

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

April 5, 2022  
3:00 pm ET

Coordinator: ...and thank you for standing by. At this time all participants are in a listen-only mode. During the Q-and-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, you may disconnect at this time. Now I'd like to turn the call 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'd like to now turn to Anne Marie Costello, our Deputy Center Director. And she will provide highlights for today's discussion. Anne Marie?

Anne Marie Costello: Thanks, Jackie, and hi, everyone, and welcome to today's all-state call.

Today our call will focus on two new tools that CMS released yesterday to support states in your unwinding planning efforts. We are joined by a few very special guests.

As you know, throughout January and February, CMS met with every state, DC, and most territories to talk through your unwinding planning. We really appreciate the time that you all took to meet with us. The discussions provided invaluable insight into your planning efforts, and we hope that they were helpful to you as well.

For our first presentation today, Jessica Stephens, our CMCS lead for the state calls, will provide an overview of a number of best and promising practices gleaned from those discussions, including enrollee communications and preparation strategies that your fellow states are implementing as they prepare to return to normal eligibility enrollment operations.

Then we're excited to be joined by three state Medicaid agency representatives -- LaTonya Palmer from Kansas, Kim Hagan from Tennessee, and Alyssa Cohen from New Hampshire, who will each share more about some of the strategies highlighted in the deck that Jessica presents.

For our second presentation, Sarah Lichtman Spector and Marc Steinberg from our Children and Adults Health Programs Group will present a new tool that provides states with strategic approaches to processing fair hearings as states resume normal eligibility enrollment operations.

Concerns about processing a large volume of fair hearings was a common theme in our state calls. So we did some thinking with the state workgroup and are happy to share some ideas to managing the work that we hope are helpful to you.

Finally, Jen Bowdoin from our Disabled and Elderly Health Programs Group will share a couple of updates. Then we're planning to hear from another special guest. And finally we'll open the lines for questions.

We'll use the Webinar for today's presentation. So if you're not logged in to the Webinar platform, I suggest you do so now.

Before we jump in, I wanted to share one update. We've had a lot of interesting questions regarding the process for requesting 1902 e-14-A waiver authority that can be used to streamline eligibility enrollment processes.

So far, 16 states have raised their hands and expressed interest. And we recognize the states would like this information as soon as possible given the potential system changes and associated timelines needed to implement those changes.

We're happy to let states know that we shared sample language with all states today by email to state Medicaid directors and to the (e-tags). The sample language provides states with detailed instructions on how to submit a request and lays out some model language that may be used in drafting the submissions, applicable state assurances, effective date guidance, and who to reach out to with any additional questions.

With that, I'll turn things over to Jessica to get us started. Jessica?

Jessica Stephens: Thank you, Anne Marie. And hi, everyone. I'm really excited to talk to you today to really reflect back to you what you shared with me, with CMS, during the conversations that Anne Marie referenced us having between December and roughly end of February this year where we talked to all states in most territories.

You know, our conversations really focused on the eligibility and enrollment aspects of unwinding. But in that, touched on a number of different issues associated with some of the (E&E) work that you're thinking about related to workforce capacity, coordination, outreach, etcetera.

What this deck does is really try to pull out concrete strategies that states are implementing or plan to implement to prepare for unwinding, and hope that it will end up being a useful tool for all of you to hear a little bit about what other states are doing, and think about your own implementation and unwinding plans.

Next slide please. So you all shared a lot with us, and this word cloud is really just a snippet of the conversations and the types of things that are on your mind, of course, in addition to Medicaid and CHIP, renewals and redeterminations are certainly front and center in the thinking that you're doing, along with systems and updates, etcetera.

Next slide please. The conversation also really focused in four key themes that we've bucketed here. Renewals and determinations, which I just noted. Contact information. Workforce capacity. And outreach partnerships and communications. And so this deck really goes through each one of those four themes and highlight some of the concrete strategies that states are implementing.

So, starting with renewals and redeterminations, next slide please. As a reminder, I know we've talked about this on previous all-state calls, states will have a 12-month unwinding period after the PHE, to initiate renewals for all individuals enrolled in Medicaid, CHIP and the basic health program, and then 14 months to complete that work. And states will need to do a full renewal for all individuals.

We've spent a good chunk of time with all of the states talking about how you're thinking about renewals, what you've been doing during the public health emergency, etcetera. And nearly all states reported having conducted some renewals during the public health emergency, in some form or another.

Over half the states indicated that it's actually going through the entire renewal process where possible, doing ex parte renewal process and sending and processing forms.

So, a number of states also indicated that it's only doing the first part of the renewal process ex parte. And then for individuals who can't be renewed on that basis, pushing forward eligibility renewals.

For the majority of states who are conducting ex parte renewals, success rates have varied. That's not necessarily new, but we, I think we've heard that some of the ex parte success rates have declined as the PHE has progressed, and increasing ex parte rates is a high priority in many states. And I'll note, as a side note, also CMS's help - is very committed to helping states do that.

You indicated that states were tracking and tagging those individuals whose coverage could not be renewed as you were doing renewals, and - but not terminating coverage for those individuals, which may influence your prioritization strategy during unwinding.

You also indicated that most states plan to conduct renewals over the full 12 months period, although there are a number of factors driving that decision. There were a handful of states indicated that budgetarian legislative factors might affect the ability to conduct, spread out their renewals through that period.

Next slide please. We talked a bit about (these approaches) to distribution and prioritization. And you know, going back to the state health official letter, there are a number of strategies made out that really also describe how states are thinking about this.

From a population-based approach, which I think is the first one that many states are thinking about, to the extent that you are able, states are thinking about how to prioritize and de-prioritize certain populations. From a prioritize perspective, they're focusing on individuals who are likely ineligible, and de-prioritizing individuals who are likely continuing to be eligible, including pregnant and post-partum individuals.

And we also talked about certain considerations like workflowed systems and the long-term impact.

Next slide. We also talked about time-based approach, which a number of states are thinking about. And importantly, helpful to note that a number of states indicated that this required less complicated system changes in some of the population-based approach, especially going from oldest to newest. But in reality, it sounded like most states were thinking about a hybrid approach that combine the two.

Next slide please. So, just I think an important reminder, consideration, that as we've said in our guidance, states have flexibility to redistribute renewals, but should consider the impact of the redistribution plan and should not prioritize or de-prioritize renewals based on FFP or in a manner that violates non-discrimination laws.

Next slide. Just briefly, the other area in which a lot of states are doing work on now is updating the enrollee contact information. Nearly every state is doing work right now to update enrollee contact information, which would be critical to ensure that in sending renewal forms, once the - once unwinding begins, that those forms don't get lost.

And a lot of you talked about working with managed care organizations, but also doing things like updating interactive voice response systems with messaging, and remind the people to update their contact information.

Next slide. And there are I think a number of different strategies additionally, including sending postcards, partnering with providers, pharmacies, stakeholders. But there's one that we wanted to highlight here, and we have LaTonya Palmer from Kansas. And I'm wondering, LaTonya, could I just pass to you for a moment to talk a little bit about this strategy in Kansas?

LaTonya Palmer: Sure. Thank you, Jessica. And good afternoon, everyone. As Jessica mentioned, my name is LaTonya Palmer. I am the Director of Eligibility at the Kansas Department of Health and Environment, so the single-state Medicaid agency in Kansas.

We implemented an aggressive outreach campaign around November 2021. And one of our areas of focus, as indicated on this slide, was communicating to members the need to update their contact information. And also, along with that, moving our members to action.

So, to get us to that point, we engaged our agency communications team to assist us with creating the message and also with placement. We utilized primarily four different mediums to communicate.

One was via paper. We created a frequently-asked questions document targeted to our members, and worked with our managed care health plans in developing wording and messaging.

One area of emphasis in that document was providing - communicating to members the need to provide their most up-to-date contact information. And

that document was shared with our provider associations, both plans and community partners, prior to - after finalizing. We found that our stakeholders have been really eager and willing to assist us with our unwinding plans.

We've also placed messaging on our Medicaid - our (Team Share) Web site, and through our call center IBR, as it sounds like many of you, other states are also utilizing that strategy.

One are that was new to us was utilizing social media. So we placed messaging on Twitter, Facebook and Instagram. And this slide has a visual of our Facebook posts encouraging our enrollees to provide us with updated contact information. Historically we hadn't used social media much as an outreach tool. And we asked ourselves, you know, why not, and really couldn't think of a reason not to use social media to assist with our outreach.

So we added social media to our outreach strategy. And we saw an immediate jump in requests to update contact information from our members. We saw an approximate 15% to 20% increase in requests.

And I looked at our most recent available data, and our numbers trending - so we're now seeing about a 35% increase since we incorporated social media to our outreach, and we believe that, you know, the messaging along with a call to action and also placing this message in various modalities has contributed to our members' response to the message and contacting us to update their contact information.

So, thank you for the opportunity to share this insight with you all. And Jessica, I'll now hand it back over to you.



Jessica Stephens: Thank you so much. And as you heard from Kansas, there's a lot going on with updated contact information, but it's just one snippet, I think, of the things that we heard in a number of different states. So, thank you.

Next slide please. I think one of the biggest, the most common themes we heard was challenges around workforce capacity. I don't think I need to tell you the challenges that you all are facing with workforce capacity. But we'll just highlight some of the things that states are thinking about, which include adopting additional flexibility, like continuing telework, or part-time work.

Leveraging experienced workers. Because part of the challenge is that, even though you might have hired new eligibility workers, they - it takes a while to train them.

Along with going back to distributing renewals to ensure that, you know, you have the workforce capacity to complete the work for the various months, conducting refresher trainings, especially for new eligibility workers, and increasing automation to the extent that that is possible.

Next slide please. But an area we want to spend just a couple of minutes, and we have two state presenters, relates to outreach partnerships and communications.

You know, even with the uncertainty of the timing of the end of the public health emergency, many states are doing a lot of work right now thinking about how to engage individuals, mostly with respect to contact information, and then returning renewal forms. And there are various things that states are doing, including social media campaigns, partnerships, developing partner networks, testing, calling, media buys, other data, using other data.

But if you go to the next slide, I want to turn it over to Kim Hagan in Tennessee to talk a little bit about one strategy being used.

Kim Hagan: Okay, great. Thanks, Jessica. Good afternoon, everyone. I'm Kim Hagan, I'm the Director of Member Services in Tennessee.

We actually launched our new online application statewide in the spring of 2019. And it took us a while to see an uptake in usage of that online application.

Prior to that - prior to 2019, the majority of our applications and renewals were submitted by mail or by phone. And so, once we worked with our systems vendor Deloitte to build and launch our online portal and mobile application, and we tried to make it as user-friendly as possible so our population would be likely to use it and have a greater opportunity for no-touch processing, but in late 2019 we were still seeing a slow adoption.

So, after much discussion, and this was mainly around renewals, because that is, you know, a process where we are really focused on retaining people, but after much discussion, we decided to launch a paid ad campaign and focus on the renewal process.

Yes, we talked through it and it made a lot of sense to me as a busy mother who's more likely to check Facebook at night while, you know, sitting in a dark room, putting my son to bed, rather than getting through that paper mill, you know, on a daily basis.

So, our goal was to improve digital adoption by raising awareness of the new portal and its benefits, and to reduce churn due to renewal process.

So we embarked on a three-month pilot period, kind of bad timing. But we started January 2020, and we piloted paid media campaigns to increase awareness and education and to remind people that were up for renewal. We used Facebook ads, Instagram. And then we had paid Google Search ads to send information to people who are up for that particular cohort for renewal.

Facebook and Instagram were used to hyper-target members up for renewals, and we use standard messaging such as "Did you know you can renew your TennCare benefits online?" or "Renewals are due today," once we got to those due dates.

The urgency - urgent messages did improve click-through rates on those two platforms. Google ads were used primarily as educational tools for individuals who are already searching for TennCare related terms.

And so even though our pilot project ended early due to the PHE in March of 2020, we did see member portal usage increase because of this campaign. So we saw a 107% increase in renewals being returned over the previous four-month average. We saw 16,000 new accounts created and 40,000 users visited our online portal during this campaign.

So this is something that we are going to try again once the unwinding begins. We're going to, you know, change some of our ads and make them more targeted to individuals. But we look forward to seeing great results during the unwinding.

So, back to you, Jessica.

Jessica Stephens: Thank you, Kim. And we were quite impressed by these data, so I'm glad that you were able to share.

Next slide please. I might actually just turn this right over to Alyssa Cohen to talk a little bit about a strategy that New Hampshire is doing that I know a number of states have already modeled. Alyssa, can I turn to you about your Pink Letter Campaign?

Alyssa Cohen: Absolutely. Thank you, Jessica. So, good afternoon, everybody. As Jessica said, my name is Alyssa Cohen, I am the Deputy Medicaid Director here in New Hampshire.

So, New Hampshire, we were looking for a way to engage with and motivate our beneficiaries to complete their redeterminations during the PHE, before the end. And this is something that we had been thinking about and working on really since July of 2020, where we convened, started convening weekly standard interdepartmental meetings, to strategize how to best manage the unwind.

And then in June of last year, of 2021, we came up with the idea of sending out notices about the importance of completing redeterminations now on bright-pink paper, as a way to grab people's attention that this is something different than sort of the usual department notices, and also as a call to action, that they need to pay attention to this.

We realized as we started sending out these letters also that it was also a really good and easy tool for providers and other stakeholders that interact with our beneficiaries to remind them and assist them about the redeterminations simply by asking during any interaction "Did you get a pink letter from the department? Do you know what to do to protect your health insurance coverage, protect your family's health insurance coverage during - to prevent the gap or potential gap at the end of the PHE?"

You know, and simply by asking "Did you get a pink letter?" it was an easy way to get that message across.

So we have two versions of our pink letter. One goes out to individuals who need to complete their redeterminations. They haven't done anything, and it's just a reminder, "Complete your redetermination."

And then the one here on the slide deck goes to those who may have started their rede or we have information that indicates they may be ineligible, and so we need additional information to complete their eligibility determination. And this second one, the one that's in the slide deck, we also sent out a checklist that goes with this letter, saying exactly what we are missing, what we need the individuals to send back with.

These letters are posted on our Web site, where they're also translated into Spanish, as well as we include language tagline sheets with our mailings, so that, I believe it's the top 20 languages in New Hampshire. So it basically says, if you need assistance understanding this letter in your language, please call, and it gives the language bank number.

And then actually, just last week, we were able to post - we had the overdue rede letter translated into ASL, and that is posted on our Web site as well, and shared with the stakeholder organizations that work with the deaf and hard-of-hearing in New Hampshire.

The other part of our pink letter campaign, which we find has been really helpful and useful, is we send out monthly lists to our MCOs of their members getting a pink letter, so that they can do outreach, proactive outreach, as well as to those providers who ask us for the - a list of their patients or members or

clients that are at risk of closure at the end of the PHE. So we send that to them monthly, obviously, securely, and HIPAA compliant, and so that they're able to also do proactive outreach.

So we, as I mentioned, we had started this campaign back in June of 2021, and we've seen about an 18% increase in completed redeterminations since then. And we will absolutely continue to do this throughout the PHE and during the unwind.

And with that, I will turn it back to you, Jessica. Thank you.

Jessica Stephens: Thank you so much, Alyssa. And maybe with that, next slide please, maybe I'll just close out with thank yous to all of our state presenters.

And just note that, as part of the unwinding, we are continuing to gather and share some of these best and promising practices, and we'll continue to issue guidance on some of the things that we've identified. But please reach out to us if you have any questions about these strategies that you attempt to implement.

So, Jackie, I'm going to pass back to you.

Jackie Glaze: Thank you, Jessica. And I'd also like to thank our state partners for sharing their strategies with us today. So, really appreciate the information today.

So with that, we'll now transition to Sarah Lichtman Spector and Marc Steinberg. And they are going to share a new tool that their team developed to assist states with processing the fair hearing.

So, Sarah and Marc, I'll turn to you.

Sarah Lichtman Spector: Great. Thanks, Jackie. Hi, everybody. Let's go to the next slide please.

So as Anne Marie noted, we've certainly heard from states raise in a number of different forums concerns about the increased volume of fair hearing, as states think through their timing of the resumption of renewals and other eligibility actions throughout the unwinding period.

Next slide please. This deck provides steps states can take to assess their fair hearing process and capacity in preparation for the increased volume of requests, and outline strategies states can use to address the anticipated fair hearing volume. We've developed these strategies in consultation with valuable feedback from NAMD, a workgroup of states, and incorporates important state input.

Next slide please. This deck can be used as a resource to take a number of steps in thinking through this issue. First, assessing the state's current capacity and estimating the increase of volume. Second, looking to the strategies and options within those strategies, so states may consider to increase - to address that increase in fair hearing volumes.

And third, a mitigation that states may want to employ using Section 1902 e-14 authority if the state believes that it will not be able to address its fair hearing volume within the regular 90-day timeframe.

Next slide please. First, assessing a state's capacity. We suggest using the planning tool that CMS released on March 3rd. A link to that planning tool is on the resources slide here, as well as posted on [medicaid.gov](https://www.medicaid.gov).

And then to create a process map to assess and look for ways to streamline your process and operations. Looking at each stage of your fair hearing process, where the bottlenecks might be, and tailoring modifications or process improvements that could yield some efficiencies.

Next slide please. Step two is reviewing the strategies we've laid out here. Understanding, as Jessica pointed out, that workforce issues really are very significant across states, the first strategy we suggest is looking at potential strategic redeployments of state resources. States could redistribute their current staff, detailing staff from around the agency, for example, to the eligibility or to the hearing agency.

States could use hearing officers if they're currently using administrative law judges, who could be easier to hire and less costly, providing flexibility in the state's hiring process. And potentially leveraging contractors to the extent feasible. I'm going to talk more about that in a moment.

Next slide please. This slide lists out some key parameters on the use of private contractors in the context of your fair hearing process. Generally, states can use contractors to support the administrative functions of the fair hearing process, that do not require discretion. But must continue to use employees as the government agency, which maintain personnel standards on a merit basis for fair hearing functions that do require discretion.

So the chart on this slide sets out some examples. For example, contractors could support intake of fair hearing requests, follow-up on missing information, or help with scheduling. Whereas government agency staff must actually conduct the fair hearing, evaluate evidence, or perform other functions requiring discretion.



Now I'm going to turn to my colleague Marc Steinberg who's going to walk through the remaining strategies.

Marc Steinberg: Thanks, Sarah. Next slide please. Great.

So, in addition to think about how your states test the process, you may want to consider implementing or expanding the use of other processes such as informal resolution processes. By that we mean a process that engages with the appellants before their fair hearing is held, in an effort to address and resolve the appeal before the fair hearing takes place.

This approach can reduce the number of requests that proceed to a formal fair hearing, which then frees up resources to allow the timely processing of the remaining fair hearing requests.

There are a number of ways to operate such a process, and we're not being prescriptive, but they can range from a troubleshooting process that helps collect missing information from individuals who receive procedural denial, to a more structured mediation or pre-hearing conference, which brings the parties together for discussion.

Regardless of the structure, the goal here is to get to an informal resolution process that brings a satisfactory resolution to the appellant's concern before having to hold a fair hearing.

Next slide please. There are a number of other operational and process changes that states may want to consider. I'm not going to go into all of them here. But certainly you can think about prioritizing fair hearings for certain request types or certain populations, to ensure the most vulnerable and time-sensitive requests are addressed more quickly.

We have several other operational suggestions here for states to consider, such as using panels or scheduling by type of case of together. And then we also encourage you to think about what modalities you're using, are there other modalities you could use to increase efficiency?

Next slide please. Continuing on efficiency opportunities, we encourage states to think about expanding the use of electronic processes to help alleviate the time and the staff burden associated with processing paper documents.

We also encourage states to think about using templates to assist hearing officers in holding and adjudicating cases efficiently. For example, states can develop decision templates that lay out standard language for matters like jurisdiction and the framing of common issues, and that can save hearing officers and (AOJs) time as they work through their cases.

Next slide please. Another area that we encourage states to think about is just how they can step up their stakeholder engagements. We know that state Medicaid agencies work with a variety of internal and external stakeholders, including your sister state agencies, local agencies, and then community groups like legal services, social services, healthcare providers.

All of these entities and organizations can help you as you navigate - as you navigate the challenges ahead. For example, they can disseminate information to the community. They can help amplify your message, and we heard a little bit about that already. They can also help spot emerging issues before they become big problems.

So we really heard from states, and we encourage all of you to be in regular communication with your internal and external stakeholders as a way to

support your processes, both your eligibility determination and your fair hearing processes.

Next slide please. So we understand that, and we've flagged this already, we know that even if you're - the state adopts several of the strategies here or in others, there's a chance it will experience a backlog of fair hearing requests during the unwinding period. If this happens, states may wish to consider requesting Section 1902 e-14 authority to allow them to temporarily extend the timeframe for taking a final administrative action on a fair hearing request.

States that are interested in this authority must agree to provide benefits pending the outcome of the fair hearing and they may not recoup the costs and benefits provided to the appellant, even in cases where the state's determination is ultimately upheld at the fair hearing.

Please see our March 3rd State Health Official Letter for more information on this and other e-14 strategies. If you have additional questions or technical assistance about e-14 waivers, contact your state Medicaid lead and copy the (CMS TA) unwinding mailbox that has been flagged already, [cmsunwindingsupport@cms.hhs.gov](mailto:cmsunwindingsupport@cms.hhs.gov).

Next slide please. And finally, there's a list of resources that we encourage you all to take a look at, in particular on Slide 2, the first bullet point, [medicaid.gov](https://www.medicaid.gov), our unwinding page, as you know, many resources. This deck on fair hearings was just added to that page, so you can get it as a standalone product there.

Also the third bullet refers to the planning tool, or it links to the planning tool that Sarah referred to earlier in this presentation. And then we have statutory regulatory references and other State Health Official materials.

Thank you all. Thanks especially to our workgroup partners who helped develop this material. We look forward to engaging with all of you on this and so many other issues. Thank you.

Jackie Glaze: Thank you, Marc and Sarah. Next up is Jen Bowdoin, and she's going to provide an update on the Section 9817 reporting requirements. So, Jen, I will turn to you.

Jen Bowdoin: Thanks, Jackie. And hi, everyone. It's nice to talk with you today.

So, as a reminder, Section 9817 of the American Rescue Plan Act of 2021 provides qualifying states with a temporary 10 percentage point increase to the federal medical assistance percentage, or FMAP, for certain Medicaid expenditures for home and community-based services, or HCBS.

Among the requirements participating states are expected to comply with to receive the FMAP increase is a requirement to submit quarter HCBS spending plans and narratives to CMS on the activities that the state is implementing to enhance, expand or strengthen HCBS.

Today we are announcing that for the quarter beginning July 1, 2022, states are only required to submit an HCBS spending plan. They do not need to submit an HCBS spending narrative.

In other words, states should provide by the April 18th deadline the July 1 quarterly submissions, an updated quantitative information on the amount of funds attributable to the increased FMAP that the state has claimed or anticipates claiming, as well as anticipated or actual expenditures for the state activities to enhance, expand or strengthen HCBS.

States are not required to include in their April 18th submissions an updated HCBS spending narrative describing the state's activities, although states have the option to submit an updated narrative if, for instance, they would like to request approval for new activities or for changes to the scope or description of their approved activities.

Regardless of whether a state plans to submit an updated spending narrative for the quarter beginning July 1, 2022, states should plan to submit both the HCBS spending plan and the HCBS spending narrative no later than July 18, 2022 for the quarter beginning October 1, 2022.

If you have any questions about this change, please contact the ARP Section 9817 mailbox at [hcbsincreasedfmap@cms.hhs.gov](mailto:hcbsincreasedfmap@cms.hhs.gov).

And with that, I'm going to hand the call back over to Jackie.

Jackie Glaze: Thank you, Jen. So we'll pause now and we'll take a few questions.

And so, Ashley, can I turn to you?

Ashley Setala: Sure. So we have a couple of questions that have come in for LaTonya from Kansas about Kansas says social media campaigns to encourage beneficiaries to update their contact information. And the first one, can I ask how you secured funding for such a successful social media campaign? Was this from the state budget?

LaTonya Palmer: Hi, yes, this is LaTonya. And the strategies that we've implemented so far did not incur an additional cost to the state. The messaging that we placed on social media was just utilizing an existing communication tool that we had

access to. We didn't purchase ads or take on any additional strategies that would have a fiscal impact to the state. I hope that answers the question.

Ashley Setala: Great. Thank you. And the next question, also for you, says, did you post only on your organizational page or did you have other groups, community partners, advocacy groups, etcetera, post the messages on their respective pages, or retweet or reshare the messages?

LaTonya Palmer: Great question. The posting was just on our agency social media page. But we did put the information - share the information with our community partners and other stakeholders, letting them know that we have placed messaging on our social media Web sites, and encouraged them to share the information with their network as well.

So we placed it just with our agency Web site, but also communicated with other stakeholders that the information is out there and available, and encouraged their partnership in helping to share and spread the message.

Ashley Setala: Great. Thank you. And then one more for you. How did you partner with pharmacies? And can you expand upon that partnership more?

LaTonya Palmer: Our partnership so far has primarily been with our managed care organizations or health plans. We've worked with them to develop messaging for sharing with the providers. We haven't yet targeted specifically pharmacies. We've primarily been working with the health plans. And they in turn would work with the provider network.

Ashley Setala: Okay. Thanks. Then we've gotten a couple of questions for Jen Bowdoin, asking, can you clarify the 9817 reporting changes and the dates which states are and are not required to submit the narrative with the HCBS spending plan?

Jen Bowdoin: Yes. So I'll clarify. And so the next HCBS spending plan and narrative is due April 18th. That's what we - if you look at the schedule, you know, as specified in the SMDL, that would be when the next one is due.

Essentially what we're saying is that we would like states to provide us with the quantitative information in their spending plan. So, provide us with the information how much the state is claiming for the increased FMAP and the cost of the state's activities, in the spending plan. But states don't need to provide updated descriptive information on their activities, unless the state would like to.

So, for instance, some states would like to amend their spending plan so that they can receive CMS approval for a new activity, we would certainly allow a state to do that, but states are not required for the April 18th submission to provide an updated narrative.

For the July 18th submission, which is the one after - so, not the next one, but the one following that, we would like states to provide us with the quantitative information and the narrative information. So, a full spending plan and narrative submission in July.

Ashley Setala: Okay. Thanks, Jen. Then we have a question that says, can states automatically use information from the national change of address database as a primary address source and update address information based on information from the database without confirmation from the beneficiary?

Sarah DeLone: Hi, this is Sarah DeLone. Could we have anybody from (DPRO) on? Suzette Seng or Sara O'Connor, are you on?

It sounds like not.

Suzette Seng: (Sara), I'm on. Can we repeat the question, please, I'm so sorry?

Ashley Setala: Sure, (Suzette). It says, can states automatically use information from the national change of address database as a primary address source and update address information based on information from the database without confirmation from the beneficiary?

Suzette Seng: The answer to that, that is no. The NCOA data is - states that receive information from the NCOA database should still reach out to the individual to verify that information. And I believe if they don't return that information - or, I'm sorry, if the person does not respond, then they may update the system with the information.

Jackie Glaze: Thank you, (Suzette). So, thank you for your questions. So we're very pleased to welcome our CMS Administrator, Chiquita Brooks-LaSure, and she would like to share some remarks with everyone today. So, Administrator Brooks-LaSure, can I turn to you at this time?

She may just be logging on, so just give us just another minute.

Anne Marie Costello: Ashley, maybe we should take one more question, and then check again?

Ashley Setala: Okay. We have a question that says, a follow-up to the last question. It says, the latest SHO Letter advises that we can take in-state change of addresses from recipients via (MCOs). Why is in-state specifically called out and why is out-of-state not allowed?



Suzette Seng: Sure. Because an in-state address does not indicate a potential change of circumstance, whereas an out-of-state address does signal there might be a change in circumstance based on residency, and so the state must take all the appropriate actions based on our change in circumstance regulations.

Sarah Delone: Specifically, (Suzette), a change in circumstance that would result in termination of coverage, right?

Suzette Seng: Correct. Yes.

Sarah Delone: A change in eligibility status.

Suzette Seng: Correct.

Sarah Delone: I just wanted to follow up on the previous question that was asked about the national change of address database, that it's something that we could - might look into, whether or not the similar e-14 strategy that's offered for accepting, you know, address changes from the managed care organization, if you're not able to check with the beneficiary first, there's that e-14 strategy that's discussed in the SHO.

And I think we can take it back to consider whether that similar e-14 strategy might be available in the case of uses to this database. I think we just have to look into it a little bit more carefully.

Anne Marie Costello: Jackie, can we check again?

Jackie Glaze: Yes, let's check again. Administrator Brooks-LaSure, have you been able to join?

Okay. So we'll keep checking. So I'll turn back to you, Ashley.

Ashley Setala: Okay. So we have a question that says, on the March 22nd call, there was a question about SSI reviews in 1634 states. And we believe the response was that SSI is included in the state case load of all beneficiaries subject to review. Please verify if our understanding of this is correct, that renewals, which would primarily be ex parte, must be completed by the 1634 states on SSI population. And also that states must complete renewals on other like populations whose Medicaid eligibility is based on receipt of another type of benefit or on a particular status?

Suzette Seng: Hi. This is (Suzette) again. So, yes, the answer to that is yes, they must all be - go through the renewal process. However, the renewal process for the 1634 group and other (unintelligible)?

Jackie Glaze: Can I stop you, (Suzette), and we will pick up with the question?

(Suzette Cheng): Yes. Thank you. Yes.

Jackie Glaze: Great. Thank you. So, at this time, we would like to welcome our CMS Administrator, Chiquita Brooks-LaSure, to share some opening remarks with us today. And so, Administrator Brooks-LaSure, I'll turn to you at this point.

Chiquita Brooks-LaSure: Thank you so much. It's really a pleasure to be with you all virtually. I just left the exciting celebration about the ACA with the current President and the former President, just celebrating just the incredible gains that have been made in terms of coverage for millions of people across the country, and you are all so key in making sure that coverage in Medicaid is possible. And as we all know, it's really changed millions of people's lives across this nation.

I just wanted to take a moment to really celebrate and highlight the efforts of the Administration and the Congress on maternal health. And as you all know, 40% of the births in our country are covered through the Medicaid and CHIP program. And from the Vice President on down, maternal health and our crisis in this country is a priority.

One in three Black Americans are more likely to experience death, and it really cuts across income. I'd like to really make sure that people remember. If a person like Serena Williams can have an adverse maternal experience, we have a lot of work to do as a country.

And so, as you all know, one of the most crucial periods of time is a couple of months after women get birth. It's a crucial time for the child and it's a crucial time for the mother. And thanks to the American Rescue Plan, we're extending and able to extend to 12 months post-partum.

I just thank all of you who have been working on this critical issue in your states. And we're so excited that five states have already taken up this charge to cover Medicaid women post-partum for 12 months after the birth or the outcome of their childbirth. And we think it's just such an - a crucial part of making sure that we start addressing this critical crisis in our country.

So I want to thank all of you for all of the work that you're doing in terms of making sure that care is meaningful, and really ask those of you who are not in states who are thinking about expanding this coverage, to ask you to consider partnering with us in extending post-partum coverage.

Again, I just want to thank the states that have already taken the charge. Louisiana is the latest state that we are celebrating. And I know many of you

all in your states are working on this critical issue. And we look forward to getting your waivers and your state plan amendments and moving forward to continue to expand coverage.

So, thank you so much. It's really, as I said, a pleasure to join you. I know that you've been talking with the CMS team on just an incredible amount of work that needs to be done. I thank all of you for your leadership during this pandemic and just how all of you have been on the frontlines and making sure that millions of people have coverage, and know that the work is not yet done, but I thank you on behalf of the CMS team as well as the millions of people that are served by our programs.

Jackie Glaze: Thank you very much, Administrator Brooks-LaSure. We really appreciate the time today and spending some time with us. So, thank you very much.

I'll turn back to you, Ashley, and we'll continue with our questions. So, continue to add your questions to the chat and then we will also take some questions via the phone. So, Ashley, I'll turn it back to you.

Ashley Setala: Okay. And let's see. The next question says...

Jackie Glaze: Ashley, I wonder if you could go back to the question that (Suzette) was in the middle of answering.

Ashley Setala: Yes.

Jackie Glaze: Thank you. Go ahead, (Suzette).

Suzette Seng: Sure. So the question was whether states needed to conduct renewals for SSI recipients or SSI-based Medicaid in 1634 states or for other individuals whose

Medicaid eligibility is derived from eligibility in another program, so the (foster 4E kids) is I think the other example.

And the answer is yes, states must continue to or must conduct renewals for these eligibility groups. But I think the use of the word ex parte was correct. The state would need to do an ex parte renewal. And for 1634 states, that would mean ensuring that the individual continues to be eligible for in receipt of SSI. And the same would go for the (4E) kids. So it must do renewals, but it would be the regular way you renew and make these individuals eligible for those 1634 and (4E) kids.

Jackie Glaze: Thank you, (Suzette). So let's transition to the phone lines. And operator, could you please provide instructions, and then open the phone lines and see if we have some questions in the queue?

Coordinator: Yes. The phone lines are now open for questions. If you would like to ask a question over the phone, please press star 1, and record your name. If you'd like to withdraw your question, press star 2. Thank you.

There's a question in the queue from Nicole. Your line is now open.

Nicole: Hi. I have a question about one of the strategies about using the SNAP data for determining eligibility. In the - and I'm sorry, I wasn't - I'm not prepared, I'm trying to pull up the strategy so I can speak specifically about the one that I wanted to talk about.

It says that we can use the SNAP data, but it doesn't say specifically how we can use that SNAP data. So I know that we can align the renewal to the SNAP information, but if somebody is like, is open for SNAP, and can we just

say, because they're open for SNAP, we can push their renewal date out that 12 months? Like, just in general?

Suzette Seng: Yes. The state would use. So with the (E4) (unintelligible) allows for the state to use SNAP program eligibility and enrollment in order to make MAGI based renewal.

Sarah DeLone: So, Nicole, if the person has, let's say, SNAP determines the household income for purposes of SNAP, and it's at, you know, 100% of the federal poverty level, and your state has expanded to the adult group and, you know, you've got - it's an adult (unintelligible) you can use that 100%, bump it up against the income standard for the adult group, which is 133%, and renew the person using the SNAP data, that would be - the SNAP determination of income, that would be the (E4) change strategy.

Nicole: Okay. So it's not necessarily just saying somebody had a SNAP eligibility determination in, say, the past three months, they're still within the SNAP eligibility period, we can just say they're eligible and keep them open, or, you know, extend their renewal period out to match that SNAP one? Something like...

Sarah DeLone: (Suzette), I think there's probably ways that the state could organize it, and maybe this is best for a, you know, a call, individual TA calls. Do you think that makes sense?

Suzette Seng: Yes. That's right. That's right. And we can help the state figure out like renewal dates and how to - how you would go about implementing. We're happy to have that conversation.

Nicole: Okay. We'll reach out to our state lead for more assistance on that then.

Suzette Seng:      Fantastic.

Nicole:             Thank you.

Coordinator:        There is another question in the queue from Renee. Your line is open.

(Renee Moller):    Hi. Thanks so much. This is (Renee Moller) with California. So I just have a quick question on the fair hearing process and beneficiaries and aid paid pending. I just wanted to get clarity in terms of a timing. I know in the guidance it does talk about states could ask for flexibility for increasing the time period, and which beneficiaries can request a fair hearing. But there's also language that pertains to aid paid pending prior to the adjudication of the hearing.

And I just wanted to get clarity about the timing for that aid paid pending and when that would be invoked.

In California we use the 10-day advance notice, so, within that 10-day time period, they can raise their hand for a fair hearing, and then aid paid pending would continue. And they will not be discontinued from coverage until such time that the fair hearing was adjudicated.

But it's not as clear in the guidance in terms of if states can still do that or do we have to allow for additional time. I think that's the flexibility. But it's just not clear on when they request the hearing and when that aid should be continued or restored. So if you guys could provide some additional guidance around that, that would be greatly appreciated.

Sarah Lichtman Spector: Hi, (Renee). This is Sarah Lichtman Spector. I can jump in. Appreciate that question. Let me kind of take it in two parts.

The first thing that you referred to the e-14 authority that's described in the letter, is actually that allows states to take a longer period of time to take final administrative action. It's not actually related to extending an initial time period that an individual would request a fair hearing.

And that's why it's connected to if a state is going to take a longer period of time than the regular 90 days that a state - a condition of that flexibility might be providing benefits pending during that period.

With that said, with respect to your very specific question about reinstatement, it's a really good one. It's one we're considering carefully. And I will - we promise to get back to both California and states at large. And I want to put a bookmark in that specific part of your question. Thank you.

(Renee Moller): Oh, thanks, Sarah. And just one more real quick question. About the Medicare open enrollment and that not being a special enrollment period, is that enrollment, recognizing the continuation of coverage in Medicaid, is that enrollment just generally regarding their enrollment into Medicare, not necessarily Medicare managed care plan, but just Medicare writ large? If you could provide clarity on that, that would be great.

Marc Steinberg: This is Marc Steinberg. Yes, we can - but, yes, it is - when we're referring to this Medicare enrollment the initial enrollment into Medicare overall, not changing Medicare plans that has - had been raised as concern for people who have had coverage during the PHE and missed their initial enrollment period. It's that one time, first sign-up for Medicare, that is what we have been considering. The initial enrollment period (unintelligible).



(Renee Moller): Okay, thank you.

Jackie Glaze: Thanks, everyone. And we appreciate the questions today. And in closing, would like to thank our team and our state partners for their presentations today.

Our next call will be on Tuesday, April the 19th, from 3:00 to 4:00 p.m. Eastern Standard Time. And we will send the topics and invitations shortly. If you do have questions between the calls, please reach out to us, your state leads, or bring the questions to the next call.

We thank you very much for joining us today 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.

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