EIS-HHS CMS

CMS Contact: Tonia Brown

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Coordinator: Thank you all for standing by. Today's call is being recorded. If you have any objections, you may disconnect at this time. All participants are in a listen-only mode until the question and answer session for today's conference. At that time, you may press star 1 on your phone to ask a question. I would now like to turn the conference over to (Jackie Glaze). You may begin.

(Jackie Glaze): Thank you. And good afternoon, and welcome everyone to today's All State call and webinar. I will now turn to (Dan Psi), our Center Director, for opening remarks. (Dan)?

(Dan Psi): Thanks, (Jackie). Good afternoon. I just want to start with a thank you to everybody at the state level and other colleagues on the phone, for a lot of intense, very hard work on the front lines. I miss it, saying at the state level. I also love being here at CMS. But there's a lot flying around, which we'll have some good discussion around. So I wanted to start with a thank you to all our state colleagues and then, of course, to CMS staff.

So there are two time-sensitive topics we have been getting quite a bit of discussion on or incoming, that we wanted to highlight, the team will highlight today. So the first are a range of eligibility topics around a very pressing issue with Afghan individuals. And I know there have been a range of discussions with several states that are most particularly kind of in the thick of things at this point.

We've been getting incoming questions from multiple states and we thought we would take some time to go through that piece, which is very important. Second, on our - continuing on our topic of approaches and partnering together on how to best support unwinding whenever that happens, from the public health emergency, we'll have a set of FAQ questions that have come in.

We've had a lot of very good, productive discussion together with states, including with a workgroup facilitated by (NAMD). So a very, very important topic for everyone. We want to make sure we're able to help preserve coverage for individuals, whether it be on Medicaid and minimizing administrative churn, or helping to transition to the marketplace and other coverage options.

And at the same time, we're extremely cognizant of the operational and other realities on the ground, for state programs administering many of these pieces. So there's a lot to partner on and work through on, and essentially hold hands on together in what will be a very important and, you know, intense ride over the coming part of the period of time.

So we continue to invite just thoughts and questions. There are a lot of really good, detailed, nuanced questions that have been coming up from states relative to renewals, and a range of topics that are - that I believe (Jessica)

and (Shannon) will go through a little bit more today, along with some other topics.

I did want to just note two other things that folks may ask about on the open-ended Q&A. HCBS spending plans - we continue - the team continues to make progress on going through those. We are continuing to be excited about the funding and financing support options for states and the delivery system overall. And really enhancing capacity within HCBS and taking as broad a view of that as possible.

And so we, I think in past discussions, had anticipated some point in the not too distant future, being able to post a range of the different spending plans, approval letters, things of that sort, so states have an opportunity to see what each other - what others are doing, and for us to continue to support and encourage as much innovation in this space as possible, to expand capacity.

And then I also want to thank both (NAMD) and folks who responded to the (NAMD) survey around where various states are on understanding vaccination rates of the Medicaid population, data connectivity issues, the extent to which states have been able to engage managed care plans, and helping to support things of that sort.

I think folks will remember we put out some additional federal flexibilities and funding opportunities relative to state strategies to help increase uptake of vaccination rates for Medicaid enrollees. And we're, I don't know what the term is, open for business for any ideas or other things, or proposals folks have to really help advance that.

So with that, thank you all again. And I think I'm turning it to (Karen). (Karen)? Yes, (Karen), to (Karen Shields). Thank you.

(Karen Shields): Thanks, (Dan), and hello, everyone. As (Dan) mentioned, we have a couple of topics we're going to cover on today's call. So I wanted to introduce the speakers for those topics. First up, (Sarah Spector) from our Children and Adult Health Programs Group, will provide some clarifications regarding Medicaid and CHIP eligibility for Afghan individuals who have recently relocated to the United States.

After (Sarah)'s presentation, (Jessica Stevens) and (Shannon Lovejoy), also from the Children and Adults Health Programs Group, will answer frequently asked questions related to CMS's August guidance on planning to resume routine Medicaid CHIP and BHP eligibility and enrollment operations, at the end of the COVID-19 public health emergency.

And after the unwinding show FAQs, we'll open the lines up for questions. And we'll use a webinar for the open Q&A session at the end of the call. So if you are not currently logged in to the webinar platform, you should feel free to go ahead and do so now. With that, I'm going to turn things over to (Sarah), to start her updates.

(Sarah Spector): Great. Thanks so much, (Karen) and hi, everyone. I think folks know that Afghan evacuees have been arriving in the United States. And they are currently living in the following states during their processing. They are living in Indiana, Maryland, New Jersey, New Mexico, Pennsylvania, Texas, Virginia, and Wisconsin.

Ultimately, the evacuees will be resettled into communities, which may or may not be in the state in which they are initially located. As (Karen) and (Dan) noted, we've gotten quite a lot of questions recently, and so we

thought it was an opportune moment to really be able to talk to you all broadly about the situation.

Afghans will be eligible for health insurance through Medicaid, CHIP, the marketplace, or refugee medical assistance, often referred to as RMA that's provided through the Office of Refugee Resettlement in the Administration for Children or Families. And the eligibility for each program is going to depend on the individual's immigration status and the state in where the evacuee is residing.

So the Afghan evacuees who are entering the United States, have three main immigration statuses, and I'm going to walk through those now and talk to you through their program eligibility. The first is called Special Immigrant Visa, or SIV. And Afghans who are granted a Special Immigrant Visa, have been affiliated with the US on a mission in Afghanistan. For example, they've been translators or interpreters or are their family or spouse.

SIVs are a direct pathway for a US Green Card or lawful permanent resident status. These Afghans who have been granted Special Immigrant Visa are in a qualified noncitizen status, and are eligible for Medicaid or CHIP to the same extent as refugees. Which means they do not have a five-year waiting period if they meet all the other eligibility requirements for coverage in the state.

In addition, Afghans who have Special Immigrant Visa status, who are ineligible for Medicaid and CHIP because they are over the income limits and do not have other coverage, for example, employer-sponsored insurance, may be eligible for marketplace coverage with financial assistance. The second immigration type is called Special Immigrant Parolees.

Special Immigrant Parolees are eligible for a special immigrant visa, but were evacuated to the US before completing that process to receive a Special Immigrant Visa. And just like the Special Immigrant Visa holders I just spoke about, these Afghans who have been granted Special Immigrant Parole for more than one year, are in a qualified noncitizen status, and are eligible for Medicaid or CHIP as refugees, without the five-year waiting period.

So they will be eligible for Medicaid or CHIP if they're meeting the other eligibility requirements for coverage in the state. Similarly, they can be eligible for marketplace coverage. And similarly, they could be eligible for refugee medical assistance if they are ineligible for Medicaid or CHIP, for up to eight months following the date of their arrival. RMAs as most of you know, have benefits that generally mirror Medicaid coverage and are administered through the state Medicaid programs. But it is 100% ACS federally funded.

The third type of immigration status is Nonspecial Immigrant Parolees. And these Nonspecial Immigrant Parolees are Afghans who were evacuated for urgent humanitarian reasons, but have not been granted a Special Immigrant Visa. They're eligible to apply for work authorization and are also eligible to apply for asylum upon arrival of the US.

Afghans who are granted the Nonspecial Immigrant Parole, for more than one year, are qualified noncitizens. But generally are also subject to the five-year waiting period before they can qualify for full Medicaid benefits or CHIP. There's an important exception - 39 states and territories offer full Medicaid benefits or CHIP coverage, to Nonspecial Immigrant Parolees who are under 21 or a pregnant woman, without application of the five-year waiting period.

Under the option, states and territories have elected, commonly referred to as the CHIP or 214 option. And a list of these states that have elected the option are on Medicaid.gov. These Nonspecial Immigrant Parolees can also be eligible for marketplace coverage with financial assistance. But they are not eligible for RMA, the Refugee Medical Assistance Program.

Lastly, I want to note that all individuals who do not qualify for Medicaid based on their immigration status, may be eligible for emergency Medicaid in the state, which pays for the services necessary to treat an emergency medical condition if they meet all other eligibility requirements in the state. We are available to provide additional technical assistance to those states that are housing Afghan evacuees in particular.

I know we have ongoing technical assistance that we're providing. Certainly for additional questions, please continue to reach out to your state lead. And I'll also be available today. And I'm happy to respond to any questions when we get to the question and answer period of our call. Back to you.

(Jackie Glaze): Thank you, (Sarah), for the update. So now we'll transition to (Jessica Stevens) and (Shannon Lovejoy), and they will answer questions that were responding to the unwinding (state)s letter that was released last month. So, (Jessica) and (Shannon)?

(Jessica Stevens): Thanks, (Jackie). And first, thanks to everyone, for the really thoughtful questions that states have been sharing with us through multiple avenues. We wanted to take just a little bit of time on this call to address some of the questions that we did not get - get time to address when we did an overview of the unwinding states health official letter a couple of weeks ago,

as well as a few other questions that have come in recently that get at some frequently asked issues.

So let me go through them. (Shannon) I think will be providing most of the responses here. First, there were a bucket of questions related to FFP; the availability of FFP, (FMAP) rates, as states plan for renewals and redeterminations once the public health emergency ends. And this is the first one, (Shannon) for you. Is FFP available during the 12-month post-PHE period for individuals who experience a change in circumstances during the PHE that might affect eligibility?

So I think the question is do states still continue to get FFP as they're completing the redetermination process?

(Shannon Lovejoy): And yes. Yes. Thanks for the question. So yes, this is one we've gotten a lot. You states will need to redetermine eligibility for a large volume of cases over the 12-month post-PHE period. And, you know, at CMS we certainly recognize that many individuals have experienced a change in circumstances during the PHE that may make them ineligible for the group in which they're enrolled.

The states may claim FFP at the applicable matching rate during the PHE and the 12-month post-PHE period, for the group in which the individual is enrolled. And this is including at the increased (FMAP) rate available for newly eligible beneficiaries in the adult group, at least until the individual is determined eligible for another eligibility group, or the individual is determined ineligible for Medicaid.

Of course, for any beneficiary to move to a new group, states must make the appropriate adjustments to claim FFP at the applicable matching rate for the new group at that time.

(Jessica Stevens): Great. Thanks. There are potentially related questions that this is more related to the FFCRA (FMAP) increase. And the question was will states be able to continue claiming the 6.2 percentage point (FMAP) increase authorized under the FFCRA for the 12-month post-PHE unwinding period, so as they complete pending work?

(Shannon Lovejoy): We definitely heard from a lot of states on this. So the temporary 6.2 percentage point increase in the (FMAP) that was authorized under the Families First Coronavirus Response Act or FFCRA, is available through the end of the quarter in which the federal PHE ends. And the availability of this (FMAP) increase is defined in statute. So unfortunately, CMS is unable to extend this temporary (FMAP) increase through the end of the 12-month post-PHE period, when states are working through their backlog of eligibility enrollment action.

You know, we acknowledge and know that a number of states have raised concerns with the potential budgetary impact of having to work through pending actions over the 12-month post-PHE period if this temporary (FMAP) increase is not extended. And, you know, while Congressional action is required to extend the temporary (FMAP) increase authorized under the FFCRA, you know, we will continue to work with states to provide any immediate technical assistance and do all, you know, work to restore routine operations once the public health emergency ends.

(Jessica Stevens): Thank, (Shannon). Some of these questions may be a bit of a review, but I think worth talking through. There have been a number of questions that have

come through about just the renewal process, renewal expectations for states as they unwind. And the first one is, are states required to complete a new redetermination of eligibility for all individuals once the PHE ends?

(Shannon Lovejoy): Yes. And we also discussed this in the state health official letter. So, yes, states must redetermine eligibility for all individuals enrolled and receiving benefits prior to the public health emergency, during that 12-month period after the PHE ends. So this means that a redetermination is required after the PHE, even if the individual is determined ineligible during the PHE, or if the individual failed to respond to a request for information that was sent during the PHE.

(Jessica Stevens): Great. Thanks. And I'll acknowledge that there have been a number of little twists on that particular question that are with us and that we're working through. I'm sure some of you may ask some of those today, but recognize that there are more detailed questions to come on that. But another one that I think speaks a little bit more to the process is, generally speaking, the question was does the unwinding guidance change the process for states to redetermine eligibility for individuals after the PHE ends?

In other words, have the renewal requirements changed in any way, Shannon?

(Shannon Lovejoy): This is also a really good question. No. The renewal requirements have not changed. And the unwinding guidance does not change the process. So states must continue to redetermine eligibility consistent with renewal requirements, which are outlined in regulation, at 42 CFR 435916. So this includes, of course, you know, first, attempting to redetermine eligibility based on available information without contacting the individual.

And two, when information must be requested from an individual in order to complete a redetermination, states still need to make sure that they're sending prepopulated renewal forms and providing (MAJI) beneficiaries a minimum of 30 days to respond or sending non-(MAGI) beneficiaries a renewal form that can be, but is not required to be, prepopulated. And providing these beneficiaries with a reasonable period of time to respond. So, yes, the guidance does not change this process.

(Jessica Stevens): Okay. And what about ex parte renewals? I know there - a couple of states have asked about flexibility related to the requirement to attempt to renew eligibility based on available information after the PHE ends. What can you say about that?

(Shannon Lovejoy): So no, there is no flexibility around this requirement. You know, states must attempt to redetermine eligibility based on available information prior to requesting information and sending renewal forms to the individual. So this means that states should be consistent with the state's verification plan, checking data sources, and other available information for all beneficiaries.

And of course, at that point, if the state's unable to renew eligibility for the individual based on the available information, the state must provide the individual with a form to complete on paper or by phone, or online. And there's no exceptions to the requirement. You know, we have heard and recognize that some states have been concerned about their system capacity to process a large volume of renewals after the public health emergency ends.

And, you know, we are encouraging states to distribute renewals across the 12-month post-PHE period to help alleviate some of these challenges, as well as ensuring states are able to, you know, promote continuity of coverage and

maintain for eligible individuals and manage their workload in a manner that is sustainable in future years.

(Jessica Stevens): Great. Thank you. More specifically to when states start. When may states begin initiating redeterminations and closing cases for individuals found ineligible? Yes. This is a more tricky one I think.

(Shannon Lovejoy): Yes. And I may not have the most satisfying answer to this. This is a question that I know many of you have been asking and we've been getting in I think, a little bit more frequently, about, you know, when the 12-month post-PHE period begins, as well as when states can initiate redeterminations in order to close out cases for those individuals who are found ineligible after the PHE ends.

And we have been gathering information from states on the amount of advance notice to begin implementing state plans to resume routine operations, as well as information from states about the timeframe that states require to complete a redetermination for a particular cohort of cases. And this is an area where we plan to provide states further guidance. And we still welcome additional feedback from states on this.

(Jessica Stevens): Great. Thank you. I think this is one question that we partially answered during our last call, but I think it's worth revisiting. Are states required to send a notice to individuals who the state determines no longer meet eligibility requirements, or who do not return information needed to complete a renewal or redetermination, conducted during the PHE? So focus on what states should be sending notices about right now.

(Shannon Lovejoy): Yes. And this was a question that was asked on the last call that we did not - were not able to fully address at the time. So we know that many states

are conducting redeterminations and renewals during the PHE, even though we know that they're not terminating individuals determined ineligible, or terminating coverage for those who did not return needed information.

And these states are - and these states may, but they're not required to send notices to individuals who are found ineligible during the PHE. You know, we recognize that some states have been able to send notices during the PHE, informing Medicaid beneficiaries who were found ineligible, that their enrollment is continuing during the year, but, you know, would have been terminated at the end of the PHE unless the individuals notified the state of a change in circumstances.

But, you know, going back to one of our previous questions that we just talked through, for Medicaid beneficiaries who are determined ineligible during the PHE, regardless of whether the state provided the individual with a notice of that determination, states must complete another redetermination of eligibility after the PHE ends.

And so for those individuals who are determined ineligible again after the PHE, at that point states must send the required advance notice of termination or other adverse action, and provide fair hearing rights in accordance with regulations that are at 42 CFR Part 431(e).

(Jessica Stevens): Great. Thank you, Shannon. And I'm sure the states have follow up questions. We can get to some of those in the Q&A. Just a couple more to tackle - first is around again, the timing of renewals and redeterminations and compliance with, you know, not conducting a (MAGI) determination more than 12-months.

If the state determined an individual is eligible or the individual did not return their renewal form during the PHE, does the state have to wait 12-months consistent with, you know, federal requirements for (MAGI) beneficiaries, even if PHE has ended?

(Shannon Lovejoy): Yes, so we really appreciated these questions. And it's going to take a little bit longer on this question. So, you know, we acknowledge that we're in a very unprecedented situation where, you know, states are completing redeterminations during the PHE, but are keeping individual, all individuals enrolled, even if the person was found ineligible.

So, you know, for - I'll start with eligible individuals. So if an individual was determined eligible during the PHE, and granted a new 12-month eligibility period, the state may not complete another regular renewal until the end of the individual's eligibility period. Again, that's for individuals determined eligible. So for individuals who had a redetermination during the PHE, but were not found eligible, there's a little bit of a difference there.

So for individuals determined not eligible at renewal that was conducted during the PHE, but not terminated, states are not required to wait for a full 12-months from the date of that renewal to conduct another renewal following the end of the public health emergency. You know, I think as we've talked about in other guidance, states are expected to develop a plan to prioritize and distribute pending work across their 12-month post-PHE period.

And so for someone who was found ineligible during the PHE, states can pick up that case back at any point during the 12-month post-PHE period to complete another renewal of eligibility, based on the plan that the state developed. And maybe to help, because I know that's a lot to take in, so to help with that I'll walk through a bit of an example.

So let's say that you're working on a case right now for John Smith. And this month, in September of 2021, while the PHE is still in effect, you find that John is ineligible. And let's say in this example that the public health emergency ends in January, so January 2022, and that the 12-month post-PHE period begins in February 2022. Again, just for the purpose of this example.

So the states must conduct a new renewal for John at some point during the 12-month post-PHE period. However, remember that we had found John ineligible this month, September 2021. When the state takes John's case back up, in our example, in the 12-month post-PHE period, the state can conduct the new renewal at any point during the 12-month post-PHE period. It doesn't need to wait until September of 2022 in order to pick up the case and complete the new redetermination.

Again, this is because John was found ineligible during the PHE. I know that was a long answer, but hopefully that - I covered that one.

(Jessica Stevens): Okay. Thank you. I think just one more question before we open it up for other follow ups. Do states have the option to align pending eligibility in enrollment actions with completing a renewal and/or for individuals who receive SNAP, Supplemental Nutrition Assistance Program benefits, with a SNAP recertification? I think this is a question that we tackled maybe back in December with the release of the first state health official letter.

(Shannon Lovejoy): Yes. Yes, this is covered in that first state health official letter that was released back in December. And the short answer is yes, the new state health official letter that came out last month doesn't change the ability to take

advantage of some of these options. So in that December letter, on returning to routine operations after the PHE ends, states were provided the option to process pending eligibility action, including processing changes in circumstances, as well as post-enrollment verifications with the individual's renewal.

There's also the option to align pending eligibility actions and renewals with an individual SNAP recertification. And these options are still available to states. We just note that because the timeframe for states to complete pending work has been extended to 12-months following the end of the PHE, that these options are available for that entire 12-month period.

And, of course, you know, the option to align pending Medicaid actions with the beneficiary SNAP recertification, may also provide states with a unique opportunity to align Medicaid and SNAP renewals in future years, at least for this period of time.

(Jessica Stevens): Great. Thank you. I won't say that those are the only questions we received, as states know they've sent many more. I tried to capture a number of issues in the ones that I just read out. But I think (Jackie), I'll turn it back to you. And of course, we're happy to answer more.

(Jackie Glaze): Thank you, (Jessica) and (Shannon), for your information that you've shared today. So we are ready to start taking questions. And we will begin with the chat function. We've already received quite a few questions, so we'll begin there. And continue to send your questions in. And then we'll follow by taking your questions through the phone line. So I'll turn now to you, (Ashley).

(Ashley): Okay. Thanks, Jacqui. So our first question is actually around the vaccine incentive presentation that we presented on our last all state call. And it says, for vaccine incentives will CMS provide 50/50 FFP for the administrative costs of developing and contracting for a COVID vaccination incentive program, as well as FFP for the cost of the actual incentive? And if so, at what rate?

(Amber McCarrell): Hi. This is (Amber McCarrell) from the Financial Management Group. I'm not - I think we would need to see the details of the state proposal. So I would encourage you to work with your state leads to share the details of the proposal with us. And then we can provide one-on-one technical assistance.

(Ashley): Okay. Thanks, (Amber). Then we have a couple of questions that have come in around today's presentation around eligibility for Afghan evacuees. And the first question says, will (SAVE) or VLP verify the Special Immigrant Parole status?

(Sarah Spector): Yes. This is (Sarah). So the Special Immigrant Parolees are the second grouping I talked about. And they do have special codes that (SAVE) has developed, and indeed they have sent out notification already about what those codes are. There are two of them - I can see if I can pull them up quickly. I don't want to say them wrong.

So those can be verified to (SAVE). And anyone with a direct connection with (SAVE) or using the (GUI) could - I understand they're in production now, (SAVE) notified their users back in August, about those new codes. The hub is looking at changes, and we are working with our partners at (SCSIO) on impact to the hub.

(Ashley): Okay. Thanks, (Sarah). And then we have one more question around eligibility for Afghan evacuees. And it says, regarding eligibility for Afghan evacuees, can you please clarify parole status for humanitarian reasons for pregnant women and children? (SHOW) 10-006 says of those granted parole for less than one year, but we know some will be granted parole for a longer period of time. Are they still eligible if longer than one year?

(Sarah Spector): Yes. That's a terrific question. So there are covered as lawfully - the easy answer is they are covered if you have elected that option to cover your children or pregnant women as parolees, either for less than one year or more than one year. They are officially qualified noncitizens and eligible in all 50 states if they are paroled for more than one year and if they are paroled for less than one year.

As you noted in the state health official letter, they explicitly cover it and extend that coverage as lawfully present to parolees, even those parolees paroled for under one year.

(Ashley): Okay. And then we have one more related question that came in. And it says, we have a question about the individuals entering the - I'm sorry, I lost it - entering the Operation Allies Refuge. Can you please clarify again the difference between populations 2 and 3 that you spoke of? Are they both parolees and the only difference is group 2 has been paroled for more than a year and group 3 has been paroled for less than a year?

(Sarah Spector): Yes. No. Important question. So they are both parolees, but the group 2 that I spoke of, are Special Immigrant Parolees, and they do have special codes. DHS (SAVE) calls them (COA) codes, and I pulled them up. I can read - the first question you gave me, the two (COA) codes are FQ4. And

what that means is Special Immigrant Parolees. And really those individuals should be treated as refugees and not subject to the five-year bar.

While they were granted parole status it's Special Immigrant Parole status. And they are more similar in terms of their treatment for Medicaid and CHIP, to the first group. They are they are special immigrants. They are just being given special codes and special parole on their way to being special immigrants, is my understanding. So for Medicaid and CHIP treatment purposes, they are treated as refugees. Meaning they are eligible for Medicaid and CHIP without a five-year waiting period, if they are otherwise eligible in the state.

The last group, the humanitarian paroles are not special immigrants. So they are just regular parolees, whether - you can look at whether or not they are here for more than one year or less than one year. They are, we understand, being given their own special codes on (SAVE). But in reality they - it could be a parolee for any reason.

And they are going to be qualified noncitizens if they are paroled for more than one year. But they will be subject to the five-year waiting period. And a Medicaid or CHIP agency would analyze those individuals in terms of their eligibility and treatment for Medicaid and CHIP, like any other parolee in the United States for any other reason.

(Ashley): Okay. Thanks, Sarah. So now we have a number of questions that have come in around our unwinding guidance. And the first question says, in (SHOW) 21-001 CMS advises that states must complete renewals for all members who have their renewals delayed during the public health emergency. If after the public health emergency ends a member self-reports a change that makes

them ineligible for coverage, do we still need to complete a redetermination prior to taking an adverse action based on this reported information?

(Jessica Stevens): Let me just - this is (Jessica). Let me...

(Shannon Lovejoy): So this...

(Jessica Stevens): ...make sure - oh, go ahead, (Shannon). Go ahead.

(Shannon Lovejoy): No. I was just going to ask if (Ashley) could repeat the question just to make sure I understood.

(Ashley): Yes. It says, if after the public health emergency ends a member self-reports a change that makes them ineligible for coverage, do we still need to complete a redetermination prior to taking an adverse action based on this self-reported information?

(Shannon Lovejoy): Yes. So in this situation here it seems like the individual reported a change in circumstance after the PHE. And if the, you know, if it's a change in circumstance the state follows the process to redetermine eligibility based on the change. And, of course, if the individual is found ineligible and - based on the change, and ineligible for Medicaid on all bases, then at that point after the PHE, the state, you know, may send a required advance notice.

(Ashley): Okay. Thank you. The next question says, can a redetermination that finds a beneficiary ineligible result in termination of coverage at the end of the month following the month in which the PHE ends?

(Shannon Lovejoy): So I think this gets a little bit at the question that we tried to respond to in the Q&A earlier, just regarding the timing of when the post-PHE period will begin, as well as when states begin initiating the renewal redeterminations, in order to begin terminating coverage and meeting the requirement to complete redetermination of eligibility after the PHE ends.

So this is an area where we're continuing to work on additional guidance. But we certainly welcome feedback from states on the timing that they need to begin, you know, implementing their plans to resume routine operations, as well as just the general timeframe states take to initiate and complete a full renewal for individuals, to help us as we think through this issue more.

(Ashley): Okay. The next question says, if a client's lost eligibility during the PHE because they reported an increase of income, they remained on Medicaid because of the (MOE) requirement. Post-PHE if the state performs a check with external sources and determines the client's income is now within the Medicaid threshold, should the state be asking the client to verify the income? Or should the state be automatically using this income from external sources to redetermine their eligibility and make the client eligible again?

(Jessica Stevens): Thanks. You - this is (Jessica). They should be using - they should be redetermining eligibility based on the current information and not based on - not trying to sort of go back and figure out. So I think - sort of restated, I think the scenario is a circumstance where somebody is - might have been ineligible for a period of time, but due to the FFCRA they continued to be enrolled.

Post-PHE they conduct a renewal again and they find out the person is eligible. Based on that available information, assuming that this is an ex parte renewal, the state should renew eligibility for that individual without requesting additional information. That is in part, one of the reasons for doing an additional renewal or redetermination once the public health emergency ends, recognizing that people's information fluctuates.

And while somebody might have temporarily had an increase in income during the PHE period, by the time that the state conducts a renewal redetermination for that individual, they may be eligible and should be made eligible prospectively.

(Ashley): Okay. The next question says, do we need to send a full renewal packet to everyone? Or does a full redetermination mean we can redetermine eligibility based on reported changes like outlined in 42 CFR 435916(d)?

(Shannon Lovejoy): So maybe I'll just walk through the process. So for after the PHE ends, you know, if a state is working on a change in circumstance, not necessarily renewal. So remember, states have the option to align work on pending changes, changes in circumstances with an individual's renewal. If the state is only acting on a particular change in circumstance, and not going through the full renewal process because it's not the renewal, the state follows the procedures to process the change in circumstances.

However, if this is a renewal and if the individual's annual renewal, the state is choosing to align, you know, all pending work renewal, the state must follow the renewal requirements that are in regulation at 42 CFR 435916, which means that the state must first attempt to renew eligibility based on available information before sending out a renewal form to the individual.

(Jessica Stevens): And maybe just - exactly what (Shannon) said in a slightly different way, because I feel like we've gotten this question a few times. Everyone after the public health emergency ends, must go through an ex parte renewal first. In other words, it would not be sufficient to send a renewal packet or renewal forms, or using essentially, do a redetermination based on the change in circumstance for any individual.

For each person, the state would need to first, you know, attempt an ex parte renewal or administrative renewal, and provide the individual with a minimum of 30-days for (MAGI) to provide additional information, as if you were just doing your regular annual renewal for the beneficiary.

(Ashley): Okay. The next question says in the (SHOW) letter it mentions that CMS will use application processing indicators from before the PHE, to decide if corrective action is needed at the four-month mark after the PHE. What do those standards look like and how much leeway is there?

(Shannon Lovejoy): So I think...

(Jessica Stevens): That might have been - I think what the questioner is referencing is guidance in the December 2020 (SHOW) that talked about the expectation for state set applications to resume timely operations - timely processing of applications within four months. And I think sort of separately states, you know, through performance indicator data right now and in certain circumstances, through other modes, report timely application processing data.

First, the standards for timely processing of applications are in regulations and not necessarily based on what a state was doing before. The expectation is that for applications that are submitted on the basis of the disability, a state has no more than 90-days to complete a determination.

For all other applications, so this means for (MAGI) applications and any other application, not based on disability status, that individual - I'm sorry, the state must complete a determination within a maximum of 45-days.

I think that's what the questioner might have been referencing. But if there's a follow up question, please go ahead and ask that.

(Jackie Glaze): Thank you, (Jessica). I think we're ready to open up the phone lines and see if we have any questions there. So Operator, can you provide instructions to our participants and then take questions? Operator? (Ashley), I'll go back to you and then see if we can open the phone lines in a minute or two.

(Ashley): Okay. Sounds good.

(Jackie Glaze): Thank you.

(Ashley): So the next question says, do we have to wait until the redetermination to just terminate? Or do we also have to wait until the redetermination to reduce benefits or start charging new or increased premiums?

(Jessica Stevens): For...

(Shannon Lovejoy): Yes.

(Jessica Stevens): For all? Yes. Go ahead (Shannon). We both said it...

(Shannon Lovejoy): Yes. Yes. So I was going to say, so the requirement after the PHE, you know, before taking any type of adverse action, so that includes terminating coverage for individuals who are found ineligible after new renewals

conducted, after the PHE, or for individuals who might have increased premiums after a redetermination. Yes. A new renewal is required after the PHE, for all types of adverse action.

(Ashley): Okay. Then we have a question that says, are there any audit findings or penalties if states wait until the end of the federal PHE to resume renewal?

(Jessica Stevens): So I'm going to answer the question with a few more words, making sure that we understand it. I think what the state - the person who asked the question is asking is if a state with a 12- month period doesn't start renewals until the 11th or the 12th month period, is that permissible? The answer is no, in short. But explained in a little bit more detail, the state needs to complete renewals for individuals within the 12-month period.

We are strongly and I know we've had a number of conversations with states that, you know, are working within the state about with - to conduct these in a shorter period of time. But are strongly encouraging all states to think about ways to spread this work over the full 12-month period. And I think there are a number of reasons for that, including benefits to the state.

The first is that whenever renewals are conducted in the 12-month period, that becomes the renewal timelines for future years. And as we've heard from states in the past, it is in a state's best interest to distribute that work as evenly as possible over the course of a full 12-month period, so that you don't end up with large groupings of renewals in any particular month.

At the same time, states should plan to complete the work within the 12-month period. So waiting until month 11 of the 12-month period after the PHE ends to begin work, really would mean that the state would need to do, you know, half of the entire population in month 11 and the other half in

month 12, which is likely to lead to probably inappropriate terminations of coverage just due to the volume; potential beneficiary confusion; and other issues.

So I think for all those reasons, we really encourage states to think about the ways in which to spread this out really slowly over the 12-month period, consistent with the guidance we just put out.

(Ashley): Okay. Then we have a question that says, CMS has previously told states that if we intend to not collect premiums after the PHE ends, we'll need to submit a (SPA). So can states continue to do so without a (SPA)?

(Jessica Stevens): I'll throw this to our colleagues on the line. (Erin)?

(Erin): I'm sorry. Can you repeat the question, (Ashley)?

(Ashley): Sure. It says CMS has previously told states that if we intend to not collect premiums after the PHE ends, we'll need to submit a (SPA). So can states continue to do so without a (SPA)? And I think this is for the period until they conduct a person's redetermination in the unwinding period.

(Erin): I think we've probably - I think maybe if we can follow up with that one, either with the state directly, or answer on next week's call, I think we've got a couple of people - we don't have the right people on the call to dig into that. We may want to follow up with the state.

(Ashley): Okay. Then we have a question that says, if a client was determined ineligible during the PHE or if a client who was determined ineligible during the PHE reports a change post-PHE, prior to the state initiating their redetermination and they remain ineligible for Medicaid, should the state

terminate their Medicaid eligibility based on the latest redetermination - or latest determination?

For example, the state determines based on the change report from the client on January 10, 2022, should the state now terminate the eligibility effective January 31st, based on the latest redetermination, assuming that the PHE ends December 31st?

(Shannon Lovejoy): So we know that there will be a number of individuals who either at the state had determined that they were eligible during the PHE, so they're in the middle of the eligibility period, you know, by the time the public health emergency ends. Or the state may have conducted or attempted to finish a redetermination during the PHE, but kept the individual enrolled because the individual was not found eligible at that time.

And so we know that states will, you know, continue to receive information about changes in circumstances during the post-PHE period. And, you know, states can either align their work in a post-PHE period to conduct everything whenever they pick the case up for renewal, based on either the plan that they've set forward or when the individual's renewal date comes up during the post-PHE period.

You know, then states also could choose to process changes in circumstances separately from renewals. And if a state is choosing to do that they can, you know, act on a change in circumstance reported during the post-PHE period.

(Ashley): Okay. And then the - I think maybe - we have time for maybe one more question. And it says, if the state decides to prioritize the renewals for the COVID population, is it okay for the state to delay some of the other

renewal dates past the person's 12-month anniversary, to be able to spread the renewals across the 12-months post the PHE restart period?

(Shannon Lovejoy): Yes. So states do have options in how they distribute the work. You know, and I'm not sure what is meant by COVID population in this particular question that's referring to maybe individuals enrolled in the COVID testing group that some states adopted, or if it's referring to individuals who are - just continued on coverage during the public health emergency because the state's claiming a temporary (FMAP) increase.

But there are options for states to, you know, distribute workload across the 12-month post-PHE period. And it is an area where we're looking to provide states more guidance to help them think through how to distribute their work. But of course, if someone has a renewal that they do during that period, you know, states can - during the 12-month post-PHE period, the state can choose, depending on how they've outlined their plan and work distribution to pick up the renewal when it's due.

They also potentially in their plans, might have pushed back the date a little bit within that 12-month post-PHE period. The only thing that a state cannot - for sure cannot do, well not the only thing, but one of the things states cannot do is if someone - what sounds, you know, is in a 12-month eligibility period the state cannot move up the renewal date for someone who was, you know, was found eligible and is in the middle of their 12-month eligibility period.

That is, you know, would come due during the 12-month post-PHE period. But if a state wants to push it back a little bit in terms of when they complete the renewal because of how they're distributing work within that 12-month post-PHE period, that's certainly one of the options.

(Jackie Glaze): Thank you. And thanks, everyone, for the questions today. I'd also like to thank the team for their presentations and information that they shared. Looking forward, we will meet with you again on Tuesday, September 28. We will send the invitation shortly. And of course, if you have questions that come up before the next call, please reach out to us, your state leads, or you can bring your questions next week - in two weeks.

So if you'd like to presubmit a question in advance for the open Q&A portion of the next call, you can email it to the MedicaidCOVID19@CMS.HHS.gov mailbox by 1:00 pm Eastern Time on the day of the call. So we appreciate your time today, and hope everyone has a good afternoon. Thank you.

Coordinator: And this concludes today's conference. Thank you for participating. You may disconnect at this time.

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