Centers for Medicare & Medicaid Services

COVID-19 Medicaid & CHIP All State Call

January 12, 2021

3:00 pm ET

Operator: Greetings, and welcome to the CMCS All-State Medicaid and CHIP Call webinar. During the presentation, all participants will be in the listen only mode. Afterwards, we will conduct a question and answer session. If you have a question, please press the one followed by the four on your telephone at any time during the presentation. You may also ask a written question in the chat box at the bottom left of your screen. If at any time during the webinar you need to reach an operator, please press star zero. As a reminder, this webinar is being recorded on Tuesday, January 12th, 2021. I would now like to turn the webinar over to Jackie Glaze. Please go ahead.

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

Anne Marie Costello: Thanks, Jackie, and welcome to today's call and thanks to everyone for joining us. We have another full agenda and we'll cover two major topics today. First, we'll hear from Kirsten Jensen in our Disabled and Elderly Health Programs Group about a state health official (SHO) letter released on December 30th. The state health official letter provides guidance to states on the new mandatory Medicaid State Plan Benefits to medication-assisted treatment. After Kirsten's presentation, we'll take your questions on the SHO letter. Then we'll hear from CMCS staff about the highlights of our most recent set of Medicaid and CHIP frequently asked questions (FAQs) released last week. Ashley Setala from our Center Director's Office will give you an overview of some updates that we made to the FAQ document. Sarah Lichtman Spector from our Children & Adults Health Programs Group will cover the highlights of our Eligibility and Enrollment FAQs. John Giles from our Disabled & Elderly Health Programs Group will discuss the Managed Care FAQs. And Rory Howe from our Financial Management Group will summarize a few key financial questions. After the FAQ presentation, we'll open the lines for your general questions.

Anne Marie Costello: Before we jump into today's presentation, I want to give a few updates. First, I want to make sure that you are aware that last Thursday, Secretary Azar officially renewed the COVID-19 Public Health Emergency (PHE). The renewal will take effect on January 21st, and will extend the PHE for another 90 days through April 30th. Second, I want to briefly discuss some of the work CMCS has been doing regarding vaccine administration reimbursement. As you may recall, under the FFCRA, the COVID-19 vaccine is a covered service if a state is receiving the 6.2 percentage point FMAP increase. The only exception for this coverage is for beneficiaries receiving their Medicaid coverage through limited benefit packages. This could include individuals only eligible for family planning benefits,

individuals eligible for tuberculosis-related benefits, individuals eligible for the optional COVID-19 testing group, and Section 1115(a)(2) expenditure authorities limited benefit groups. States that want to expand coverage to include vaccine administration for beneficiaries receiving limited benefits may submit an emergency 1115 Demonstration application to your 1115 project officer.

Anne Marie Costello: Our team stands ready to evaluate these applications and will review them expeditiously. Finally, yesterday CMS announced the launch of a new innovative web platform to help standardize 1135 waiver requests and other Public Health Emergency related inquiries the agency receives. CMS designed the 1135 web-based tool, primarily to reduce the burden on Medicare providers by streamlining how they document and submit 1135 waiver requests and PHE related inquiries. The tool is located on the CMS.gov Coronavirus Waivers and Flexibilities webpage. State Medicaid and CHIP agencies can continue to use the current process to submit Medicaid 1135 waiver requests by emailing their MCOG state lead, Jackie Glaze, and Courtney Miller. CMCS remains committed to a "no wrong door approach" to state Medicaid and CHIP agencies, and regardless of the point of entry, we will ensure that your 1135 waiver requests are processed timely.

Anne Marie Costello: If you have any questions about the new 1135 waiver portal, please feel free to ask during the Q&A portion of our call today. Before we start our first presentation, I'd like to remind you to log into the webinar if you haven't done so already, because we're using slides for this portion of the call. With that, I'll turn things over to Kirsten Jensen to start our first presentation. Kirsten.

Kirsten Jensen: Thank you, Ann Marie. This is Kirsten Jensen and I will be talking today about Section 1006(b) of the Support Act, which established a new mandatory state plan benefit for medication-assisted treatment (MAT). It established a new 1905(a)(29) benefit. And what was previously at 1905(a)(29) has moved to 1905(a)(30). This provision became effective on October 1st, 2020, and will be in effect through September 30th, 2025. Next slide, please. The mandatory MAT benefit includes both drugs for the treatment of MAT, as well as counseling services and behavioral therapy. We've listed here a few services that may be defined as behavioral therapies, such as individual and group therapy, peer support services, and crisis support services. Next slide, please. I should say here, this is one of the few benefits where we have both the services and the drugs covered in one benefit, so that may be a change for some state programs as we look at how we bring this new mandatory benefit online and talk about some of the state plan requirements later. But in terms of the drugs, the new benefit covers all FDA approved or licensed drugs and biologicals to treat opioid use disorder (OUD). This would include all forms of drugs and combinations of drugs. Currently the three MAT drugs that are FDA approved and recognized by SAMHSA include methadone, buprenorphine, and naltrexone, and combinations of these drugs. Methadone is only approved for OUD purposes if provided by an Opioid Treatment Program, and it is not available for OUD treatment from a pharmacy. States are not required to cover opioid withdrawal medications under

this new MAT benefit, but we do remind states that those drugs would be covered by Medicaid if they are covered outpatient drugs. Next slide, please.

Kirsten Jensen: States can bill for Section 1927 Medicaid rebates for these drugs, as long as there is a manufacturer rebate agreement in effect, and the drug is not excluded from rebates because it is paid for as part of a bundle, such as methadone. Should an FDA-approved MAT drug or biological for OUD not meet the definition of a covered outpatient drug, the state would still be required to cover the drug or biological under this benefit, but that drug or biological would be eligible for federal reimbursement, but not for the rebates. States could subject MAT drugs or biologicals to prior approval or other utilization management mechanisms, such as a generic first policy, preferred drug lists, clinical criteria, and quantity limits. Next slide, please.

Kirsten Jensen: States will need to submit a new state plan amendment (SPA) to cover the new mandatory benefit of Section 1905(a)(29) of the Act. We have created a template for the coverage side of the state plan amendments. The template is written in a structured data format. It is available on Medicaid.gov. We did not issue a new 419(b) page for this benefit, although a new 419(b) page will need to be submitted as well for this coverage. We are asking that states that already have either all or part of this coverage in their state plan move that coverage to this new mandatory benefit. The reason for that is, because this is a mandatory benefit coverage of these services must be covered under the mandatory benefit first before any optional benefits come into play. So we are happy to work with you on the details of how to do that, but that is something that is part of our coverage requirements. And that's true for all mandatory benefits in this state plan.

Kirsten Jensen: And as is described in the next slide, states with an approved Section 1135 will need to submit a SPA by March 31st. And we can go to the next slide to talk about 1135 process.

Kirsten Jensen: Given that the quarter in which the provision became effective has passed, we are giving states an opportunity to request Section 1135 authority to reach back and protect that October 1st effective date. So, states should request the 1135 and that will help preserve that effective date. CMS is also giving states the opportunity to request this authority to modify regulatory deadlines and public notice requirements for these SPAs. Please submit those requests to Jackie Glaze, and you'll see the email here, Jackie.glaze@cms.hhs.gov. And we recognize that January 14th is just a couple of days away here. This deadline was originally tied to the Public Health Emergency ending on January 21st. Given that it's extended, we're asking that you contact your state leads, and we'll work with you to get you some more time regarding this particular request. Next slide, please.

Kirsten Jensen: There is an exception for provider shortage from this provision, and this process is described in the letter. States may be excused from the mandatory coverage requirements if the state certifies to the satisfaction of the Secretary that implementing this provision statewide for all individuals eligible to enroll would

not be feasible by reason of a shortage of qualified providers. We go through the criteria in the letter and the managed care requirements as well. The intention of 1006(b) Act is to increase access to MAT services, however, so CMS does expect states to conduct provider outreach and enrollment to these providers as they prepare to meet the new requirements. And we particularly think that methadone for treatment of OUD can only be provided in the Opioid Treatment Programs (OTPs), but this may be an area where some states may need to do some particular outreach to try to enroll these OTPs as Medicaid providers.

Kirsten Jensen: We have received some questions on this, and you'll see in the letter that this is really about, based on free choice of provider requirements and the requirement under free choice of provider, that any willing and qualified provider would need to be enrolled in the plan. So you can look at the letter for more detail about that. Next slide, please.

Kirsten Jensen: Oh, I got ahead of myself. So if the state has MAT providers in the state not currently enrolled, again, we're looking at any willing and qualified provider requirements to control here. And if the provider is interested in becoming a Medicaid provider, then they should be able to do so. We also have a January 14th date listed in the letter here. And again, please feel free to contact your state lead if you need a little bit more time, we can work with you on that. Next slide, please.

Kirsten Jensen: States that require legislation to comply with this new mandatory benefit should submit requests for a legislative delay extension. And this request is submitted to your original SPA waiver mailbox, as is the last one around the provider shortage, or the one CMS portal if you're a state that's participating in that particular project.

Kirsten Jensen: The first regular legislative session is defined as those sessions that begin on or after October 24th, 2018 and end on or after October 1st, 2020. The request should include documentation to support that the legislative delay is the only reason the state cannot come into compliance as of October 1, 2020. Next slide, please.

Kirsten Jensen: Here are some resources. And the SHO letter is available on Medicaid.gov, as is the coverage SPA template. So with that, I will turn it back over to Jackie Glaze for questions.

Jackie Glaze: Thank you, Kirsten. And we appreciate your presentation on the requirements within the MAT SHO letter. So we're ready to take questions now, and we will begin by reviewing the questions in the chat box--we've already received a few--and then we'll follow by taking questions over the phone. So go ahead and start submitting your questions at this point.

Ashley Setala: Okay. So the first question that came through the chat for Kirsten on the SHO is, "Are states expected to add all of these services?" And I think this is in reference to slide three, that was to the mandatory MAT services.

Kirsten Jensen: States are expected to cover counseling and behavioral therapy services, but you do have some flexibility in deciding which services those will be. So we list some as possibilities, but the state does have flexibility in that regard, in terms of the drug coverage that is required. And that is more defined in the State Health Official letter.

Barbara Richards: Great, thanks Kirsten. We have another question for you in the chat, Kirsten. "Will states that currently only cover residential SUD treatment under the managed care waiver as a 1915(b)(3) service be required to cover those services for the fee-for-service population and include those residential SUD treatment services under the state plan?" And I'm happy to repeat that if it helps.

Kirsten Jensen: I'm reading it now, too, as you were speaking it, so that was helpful to me.

Barbara Richards: Okay.

Kirsten Jensen: In terms of this benefit, this is a mandatory 1905(a) State Plan Amendment, state plan benefit. So it does need to be covered in the state plan. Some of the other mandatory benefits we have are benefits like our hospital benefits, physician benefit, and labs, for instance. Those are all mandatory benefits. So this, too, is a mandatory benefit that needs to be added to your state plan and available to the fee for service population, as well as to those in managed care. In terms of the residential treatment, adding this particular benefit does not... We can maybe talk with you offline, contact your state lead, and we can have a conversation about the relationship with managed care. But this does not mean that you have to move all of your residential SUD treatment into your state plan. It does mean you need to add mandatory medication-assisted treatment to your state plan.

Kirsten Jensen: But again, if there may be more detail to that question, that we can certainly talk with you and have a conversation if you contact your state lead.

Ashley Setala: Okay. So the next question is, "What are CMS's expectations for continued coverage post the expiration of section 1060 in 2025? And would states need to submit a new SPA to continue services?"

Kirsten Jensen: That's a good question, and we're discussing that right now. The legislation right now does end at the 2025 date. We certainly don't know what Congress may do with this provision as that end date gets closer. So we will explore an answer to that question now, knowing that Congress may take a look at this again at that time. I guess in a short answer, we don't have a process for that yet, but we are working on it, and we'll get that out to you.

Kirsten Jensen: Next question?

Barbara Richards: "Are states required to cover the prescription digital therapeutics used to treat OUD? Is this under drug coverage or behavioral therapy?"

Kirsten Jensen: That's an area where we're still doing some work. It is not considered a drug. The state, as I've said before, has flexibility in terms of covering services. Medicaid is still looking into the question of digital therapeutics and coverage of that, but this benefit does not mandate that particular coverage at this point.

Ashley Setala: Okay. The next question then is, "Is the deadline to request flexibilities in SPA submission and public notice requirements still January 14th, or has this deadline been extended?"

Kirsten Jensen: We advise you to contact your state lead to talk with us about getting additional time.

Ashley Setala: Great, thanks.

Kirsten Jensen: That particular deadline was set based on the Public Health Emergency expiring on January 21st. And since that was just extended as of Friday, we can work with you for some additional time there.

Jackie Glaze: We also received a request through the chat box to clarify the date that the Public Health Emergency will now expire, and that date is April the 21st of 2021. So we do have additional questions-

Anne Marie Costello: Jackie, may I say, I think it's April 20th.

Jackie Glaze: That's right. April 20th. That's right. That's right. Sorry about that. Yes. Thank you, Anne Marie.

Anne Marie Costello: That's okay.

Jackie Glaze: So let's go back and take some questions through the phone line, and then we will have more time at the end of the session as well.

Operator: Thank you. If you would like to register a question, please press the one four on your telephone. You will hear a three-tone prompt to acknowledge your request. Your line will then be accessed from the conference to obtain information. If your question has been answered and you would like to withdraw your registration, please press the one followed by the three. Once again, to register a question, please press the one four on your telephone. One moment, please, for the first question.

Operator: Once again, to register a question, please press the one four on your telephone keypad. We do have a question, we're just retrieving the name. Thank you. [Pause] We have a question from Eve Lickers. Please proceed.

Eve Lickers: Good afternoon. We had a question as to whether or not public notice is needed if we are currently providing the services under another category of service and we

are not making any methodology changes when we move it to the mandatory category.

Jeremy Silanskis: Hey, Kirsten, this is Jeremy. Want me to take that one?

Kirsten Jensen: Yes, please. Thank you.

Jeremy Silanskis: Sure. So that public notice requirement is required if you make changes in the methods and standards of your state plan, and in that instance, you would not be doing that. It would be more of a mechanical change, where you'd be moving those methods and standards from one section of the plan to another. So I don't think you would need to do public notice in that way, because providers would not be affected, not paid differently for these services.

Eve Lickers: Okay. Well, thank you very much.

Operator: There are no further questions at this time.

Jackie Glaze: Thank you. So we will move on to the next agenda item, and then again, we do have more time at the end of today's session to take more questions. So now we have a group of presenters that will present on the batch six of the FAQs that was recently released, and Ashley Setala will begin. So Ashley.

Ashley Setala: Thanks, Jackie. And hi, everyone. So we wanted to let you all know about a few other changes that we made to that FAQ document last week, in addition to releasing batch six. So as we have in the past when we've released FAQs, when we released batch six, we posted a document that included just the new batch six questions, as well as an updated general FAQ document that integrates the new questions in with those that were released in our first five sets of FAQs. This time around, we also integrated the two sets of legislative FAQs that CMS released in the spring.

Ashley Setala: So the general FAQ document that's available on Medicaid.gov is now a comprehensive document that includes all of the Medicaid and CHIP FAQs that CMS issued to support states during that PHE. And as I know that you are all well aware, on November 2nd, a new regulation became effective that reinterprets the continuous enrollment condition that's included in section 6008(b)(3) of the FFCRA. We issued a number of FAQs throughout the spring and summer that relied on the original interpretation of the continuous enrollment condition, and while most of those FAQs are still in effect following the November 2nd effective date of the new interpretation, some are fully or partially superseded by this new interpretation. To help you navigate these changes, we have culled all of the 6008(b)(3) questions into a single section of the consolidated FAQ documents. They are located in the second chapter of the document, which is titled Eligibility and Enrollment, in subsection I, which is called Continuing Coverage Under Section 6008 of the Families First

Coronavirus Response Act. And it says on page 43 of our new sort of map for general FAQ documents.

Ashley Setala: And in section I we've included the original full text of each FAQ, and at the end of each question, we've added a note explaining that the question is either applicable both before and after the effective date of the new regulation, which is November 2nd, applicable on or after November 2nd with certain caveats, or applicable before November 2nd only. And we also added a paragraph at the beginning of the section that explains these changes in more detail for your reference. So we hope that you will take a look at the updated FAQs, and certainly feel free to send us any questions that you have about the changes that were made. And now I'm going to turn things over to Rory Howe to cover some of the financing questions that were in batch six.

Rory Howe: Thanks, Ashley. And good afternoon, everyone. I'm providing a brief overview of some recently released FAQs on how states and providers should treat Provider Relief Fund revenue for purposes of Medicaid Disproportionate Share Hospital payment limits, upper payment limits, Medicaid cost reimbursement, and healthcare-related taxes. So the FAQs provide detailed guidance on each of these four areas, but I just want to provide a high-level overview of each now.

Rory Howe: So the first two areas are the most straightforward. Provider Relief Fund revenue does not directly affect Medicaid upper payment limit demonstrations or Medicaid cost reimbursement. On the third area, Medicaid DSH payment limits, which are also known as hospital-specific DSH limits, Provider Relief Fund general and targeted distribution payments should not be included in the determination of the hospital-specific DSH limit. However, when a provider receives a reimbursement from either the Families First Coronavirus Response Act Relief Fund for COVID-19 testing and testing-related services, or through the Uninsured Relief Fund for COVID-19 care or treatment furnished to uninsured individuals. And those payments are to hospitals for inpatient or outpatient hospital services, specifically. Those amounts should be included in calculating the uninsured component of the hospital specific patient limit.

Rory Howe: Finally, the last question relates to whether Provider Relief Fund revenue must be counted in determining whether healthcare related tax meets the regulatory 6% revenue limit for healthcare related taxes. For this purpose, whether the revenue must be included in this test is tied to whether the particular state has imposed its healthcare related tax on that revenue or not.

Rory Howe: I know this is detailed information. I would encourage you to please take a look. If you're interested and the guidance is relevant to you, we're happy to provide technical assistance. And we'll note that the FAQs really relates to the Provider Relief Fund for Medicaid purposes, and they do link to broader guidance. That speaks directly to the availability of Provider Relief Fund payments. That's all I had to cover and thanks everyone. I'll turn it over to John Giles.

John Giles: Thanks, Rory. Good afternoon, everyone. So in the recently published frequently asked questions we have included Medicaid managed care guidance on rate development, non-risk payment arrangements, as well as state directed payments specifically related to the COVID-19 Public Health Emergency. Specifically the new guidance for managed care provides information and direction for states, as well as their actuaries regarding strategies to account for the effects of COVID-19 on managed care rate development, including options that states may choose to utilize, including risk sharing mechanisms, as well as covering COVID-19 costs in a non-risk payment arrangement outside of the managed care capitation rates.

John Giles: This guidance also includes information on the factors that states and their actuaries should consider when designing and implementing risk mitigation strategies to address COVID-19, including that the risk mitigations should be two-sided across all benefit costs. We make recommendations that risk mitigation strategies should be adequately narrow and symmetrical. And CMS recommends that states work in partnership with their managed care plans to determine the risk sharing strategy that best provides protection to both states and their plans during the Public Health Emergency. We also address the factors that states should consider when using a non-risk payment arrangement to address COVID-19 costs outside of the managed care capitation rates.

John Giles: We would note that CMS also recently published the 2020 Medicaid Managed Care Final Rule, and this final rule did include new requirements for state risk sharing mechanisms. In accordance with our finalized rule, all applicable risk sharing mechanisms must be documented in the contract and rate certification documents for the rating period prior to the start of the rating period and risk sharing mechanisms may not be added or modified after the start of the rating period. This final rule was effective on December 14th, 2020, and is noted in the FAQ.

John Giles: Finally, our guidance also provides information on what states and their actuaries should consider when setting Medicaid managed care capitation rates during waiting periods that overlapped with the Public Health Emergency and what CMS would expect to be documented in the state's rate certification. CMS recommends that states and their actuaries evaluate all state specific and other applicable national or regional data that is available to them, including COVID-19 cases, Medicaid eligibility and enrollment changes, utilization implications, and deferred caseload.

John Giles: Even as the data for the initial periods of the public health emergencies begin to emerge, CMS continues to recognize the significant level of uncertainty that exists around the impact of the COVID-19 pandemic, including direct and indirect costs and savings. Our guidance does specify that as states develop rates for the next contract waiting period, states should be making some assessments and evaluation in the managed care capitation rates to account for the COVID-19 Public Health Emergency.

John Giles: I believe with that, I will turn it to Sarah Lichtman Spector.

Sarah Lichtman Spector: Great, thanks so much and hi, everyone. I want to start by highlighting some answers about premiums in the recently released set of FAQs, especially as many states have suspended premiums during the PHE. While states may move individuals who no longer qualify in their current eligibility groups that do not charge premiums to a new eligibility group that charges a premium during the PHE, states may not charge this new premium to the individual until the end of the calendar quarter in which the PHE ends.

Sarah Lichtman Spector: However, states that adopt new optional eligibility groups during the PHE may charge premiums during the PHE to individuals enrolled in a new eligibility group, as long as they comply with two criteria. One, these individuals were not previously eligible under a different eligibility group that did not charge premiums. And the individuals who failed to pay premiums are not disenrolled until the end of the month in which the PHE ends.

Sarah Lichtman Spector: We also want to clarify an answer that we provided previously on an All State Call regarding resuming charging premiums after a state suspended premiums during the PHE. We previously stated that states cannot resume charging premiums until the end of the calendar quarter in which the PHE ends. As discussed in the recently released FAQs, we want to clarify that states cannot resume charging of premiums until the end of the calendar quarter in which the PHE ends if the premiums charged are higher than what the state charged as of January 1 2020.

Sarah Lichtman Spector: However, if a state wants to charge premiums at or below the level charged as of January 1, 2020, the state may do so at any point during the PHE. Because these premiums would not exceed those in place on January 1, 2020, resumption would not violate the condition described in section 6008 (b)(2) of the FFCRA. We also want to note that the state would not be able to terminate individuals for failure to pay this premium until the month after the PHE ends in order to comply with the section 6008 (b)(3) of the FFCRA. As such any premiums that a state wanted to resume prior to the month after the PHE ends would in effect be voluntary for the individual.

Sarah Lichtman Spector: I also want to note that the FAQs touch on a broad spectrum of Medicaid and CHIP eligibility and enrollment policies, which include questions on implementation of the requirement to apply for other benefits and to cooperate with the child support enforcement agency, treatment of certain sources of income established under the CARES Act such as the Federal Pandemic Unemployment Compensation on the MAGI and non-MAGI Medicaid financial methodologies, and a few questions about the optional testing for the uninsured group.

Sarah Lichtman Spector: We encourage you to take a close look at these new questions and answers, and as always, we are available to provide additional technical assistance. Thanks. I think that's it for me. So I am passing it back, I think to Jackie.

Jackie Glaze: Thank you, Sarah and thank you, team for your presentations. So we'll begin taking your questions and we will start with the chat box. So ask any questions that you may have about the presentations today, or any other general questions, and then we'll follow by calls through the phone. So go ahead and start submitting your questions.

Barbara Richards: One of the questions we have in the chat is either for Anne Marie or Judith or friends in the State Demonstrations Group. "Could you please restate what was said in the introduction about the COVID-19 vaccine and coverage of a vaccine for those on limited benefit plans?"

Judith Cash: Sure, Barb, this is Judith Cash and I'm happy to answer that. I think what Ann Marie indicated at the beginning of the call is consistent with what we indicated in the vaccine toolkit, which is an acknowledgement that there are some individuals who are covered in Medicaid but are covered in groups in which the benefit package is limited to a specific set of benefits, not the full Medicaid benefit package. And as a result may not be eligible to receive the vaccine as part of that package.

Judith Cash: But if that is the case, if you cover, for example, the optional COVID testing group, for example, a family planning only group, there may be others that you cover either in your state plan or through 1115 (a)(2) demonstration authority. If you would like to cover the vaccines for those individuals, you may request section 1115 (a)(2) authority to do that. And you just need to reach out to your project officer. If you're a state that already has an 1115 demonstration, you have a state project officer who can help you to submit that request, and you can use the 1115 COVID emergency template that we had put out back in March, and it's still available on Medicaid.gov.

Ashley Setala: Okay, great. Thanks, Judith. So we have a number of questions that have come in on the MAT SHO and the first one is, "will CMS be providing more guidance on the payment page requirements? And what would payment pages look like if services or drugs are already covered under multiple places in the state plan? Can the new payment page refer to other sections of the state plan?"

Jeremy Silanskis: Okay, so this is Jeremy. I don't think we were intending to do additional specific guidance on the payment pages. What I would suggest is that we work with you in collaboration on what that might look like, and I don't think it's going to be specific to how a state plan is currently structured and what you'd like to do, whether that's adding benefits or moving things around those state plans, so it could vary. But I think the bottom line is that, what you'd want to do is set out a new methodology for this mandatory benefit, and then describe those various components and not refer to different sections of the state plan. I think that would be very confusing. I think your best approach would be to bring those methods into the MAT payment methodology and describe them specific to the new mandatory benefit.

Barbara Richards: Great. Thanks, Jeremy. We also have other questions on the MAT SHO letter. "Since this section of the SUPPORT Act has an expiration date, can the state keep the existing language in their current state plan in the other benefit categories and indicate that it is not in effect during the time period of the SUPPORT Act section?"

Kirsten Jensen: This is Kirsten Jensen. I'd like to take that one back along with another previous question about how we're going to handle the mechanics of this. So we'll take this one back and get back with you, Joel.

Ashley Setala: Okay, thanks, Kirsten. So the next-

Kirsten Jensen: I'm sorry... I just want to make sure that we have effective dates and we can do these things and have it be as clean as possible in the state plan as states are moving other coverage into the mandatory MAT benefit.

Ashley Setala: Great. So the next question is, "is it possible to include the 1135 waiver request in the MAT state plan pre-print?"

Kirsten Jensen: This is Kirsten Jensen, again. It's actually two separate processes and we did discuss approaching it that way, but we elected to pursue having the state plan pre-print as it is, and following the 1135 request, which actually sit outside of the state plan as an authorizing authority to have that process be separate. We are tracking them and we're tracking the other exception and legislative delay requests that are coming in so that we have everything in one place and can see what a state has submitted and what's been approved for that particular state.

Barbara Richards: Great, thanks. Kirsten, another question for you. "Did the provisions outlined in the MAT SHO letter also apply to the territories?"

Kirsten Jensen: Yes, we're working on that question now as well. So we will have more to you about that shortly.

Ashley Setala: Okay. And then another question on the MAT SHO. "As a utilization management tool, can a state require prior authorization for MAT drugs without assigned label or rebate agreement? For example, a prescriber must submit documentation that the non rebated drug is the only available and medically appropriate product for treating the member."

Kirsten Jensen: John or Cindy, could I turn to you for that please?

John Coster: So, there may be situations where a drug that is not subject to a rebate agreement would have to be covered by the state. But I think we made clear in the SHO that the state could prefer drugs that were subject to a rebate agreement over those that were not. A situation would be a case where only the drug that was not subject to a rebate agreement was necessary for the patients or the physician wanted to have that drug.

John Coster: So I guess the answer to your question is there may be situations where a drug is not subject to a rebate agreement and it would still have to be covered. FFP would be available. But I think we made it clear that the state can prefer the rebatable drugs first, but there may be situations where that non-rebatable drug would have to be covered. That's the best answer I can give you.

Barbara Richards: Great, thanks, John. Another MAT SHO question. "Is the expectation that the prescription drug aspect be combined with the medical benefit in one place under MAT SPA and what are CMS's expectations related to Naloxone."

Kirsten Jensen: This is Kirsten. I can take the first part of the question. And yes, the expectation is that medication assisted treatment benefit is a set of services and a set of drugs that will be covered under 1905(a)(29). And the requirements for that are set forth in the SHO, and we've reviewed that on in the presentation today. So they are to be covered together under this 1905(a)(29) benefit. And the drugs are for the purpose of OUD treatment. And then on your more specific drug question I have to defer to John on that.

Barbara Richards: And John, let me just repeat that specific question. It was what are CMS's expectations related to Naloxone?

John Coster: Yeah, we looked at three drugs in the SHO that are currently approved by the FDA that have a specific indication for opioid dependency. And those are Methadone, Buprenorphine and Naltrexone. Suboxone contains Buprenorphine and Naloxone, so clearly that would be a drug that would have to be covered. But separately, Naloxone is not considered to be treatment of opioid dependency. So if the question is, is that required to be covered under the MAT benefit, separate and apart from it being an ingredient of Suboxone, I would say no, because it's not specifically labeled for treatment of opioid dependency.

Ashley Setala: Okay. Thanks, John. The next question is-

Jackie Glaze: Oh, Ashley, I thought we'd check the phone lines to see if we have any calls coming through and then we'll go back to the web or the chat box. So, operator, can you see if we have questions queued up?

Operator: There are no questions at this time, but as a reminder to register a question, please press the 1 4 on your telephone keypad. There are no questions at this time.

Jackie Glaze: Okay, we'll go back to the chat and then we'll check with you one more time, Frank, to see if we have any other questions coming through. So Ashley, back to you.

Ashley Setala: Okay. So the next question from the chat is "can you confirm that states that already cover MAT are required to submit a SPA?"

Kirsten Jensen: Yes. States that already cover MAT are required to submit a SPA to move coverage to this new mandatory benefit. And they also will need to submit a 419B page for the new mandatory benefit as well.

Barbara Richards: Thanks, Kirsten. "If the treatment services are covered in an existing state plan amendment for beneficiaries with either mental health and/or SUD, should these services be restated in the new MAT SPA?"

Kirsten Jensen: Yes. And they would be services that comport with MAT. So yes, they should be restated here as the services that are being covered as part of this benefit.

Barbara Richards: Okay. And there's a second part to that [question], Kirsten. "Should reference to SUD in the existing SPA be removed so that existing SPA addresses only services related to mental health disorders?"

Kirsten Jensen: It's a little bit more nuanced, I think, and we should have a conversation with the state too, so I'm not overstating anything here. But any services for substance use disorder that are beyond OUD could remain in your regular coverage, and then services that would be part of MAT would be covered under the mandatory benefit for OUD purposes.

Ashley Setala: Okay. The next question is for CAPHG. And it says, "if an individual with SSI Medicaid is confirmed to be out of state by the FCS interface, are we able to terminate their coverage without violating FMAP? And same question with the PARIS interface." Jessica, do you want to take that?

Jessica Stephens: Yeah, sure. Let me start with the PARIS question first because the PARIS match alone is not a reason to terminate coverage for an individual, as the PARIS match by itself is not an indication that the individual is no longer a resident. However, in the IFC we outlined specific criteria that can be applied to identify that an individual who has been identified as enrolled in more than one state through the PARIS match can be terminated. And that is only if there's a PARIS match, the state reaches out to the individual to confirm their state residency, and the individual does not respond. And then the state takes additional measures, which we've outlined to see if they can figure out whether the person is still a state resident.

Jessica Stephens: So for example, the state must check existing databases, communicate with the other state that the PARIS match indicates that the individual is enrolled. And as I mentioned, reach out to the individual to confirm that they're not a resident and have the person not respond. In that narrow circumstance for the PARIS match, the state can determine the individual to no longer be a state resident for purposes of 6008(b)(3) and can terminate coverage.

Jessica Stephens: That exception in the IFC though is very narrowly focused only on the PARIS match and under the circumstances that I just described. So I think you just described the situation with SSI match, and if the individual does not respond to

a request to verify residency, based on that information a state cannot terminate the coverage.

Jessica Stephens: So in short, only based on information from a data source, a state can only terminate coverage if a beneficiary does not respond during a public health emergency, if it is PARIS and the state takes the additional measures I just described.

Jackie Glaze: Thanks, Jessica, can we check the phone lines one additional time and then we'll turn to Ann Marie. Operator.

Operator: We have a question from Eve Lickers. Please proceed.

Eve Lickers: Yes, I was inquiring also because the pre-prints for the MAT, the new category of service, RI 3.1A and 3.1B. We currently have an ABP where we have combined the two into one. So will there be an issue if we modify the templates in order to combine it to be aligned with what we currently have in our state plan?

Kirsten Jensen: So you've combined your regular state plan AB pages to be one submission?

Eve Lickers: Yes, because under our 3.1B we have it reserved because our categories for medically needy are receiving the same benefits as adults. So, when you look at our plan 3.1A it looks like 3.1A/3.1B. 3.1B we have as reserved, rather than duplicate everything that was in 3.1A and 3.1B.

Kirsten Jensen: If you could contact your state lead with that question, we'll have to look into how to do that, given the way that the templates have been put through PRA process. So if you could do that then I can get the right folks to take a look at that question to see how [crosstalk 00:10:52].

Eve Lickers: Okay, that would be great. Thank you.

Jackie Glaze: Thanks, Kirsten. So thanks everyone for all the questions you've had today, especially on the MAT SHO. I know we have some additional questions that we will certainly give responses to those. So at this time, I'd like now to turn to Anne Marie Costello for our closing.

Anne Marie Costello: Thanks, Jackie. I want to thank all of our speakers today for their excellent presentations and information. Looking forward, we'll meet with you again next week. The invitation and topic for the call are forthcoming. Of course, if you have questions that come up between the calls, feel free to reach out to us. Your state leads are given the questions for our next call. Thanks again for joining us today and enjoy the rest of your day. Take care. Bye.

Operator: That does conclude the webinar for today. We thank you for your participation and ask that you please disconnect your line. Have a great day everyone.