provider if certain conditions are met.

And excuse me just a second, I'm sorry. Okay, sorry. And prior to the first date a state Medicaid or CHIP agency, operating the fee-for-service program, makes patient information available through the API. The agency must establish a process for beneficiaries to opt out of data exchanges and to change their permissions at any time.

Next slide, please. So the next newly required API, from the February 2024 rule, is the Payer-to-Payer API. And for state Medicaid and CHIP agencies beginning January 1, 2027 unless granted an extension or exemption, and beginning the first rating period thereafter for Medicaid and CHIP managed care, systems must be implemented and maintained for a Payer-to-Payer API to make available the same set of data content which are the claims and encounter data and certain prior authorization information. And payers are only required to share beneficiary data with a date of service within five years of the request for data.

Additionally, the February 8, 2024 final rule prescribes that Medicaid and CHIP agencies must establish an opt-in process in the case of the Payor-to-Payor API for beneficiaries to permit data exchanges with previous and/or concurrent payers, and to change the permissions with Medicaid managed care entities. And with that I will say thanks, and pass the presentation to Melissa McChesney, from Children and Adults Health Programs Group. Thanks, Melissa.

Melissa McChesney: Great. Thank you, Brandon. Next slide, please. So we wanted to take a little time to dive in a little more on the beneficiary control of data sharing. As Brandon explained, on the previous slide, under the final rule Medicaid and CHIP agencies are required to allow beneficiaries to opt out of data sharing through the Provider Access API. And for the Payer-to-Payer API, Medicaid and CHIP agencies must receive permission from the beneficiary to opt into

the data sharing before sharing beneficiary data through the Payer-to-Payer API.

In order to make sure that beneficiaries understand their opportunity to opt-in or opt-out, depending on the API, Medicaid and CHIP agencies must provide beneficiaries with plain language educational resources that explain the benefits of data sharing via the Provider Access API and the Payer-to-Payer API. And the beneficiary's ability to opt-in or opt-out depending on the API and the requirements and instructions for doing so. These have flexibility in how they implement their processes to gather beneficiary data exchange permission.

An individual's opt-in or opt-out preference for each of the APIs could be requested on the application for the Medicaid or CHIP or through a beneficiary portal on a mobile application or Web site. States should make available alternatives such as mail, fax, or telephone for beneficiaries with limited access to Internet or for those who do not want to submit their preference via an electronic portal. And I will then pass it to Josh Bougie from the Division of State Coverage Program.

Josh Bougie: Thank you, Melissa. Next slide, please. For the final API, the Prior Authorization API, payers will populate this API with all items and services that require prior authorization, excluding drugs, along with all documentation requirements for each item or service that requires prior authorization.

Within this API, providers will be able to create and exchange prior authorization requests as well as receive all communications from the payer for prior authorization requests. The final rule will also revise prior authorization decision time frames, which I will discuss further in the next two slides. Similarly to other APIs, the prior authorization API must be

implemented by January 1, 2027 for fee-for-service programs, and by the first rating period beginning on or after January 1, 2027 for managed care plans and entities.

Next slide, please. Existing regulations for standard and expedited prior authorization decision time frames vary between payers. For Medicaid and CHIP managed care, payers currently provide decisions for standard prior authorizations as expeditiously as the enrollees' condition requires, and within state time frames not exceeding 14 calendar days. Expedited prior authorization requests must receive decisions within 72 hours of receiving the request. And both types of requests may receive an extension of up to 14 additional calendar days under certain circumstances.

For CHIP fee-for-service, current regulations do not make a distinction between standard and expedited requests, and require all prior authorization decisions within 14 days with the possibility of a 14-day extension unless state law requires different time frames. And for Medicaid fee-for-service programs, regulations are currently silent on prior authorization decision time frames.

Next slide, please. The final rule established new prior authorization decision time frames, and aligns them for all Medicaid and CHIP payers. Standard prior authorization requests will require decisions within seven calendar days and expedited requests will require prior authorization decisions within 72 hours.

The final rule also clarifies that states may require shorter decision time frames for both standard and expedited requests. The final rule also requires that all payers must provide a specific reason for any denial or of a prior authorization request within the API though, the reasons may additionally be

communicated through other familiar means to the requesting provider.

All payers will also report certain prior authorization metrics annually on their respective Web sites. By sharing appropriate data, payers can build trust with their patients and providers, and showcase their commitment to improving services. The effective date for these provisions, for fee-for-service programs, is January 1, 2026. And managed care plans and entities the effective date is by the rating period beginning on or after January 1, 2026.

Next slide, please. We remind states that longstanding beneficiary notice and fair hearings external review rights regulations continue to apply to fee-for-service prior authorization decisions independent of APIs. For beneficiary notices, states must provide the beneficiary with timely and adequate written notice of any prior authorization decision. For Medicaid, the content of this notice must include the content specified at 435917 and Subpart E of Part 431 including fair hearing rights.

Also states must provide the beneficiary notice of any termination of, suspension of, or reduction in a current prior authorization including information for fair hearing rights at least ten days in advance. For CHIP, beneficiaries must receive timely written notice for any prior authorization decisions subject to review under 4571130. And the notice must include the reasons for of the decision and external review rights.

We also remind states that beneficiaries must be given the opportunity to request a fair hearing, or CHIP external review, if a prior authorization request is denied in whole or in part, not acted upon within reasonable promptness, or is terminated, suspended, or reduced.

Next slide, please. Similar to fee-for-service, Medicaid and CHIP-managed

care have longstanding enrolling notice and appeals requirements which are - which apply to prior authorization requests apart from the new API requirements. For enrolling notices, the managed care organization Pre-Paid Inpatient Health Plan, or PIHP, Pre-Paid Ambulatory Health Plan, or PAHP, must provide timely and adequate written notice of any adverse benefit determination.

The notice must include the content of 438404, including appeals and fair hearing rights. The MCO, PIHP or PAHP, must generally provide the enrollee at least ten days advance written notice of any termination, suspension, or reduction of previously authorized services, and include appeals and fair hearing rights.

Likewise, the MCO, PIHP or PAHP, must provide the enrollee the opportunity to request an appeal for the denial or limited authorization of a requested service, service authorization decision is not reached within the time frame specified at 438210D or the reduction, suspension, or termination of a previously authorized service.

Next slide, please. Next, we'll address API compliance flexibilities for Medicaid and CHIP fee-for-service programs. Next slide, please. In the Notice of Public Rulemaking for this rule we recognize circumstances unique to state Medicaid and CHIP fee-for-service programs that can make it more challenging to meet new API requirements within the same time frame as other CMS payers.

Public comments confirmed potential pitfalls compliance dates may cause given state procurement rules. We acknowledge the state may need to initiate a public procurement process to secure contractors with requisite skills to implement API policies. The timeline for an openly competed procurement

process, together with the time needed to engage the legislature, onboard the contractor, and develop the API can be lengthier for states.

The state may need to hire new public employees to support implementation. Due to stricter guidelines, and lengthy time to hire periods, the time needed to initiate the public employee hiring process that hire and onboard new staff can make compliance efforts more difficult.

Unwinding from the PHE has an impact on future IT work. As COVID-19 recovery efforts continue state operational resources, including IT resources, remain overextended. And in all such situations, the state might need more time than other impacted payers to implement.

So to address these concerns, we not only revised API compliance dates into 2027, but also finalized processes through which state Medicaid and CHIP agencies we seek an extension of, and in specific circumstances, an exemption from most of the new API requirements.

Next slide, please. Firstly, for extensions states are able to request a one-time one-year extension from certain API technology requirements as part of their annual Advance Planning Document, or APD, submission. States must submit extension requests through the APD process by May 31, 2026. Extension requests can be made for implementing provider access, payer-to-payer, and/or prior authorization API requirements. But please note that the final rule did not allow for extensions to be granted for Patient Access API requirements.

To submit an extension request, via the APD process, the state must include a narrative justification that describes the specific and unique reasons why the fee-for-service program cannot implement the API requirements by the

compliance state, the completed and ongoing good faith efforts the state has made to date - to implement the API requirements, and finally a thorough plan to implement the API requirements by the end of the extension. We encourage states to reach out to their Medicaid Enterprises Systems, MES, state officer for technical assistance or questions.

Next slide, please. So concerning exemptions from API requirement, states with a Medicaid program, or a separate CHIP in which 90% or more of beneficiaries are enrolled in managed care organizations as calculated within Medicaid or separate CHIP, may request an exemption for its Medicaid and/or CHIP fee-for-service programs from most of the new API requirements. Similar to extension requests, exemption requests must be submitted by May 31, 2026 as part of the state's annual APD submission.

The written application must include enrollment documentation from the most recent Medicaid Managed Care Enrollment and Program Characteristics Report for Medicaid exemption requests and/or enrollment documentation from the CHIP Annual Report or CHIP exemption requests. Also, the exemption request must include an alternative plan to ensure that enrolled providers will have efficient electronic access to the same information through other means while the exemption is in effect.

Please also note that exemptions, if granted, can expire. If the state experiences shifts in their managed care enrollment that causes the state to no longer meet the 90% threshold, states must notify CMS in writing and must work with CMS to develop a timeline for API implementation within two years of the exemption expiration date. And again, we encourage states to reach out to their MES state officer for questions on the exemption submission process.

Next slide, please. For similar reasons as to why we finalized the option for state fee-for-service programs to request extensions and/or exemptions for certain API requirements, we also recognized, in the final rule, that states may have unique challenges in meeting the implementation deadlines for the new prior authorization time frames. That is seven days for standard decisions and 72 hours for expedited decisions by the deadline of January 1, 2026.

While this deadline may be feasible for some fee-for-service programs that already have efficiencies in place or other state requirements for shorter prior authorization decision time frames, many states may be unable to meet this implementation date without first having certain API technologies in place. We encourage any states that may be unable to meet the January 1, 2026 implementation deadline for the new prior authorization decision time frames to reach out to their Medicaid state lead or CHIP project officer by April 1, 2025 to discuss the state's unique circumstances.

Any flexibility granted on the implementation of the prior authorization decision time frame requirements will be temporary and limited to the specific challenges of the fee-for-service program. So next my colleague Jerome Lee, from our Data and Systems Group, will discuss the APD submission process.

Jerome Lee: Thank you, Josh. Next slide, please. We'll now take a moment to review the process for requesting extensions and exemptions, the (unintelligible) or availability of federal financial participation for implementation activities.

Next slide, please. As with any Medicaid IT system development, we encourage states to engage with their policy, legal, systems, and other teams to evaluate the API requirements and begin planning, if you haven't already. As you have heard on this call from my colleagues, compliance with the regulation will take many parts working together including our partnership

with states and CMS.

During your planning process you may decide to request an extension or an exemption request for the provider access, payer-to-payer, and prior authorization APIs. These requests will be sent to your MES state officer as part of the APD, or Advanced Planning Document review and approval process.

Please work with them for specific guidance on how to submit these requests. We want to reiterate that sending the extension, or exemption request, is separate from working with your Medicaid state lead or CHIP project officer to discuss any questions related to prior authorization rule or time frame.

Next slide, please. Enhanced Federal Financial Participation, or FFP, is available for Medicaid enterprise system projects consistent with the requesting FFP through the APD process and during the system development life cycle. Depending on the specific activity, funding is available at 90%, 75%, and 50 % FFP, and must be related directly to system planning, development, and operations.

Planning activities may include meetings, participating in workgroups directly tied to system planning, preparation, and development for the related planning of requests for proposals. As appropriate, planning funding may also be used for feasibility studies, alternative analyzes, and cost allocation analyzes. Planning provides a good opportunity to review the appropriate outcomes and metrics established within the regulation and consider any other state-specific outcomes that you all may want to submit to CMS as part of the Implementation APD.

Implementation activities may include work tied directly to design, development, and installation of the API, and other integration work for related MES systems. Maintenance and operations activities are after the APIs go live. States will be expected to be able to report on the approved outcomes and metrics that were contained within the state's IAPD to qualify for enhanced operational match using our existing procedures for oversight of systems, which includes utilizing the Operational Report Workbook to demonstrate the APIs are working as intended.

We have provided references on this slide that help break down what type of costs are eligible for this funding. And of course, please speak with your MES state officer if you have questions about the APD process, funding eligibility, reporting requirements, and necessity for certification. APIs do not generally need to be certified, but we can make that final adjudication during the APD review process. And with that, I'll pass it back to Krista to help manage any questions.

Jackie Glaze: Good afternoon. This is Jackie Glaze. We'll go ahead and move to the questions now, so - but thank you for the presentation. So as I indicated we'll start with state questions. So we'll take the process that we have in the past, and we'll ask that you - to begin submitting your questions through the chat function. And then we'll follow by taking questions through the phone line. So we do see one question. So I'll turn to Krista. And then I'll ask that you continue to submit your questions. Krista.

Krista Vrabel-Hebert: Thank you so much, Jackie. The one question in the chat is,"Could you further describe the scope of items and services encompassed in this rule? Do items and services include clinic and hospital services, dental, vision, mental health, substance use disorder treatment, physical therapy, occupational therapy, speech-language pathology, home health, home and community-

based services, non-emergency medical transportation, durable medical equipment, case management, and care coordination?" That's a lot, so if you need me to repeat the question I certainly can.

Brandon Smith: Yes, it's a great question. I'm not sure if that question comes from a state partner. If it does, I'd encourage them to reach out to their state lead.

I think if you'd go back to the preamble of the final rule, specifically the section of the preamble that discusses items and services in the context of the prior authorization decision time frames for the Medicaid side of the final rule anyway, Medicaid fee-for-service, we do add a lot of color in terms of its application to Title XIX writ large. And so that would include a lot of the, what I would call, benefit categories I just heard such as, you know, inpatient - Medicaid inpatient hospital, outpatient hospital, Medicaid home help, et cetera. Even, you know, Title 1915(c) waiver services would be incorporated within items and services so essentially, you know, anything Medicaid minus drug services. I don't know, Joshua or anyone, if you want to add more towards that.

Josh Bougie: I think that was accurate. Thank you.

Krista Vrabel-Hebert: Great. Thank you both so much. I do see another couple of questions that just popped into the chat, so I'll just move on to the next one. "Do these requirements apply to 1915(c) waivers and 1915(i) state plan option services?"

Brandon Smith: Yes, just to reiterate, I think the most important thing certainly is to have conversations, state-specific conversations. And so we would encourage some state partners to be in touch with their state lead, so we can have those conversations. But yes, just to reiterate in short, yes, as it relates to the APIs

and also the prior authorization improvement processes requirements.

Krista Vrabel-Hebert: Great. One additional question here in the chat, "How does CMS define turnover time for prior authorization? Is it from the date it is submitted to the date a decision is made?"

Brandon Smith: Josh, I don't know how you feel about that one, or anyone else on the line, turnover time isn't one that I'm recalling from the final rule. And I think maybe some context might be needed there. And so not to sound like a parrot here, but I would encourage the questioner to please reach out to their state lead with more context. And we'll be happy to provide some technical assistance you're on that one.

Krista Vrabel-Hebert: Great. At this time I'm not seeing any additional questions in the chat.

Jackie Glaze: Thank you, Krista.

Krista Vrabel-Hebert: So Jackie, do you want to open? Great.

Jackie Glaze: Yes, thank you, Krista. So (Ted), I'll ask that you to - if you could provide instructions for registering questions? And if you could please open the phone lines?

Coordinator: Yes. The phone lines are now open for questions. If you'd like to ask a question, over the phone, please press Star 1 and record your name. To withdraw your question, press Star 2. Thank you. And again, if you would like to ask a question over the phone, please press Star 1 and record your name. I'm currently seeing no phone questions at this time.

Jackie Glaze: Thank you, (Ted). So I'll circle back to you, Krista, to see if you have any

questions.

Krista Vrabel-Hebert: Yes, I do see a couple of new questions popped into the chat. The first one is actually for the HCBS team. So I'm not sure if they're on. I'll read it out loud, and then we'll see if there's somebody on who can address the question for HCBS. "For the ARPA HCBS 9817 dollars, is the date that the MOE ends the date that the state expends the dollars or the date that the state receives a certification from CMS? Could the certification be retroactive to the date that the state expended the ARPA dollars?" So again, I'm not sure if someone is on who can speak to HCBS.

Okay, I will take note of that question. And we will circle back with you, (Emma), to try to get you an answer offline. And I will move to the next question, which is related to the presentation today I believe. "If a prior authorization is processed and approved by another state agency that administers a program, and sends the authorization to the state Medicaid agency, are those authorizations subject to the prior authorization API requirements?"

Josh Bougie: This is Josh Bougie, I'll take a stab at this. We might want a little bit more clarification on if the other state agency is paying those claims because they might fall under the definition of a payer. So I think that might just be something to clarify either in the question or in follow-up with us.

Krista Vrabel-Hebert: Okay, great. And then one additional question here, "Does the extension of the PREP Act require states to reimburse pharmacies for COVID and flu vaccines and their administration outside of federal Vaccines for Children program?"

Sarah Harshman: Yes, sorry. Yes. So as a reminder, when a state covers a vaccination for a

beneficiary, such as the COVID-19 vaccination, and a practitioner who might not be within a states scope of practice, such as the pharmacist or pharmacy technician, is authorized to administer the vaccine under the HHS PREP Act declaration the Medicaid program must provide a pathway to paying that practitioner for the covered vaccine administration. So anything provided outside of the VFC program would need to be reimbursed.

Krista Vrabel-Hebert: Thank you, Sarah. I do see a couple. One follow-up question actually, which is, "What about home tests for COVID?" And I think that's a follow-up to the question that you were just answering, Sarah.

Sarah Harshman: Yes, the at-home tests for COVID-19 are not included under the HHS PREP Act. But I encourage the person who posed the question to reach out to their state lead in case there's anything else we can provide them in regards to at-home testing coverage.

Krista Vrabel-Hebert: Thank you. I do see another question here that is related to prior authorization policies. "Is CMS planning additional technical assistance for state Medicaid programs on topics such as digitizing prior authorization policies, creating accurate rules engines to inform providers whether prior authorization is required for a particular patient to receive a specific item or service?"

Brandon Smith: I don't know if Lorraine Doo or David Koppel are on.

David Koppel: Yes, hi Brandon. So I don't know that we are planning on putting out anything specific, but the right place to go for that, I think, and Lorraine can confirm, is HL7, the standards development organization that maintains FHIR and the FHIR standard and the associated implementation guides. That's really going to be the best place to get technical assistance on these APIs, and on how the

content within the APIs for prior authorization, those items and services, how that - those are supposed to be loaded, how the documentation is supposed to be structured, and so on.

You know, we can certainly help you get to the right place with HL7. But as far as real, like, technical assistance with the technology, that's going to be the best resource. And they have lots and lots of information.

Lorraine Doo: Yes, I would second that. And like for example, on Thursday they're doing a Webinar specifically for payers on use of the CRD, the requirements documentation. And they'll probably be doing another one in advance of the January Connectathon on the prior authorization support implementation guide. So there's an awful lot that's going to be happening through HL7.

The other really good resource is through the Workgroup for Electronic Data Interchange. WEDI, has been doing a number of implementation-related Webinars. So if you want, we can send over some of those links through Jerome to get out to this group and to other groups for where that kind of technical support would be available for other implementers, you know, exactly as David is saying.

Krista Vrabel-Hebert: Thank you all so much. I'm not seeing any additional questions in the chat at this time.

Jackie Glaze: Thank you, Krista. So we'll circle back. And, (Ted), if you could provide instructions once again to register the questions and open the phone lines? Thank you.

Coordinator: Just as a reminder -- you're welcome. As a reminder, to ask a question over the phone, please press Star 1 and record your name. And I'm showing no

phone questions at this time.

Jackie Glaze: Thank you, (Ted). So Krista, I'll just circle back once again, to see if you have any last minute questions.

Krista Vrabel-Hebert: No further questions over here.

Jackie Glaze: Thank you, Krista. So I think we'll go ahead and close early today. So in closing, I would like to thank our team for their presentations. And if you do have questions that come up before the next call, please feel free to reach out to us, your state leads, or bring your questions to the next call. So we do thank you for joining us, and we hope everyone has a great afternoon. Thank you.

Coordinator: This concludes today's call. Thank you for your participation. You may disconnect at this time.