Centers for Medicare & Medicaid Services

COVID-19 Medicaid & CHIP All State Call

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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 a 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. At that time, your line will be briefly accessed from the conference to obtain information. You may also submit a question via the chat feature located at the bottom left-hand corner of your screen. If at any time during the conference, you need to reach an operator, please press star zero. As a reminder, this conference is being recorded, Tuesday, March 9th, 2021. I would now like to turn the conference 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 our turn to Karen Shields, our Deputy Center Director, and she will share highlights for today's discussion.

Karen Shields: Thank you, Jackie, and welcome everyone to today's all-state call. Thanks for joining us. First up today, Kirsten Jensen from our Disabled and Elderly Health Programs Group will provide reminders on CMS's policy and requirements around non-emergency medical transportation. Then Jessica Stephens, Sarah Lichtman Spector, and Meg Barry, subject matter experts from our Children and Adults Health Program Group will answer a number of frequently asked questions we've received on Medicaid and CHIP eligibility and enrollment. After that, we'll open up the lines for general questions. I'll note that we'll use a webinar for the general Q&A portion of today's call so that states can submit questions through the chat box. So if you're not logged into the webinar platform and you want to submit a question, I suggest you do so now. Before we jump in, I wanted to highlight that a couple of weeks ago states should have received an email from your state lead requesting feedback on our all-state calls and topics that are of interest to you.

Karen Shields: I want to thank everyone who took the time to respond. We received some great feedback. And we're working to incorporate your suggestions into future calls. We value this regular opportunity to engage with all of our state partners. And we want to be sure the calls are designed to meet your needs. If you didn't get a chance to submit your feedback, and you would like to, you can feel free to email it to your state lead at any time. We

welcome your feedback. With that, I will turn things back over to the team and to Kirsten to start her update.

Kirsten Jensen: Thank you, Karen. I'm here today to talk about non-emergency medical transportation (NEMT) strategies, and particularly for mass vaccination sites, but it could be generalized to any vaccination site. As you know, states have broad latitude to design and implement their Medicaid NEMT program as long as it's in accordance with Medicaid regulations and policy. And each state's NEMT program is different, because it's been designed to meet the individual needs in each specific state and the Medicaid program and populations in your state. We understand that mass vaccination sites can be difficult to access for transportation disadvantaged individuals and states do have flexibility to implement strategies that may assist in this effort. There are some policy considerations to keep in mind as you explore solutions here. In particular, as you know, there is a long standing policy that the Medicaid program cannot pay for time when the beneficiary is not in the vehicle. And this policy is called No-Load Miles, and that policy is still in place even during this time.

Kirsten Jensen: And it applies to mass vaccination sites, where there is the ability to drop off and pick up beneficiaries. So the time spent while the beneficiary is not in the car is not reimbursable. But we have thought a little bit about how can states: What are some solutions states could bring to the table to solve for this problem? States can explore establishing designated pick-up/drop-off areas for beneficiaries who are using transportation services. So this would kind of be like a model where the transportation providers would drop off and continue on with their route. And other drivers would handle the pickup. This is more along the lines of what you might see at a taxi stand at airports and pick-up/drop-off zones. For drive-through sites, separate lanes could be used for providers transporting patients. And in this case, the beneficiary would stay in the car.

Kirsten Jensen: So that's considered a load mile. We can pay for that wait time. And any of the time that is attributed to observation waiting once the vaccine has been administered. And as long as the beneficiary is waiting in the car, that is okay. States might want to consider incorporating scheduled appointments in drive-thru vaccination sites. And particularly for the Medicaid beneficiaries. Just to enhance the ability of the transportation provider to better accommodate and arrange rides and kind of estimate what the time commitment is going to be. So those are some thoughts and ideas that we have. I'm sure that as you've thought about this, you may have come up with others. And we just wanted to provide some background and some possibility here, knowing that mass vaccination sites are up and running and Medicaid beneficiaries may in fact need

transportation to get to these sites. So with that, I will turn it back over to Jackie Glaze.

Jackie Glaze: Thank you, Kirsten. I will now transition to Jessica Stephens and the eligibility team, and they will walk through a number of questions that we received on the Medicaid and eligibility and enrollment. So Jessica, I'll turn it over to you.

Jessica Stephens: Thanks, Jackie. And good afternoon to everyone. We have a number of different areas that we're going to try and tackle, including a number of our subject matter experts. So I will just dive in. I think first are a number of questions that relate to verifications. And we have our subject matter expert, Michelle Wojcicki, on to help answer. Michelle, we received some questions about verification policies and procedures during the PHE. Are states required to tell CMS if it changes its verification policies and procedures?

Michelle Wojcicki: Thanks, Jessica. Yes. States must document the verification policies and procedures used by the state, including when the state changes its processes temporarily. The state must share these updates with CMS for modified adjusted gross income (MAGI) based determination. States may use the Medicaid and CHIP MAGI based disaster relief verification plan addendum to document verification policy and procedure changes that the state is implementing only during the emergency period. The state could instead amend its MAGI based verification plan template. If the state will be continuing verification flexibility it is using during the PHE, after the PHE ends, or is amending its policies starting after the PHE ends, the state must capture these changes in a template.

Michelle Wojcicki: States must also document changes to verifications for non-MAGI based determination in the face internal policies and procedures. If a state would like, it may also include information about temporary non-MAGI changes implemented during the public health emergency in the other section of the MAGI based disaster relief verification plan addendum. We have recently learned about changes that a number of states have implemented in their verification procedures during the PHE, which we do not have on file currently. States can certainly make permissible changes first and provide documentation later, but we encourage you to do so as soon as possible. So that one, we can provide any needed technical assistance, and two, for state's benefit regarding any potential future audit.

Jessica Stephens: Thanks, Michelle. What kinds of verification plan changes might a state find beneficial to be making now during the public health emergency? Do you have any specific ideas?

Michelle Wojcicki: Sure. States may find it helpful to make changes to the verification policies and procedures to facilitate eligibility determination processes during the public health emergency. Changes to certain verification policies may also assist states with applications, renewals, and redeterminations of eligibility after the PHE ends. We have provided some examples of possible flexibilities states may consider in previous FAQs and the unwinding state health official (SHO) letter. Temporarily suspending certain periodic data matches was one example. Also, enrolling individuals based on certain self-attested information and then conducting required verification post-enrollment is another example.

Jessica Stephens: Can you say a little bit more about post-enrollment verification or describe it in more detail? I know we've received a number of questions about that particular option.

Michelle Wojcicki: Yes. So as a reminder, all states are generally able to begin furnishing Medicaid or CHIP benefits to many applicants based on self-attested information. States are still required to check certain electronic data sources and request additional information, if needed, to verify that attestation after enrollment. For example, states must ask the quarterly wage data, and for applicants subject to an asset test, must utilize our asset verification system. When states check required data sources after enrolling individuals based on their self-attested information, we refer to that process as post-enrollment verification. With a few exceptions, such as the citizenship and immigration status, where states must provide a reasonable opportunity period to furnish documentation, in certain circumstances states may not check data sources, identify any known inconsistencies, and then enroll an individual anyways.

Michelle Wojcicki: That process is not permissible under post-enrollment verification. So in other words, if a state checks data sources for income prior to enrollment, for example, and finds that the information returned from the data is not reasonably compatible with the applicant's attestation, the state must resolve that inconsistency then prior to enrollment. However, and then in comparison, states may choose to accept self-attestation and not use a data source to verify attestation of certain eligibility criteria, such as age, date of birth, state residency, household composition. States must generally accept self-attestation of pregnancy as well.

Jessica Stephens: Thanks, Michelle. And I know earlier you mentioned the Medicaid disaster relief verification plan addendum. Just a reminder for states, where can states find that if they're interested in submitting changes? Is that available on medicaid.gov?

Michelle Wojcicki: Yes, that is available on medicaid.gov. And state's current templates are also available on medicaid.gov if they need to look at those as a reference.

Jessica Stephens: Thanks. Shifting gears just a little bit. Sarah O'Connor is on and we received a number of questions about the use of social security numbers, both during the public health emergency, but I think some of these apply more generally too. Sarah, for one specific question, is a social security number (SSN) required for individuals applying for coverage and the COVID testing group?

Sarah O'Connor: Yes. With no exceptions identified in 42 CFR 435.910, individuals seeking Medicaid are required to furnish an SSN as a condition of eligibility. This policy applies equally to individuals within coverage in the COVID testing group. Under the regulation, states must assist individuals who cannot recall or have not been issued an SSN to complete an application for an SSN. Note, that although most individuals are required to provide an SSN, states may not deny or delay services to otherwise eligible individuals, pending provision verification or issuance of an SSN.

Jessica Stephens: Can states request that a non-applicant household members provide a social security number?

Sarah O'Connor: Yes. In fact, states must give non-applicant household members an opportunity to provide their SSN. But states may not require an SSN from individuals not seeking coverage for themselves who are included in an applicant or beneficiaries household. States may request the non-applicant household members SSN. If notice is provided that furnishing the SSN is voluntary, then the state provides a statement of how the information will be used.

Jessica Stephens: And so is that general or specific to the public health emergency?

Sarah O'Connor: That's general.

Jessica Stephens: Okay. Thanks. Looks like we have one more for you related to presumptive eligibility, actually. Do the Family First Coronavirus Response Act, the FFCRA, continuous enrollment requirements during the PHE apply to individuals who are receiving benefits during period of presumptive eligibility?

Sarah O'Connor: No. Individuals who have been determined presumptively eligible for Medicaid have not received a determination of eligibility under the state plan and are therefore not enrolled for purposes of the continuous enrollment requirement described in section 6008(b)(3) of the FFCRA and

42 CFR 433.400(b) as published in the Interim Final Rule on November 2nd, 2020. Although section 6008 of the FFCRA does not provide continuous enrollment or extend the timeline of the PE period for individuals with a PE determination, states can submit a state plan amendment to elect an increase to the number of PE periods individuals may have during the public health emergency.

Jessica Stephens: Thank you, Sarah. Staying on the FFCRA and other provisions, I have a question for you, Shannon, so Shannon Lovejoy. And this is one about retroactive eligibility and the continuous enrollment requirements. In which group should an individual remain enrolled during the public health emergency for the purposes of compliance with section 433.300 of the IFC if an individual who has applied for Medicaid is eligible for one group during a period of retroactive eligibility and a different group in the month of their application?

Shannon Lovejoy: Sure. So I'll first start under our regulations at 42 CFR 435.915. So under these regulations, states must assess eligibility for up to three months prior to the month of application if the individual received services and would have been eligible for Medicaid at the time services were received. So it's possible that an individual will meet the eligibility criteria under one group for any or all of the months of their retroactive coverage period and be either determined eligible for a different eligibility group or determined ineligible for Medicaid in the month of application. So for the purposes of the continuous enrollment requirement that's described in the IFC, a beneficiary is considered enrolled in Medicaid based on a determination of eligibility in the retroactive eligibility period. And what this means is that states should keep the individual enrolled in the group in which they were determined eligible during the retroactive period, unless the state may transition the individual to a different group for which they're eligible for prospectively from the month of application, consistent with the policy outlined in the IFC.

Jessica Stephens: Thanks. Another timely one for you, Shannon. Knowing that it's been almost a year that we've been in the public health emergency, there's some questions about whether states must complete renewals for individuals enrolled in the COVID testing group. Can you answer that one?

Shannon Lovejoy: Sure. So the short answer is yes. Periodic renewals of eligibility are required for all beneficiaries, and that also includes individuals enrolled in the COVID testing group. However, we do acknowledge that some states are not completing certain renewals during the public health emergency since states claiming the temporary FMAP increase generally must keep individuals enrolled through the end of the month in which the public health emergency ends. And so as a result, we recognize that states may

not be prioritizing renewals for individuals enrolled in the COVID testing group. Though, we do want to remind states that federal financial participation for testing services provided to individuals enrolled in the COVID testing group is available only through the last day of the public health emergency. So states need to make sure that they are not claiming FFP for services provided to beneficiaries who are still enrolled in this COVID testing group after that date.

Jessica Stephens: Thanks, Shannon. Michelle, back to you for a couple of questions we have on verification, sorry, not verification, on PARIS and the IFC. So during the public health emergency and under the IFC, what steps is the state required to take prior to terminating coverage for an individual who's been identified as enrolled in Medicaid or another benefit program in another state to a PARIS match? I know that we've answered partly this one before, but it would be helpful if you could clarify.

Michelle Wojcicki: Sure. So first, and just as a reminder, a PARIS match does not conclusively establish state residency in another state. During the PHE and as the IFC provided, in order to terminate an individual who has been identified through the PARIS interstate match as enrolled in a public benefit program in another state during the PHE, the state must first take other reasonable steps available to the state to verify residency when able to do so. So those include, one, reviewing existing information in the beneficiary's record to validate state residency, two, checking available state electronic data sources, such as the Department of Motor Vehicle Records or other state benefit programs, and three, communicating with the other state in which the PARIS match has identified the beneficiary as enrolled in public benefits in an effort to determine the individual's current state residency. And then in addition, the state must also request additional information from the beneficiary to verify his or her state residency, and the beneficiary must not have responded to that request.

Jessica Stephens: Okay. Thank you. And maybe a follow-up is, are states required to implement the provisions in the IFC that permits states to terminate coverage for an individual based on a PARIS match, even if they take the steps to confirm that the individual's not a resident during the PHE? Essentially, is this a requirement?

Michelle Wojcicki: Sorry about that, Jessica. Yes, and no, that the termination permitted under this rule is at the state's option. Specifically, the state may treat a beneficiary as not being a state resident for purposes of the continuous enrollment requirement in section 6008(b)(3) at the FFCRA and may terminate the individual's coverage during the PHE if the state has identified that individual through a data match with PARIS, the person failed to respond to the request for information to verify their residency

and the state takes all reasonably available measures to attempt to verify the beneficiary's state residency.

Jessica Stephens: Got it. Thanks, Michelle. So shifting gears just a little bit again, we have a couple of follow-up questions on the guidance related to unwinding at the end of the public health emergency and the State Health Official letter, which I will ask you, Shannon. The first is a question that I know states have a lot of questions about, which is, does CMS intend to make changes to the guidance released in the December 2020 State Health Official letter on returning to routine operations when the public health emergency ends?

Shannon Lovejoy: Yes, we have been getting this question a lot lately. So at this time, the guidance that is in the State Health Official letter remains in place. And as we've mentioned before, CMS is working to provide states additional technical assistance to support states resume routine operations when the public health emergency ends. Of course, as we learn additional information about the state's needs and challenges that states are facing, CMS will certainly take that into consideration and share that with new leadership as we move forward.

Jessica Stephens: Thanks. So more to come potentially on that one. Another unwinding question is, as states are planning on how they will catch up with overdue renewals following the end of the public health emergency, are they able to align Medicaid renewals conducted after the PHE with an individual's SNAP recertification?

Shannon Lovejoy: So generally, states are not permitted under regulations to delay renewals for individuals who are also enrolled in SNAP for the purposes of aligning the Medicaid renewal and the SNAP recertification dates between the programs. With that said, however, we did in the December State Health Official letter provide states with some flexibility to do so. So specifically the SHO, or State Health Official letter, provides states with up to six months after the month in which the PHE ends to complete any pending verifications, changes in circumstances, and renewals. So to gain efficiencies, states may deprioritize work for individuals who are enrolled in both Medicaid and SNAP by waiting to act on a pending Medicaid verification, change in circumstance, or a renewal to align with the individual's SNAP recertification, as long as the SNAP recertification is scheduled for completion within six months after the month in which the PHE ends. But delaying any Medicaid actions beyond that six month period is not permitted.

Jessica Stephens: Thank you, Shannon. Suzette Seng I know is also on, and we have been receiving a number of other questions about ways in which states can coordinate, particularly between SNAP and Medicaid determinations. Is

there more you can share Suzette about other ways that states can use SNAP or other programs' information to make Medicaid determinations at application and/or renewal?

Suzette Seng: Yes. Thank you, Jessica. So there are a number of ways states may use information from SNAP and other benefit programs when making a Medicaid determination. We're happy to talk through some of those this afternoon, talk through some of those strategies. I will start with using SNAP or other program information as a verification first. So states may use recent and reliable information from other programs as a verification source. When used as a verification source, states rely on the underlying information provided to the other program to complete or verify MAGI determination. For example, a state could use an individual's wage information verified by the state in the recent SNAP or TANF determination to verify income if the Medicaid agency accesses state SNAP on TANF data.

Suzette Seng: States may also rely on other human services program determination to make Medicaid MAGI determination through a couple of different strategies, including the express lane eligibility for kids. States may rely on eligibility information from the express lane agencies' programs to streamline and simplify enrollment and renewal in Medicaid and CHIP. Some examples of assessment agencies include SNAP, the school lunch program, TANF, Head Start, and WIC, among others. ELE is a long standing option that many states have adopted to streamline enrollment or renewal in Medicaid or CHIP and remains available to states through the submission of a state plan amendment. Children can be enrolled or renewed based on the gross income and certain other information made by the other program without additional verification.

Suzette Seng: States may also adopt the facilitated enrollment state plan option. This strategy allows states to use the income determination made by another means tested program to make MAGI Medicaid determination for all MAGI population, and this includes adults. For this option, unlike the express lane option we just talked through, states typically need to collect answers to a few questions to ensure that individuals are certainly eligible for Medicaid. More information regarding this option can be found in our August 31st, 2015 State Health Official letter. And the option may be used at both application and renewal. We have a number of states who have already submitted state plan amendments to adopt this option, and they have found it to be very successful. States have implemented this strategy using information from SNAP, TANF, and the Low Income Heating and Energy Assistance Program, or LIHEAP.

Jessica Stephens: Great, Suzette. That's a lot of good information, and I'm sure that states may have questions that we might not be able to get to all today. What should a state do if they're thinking about learning more about any of these options or considering implementing them in the near future?

Suzette Seng: Sure. CMS is happy to work with states who are interested in exploring any of these options, or have questions about other ways in which they can streamline enrollment or renewal for eligible individuals. They may be particularly interested in considering some of these options now as they plan for the end of the public health emergency, since these strategies may be helpful to reduce burden at application and/or renewal. So if a state is interested or has additional questions, please contact your state lead, who will be able to connect you to the correct subject matter experts so we can answer your questions and talk through what the strategy would look like.

Jessica Stephens: Great, thanks. And I think that applies probably to almost anything that we're mentioning here that we can't immediately answer when we get to more Q&A. One more in this bucket, which is for you Kirstin Michel, are Medicaid and CHIP agencies required to accept applications and signatures submitted electronically and via the telephone?

Kirstin Michel: Thanks, Jessica. Yes, consistent with 42 CFR 435.907, states must accept applications submitted electronically and via the telephone, as well as by mail and in person. With more restricted access to in-person assistance and submission during the public health emergency in many states, the ability to submit applications by phone and online is even more critical. It is permissible for states to encourage applicants or beneficiaries to use certain modalities, but must make all modalities available.

Kirstin Michel: We also note that the use of electronic and telephonic modes for submitting applications, renewals, and other information and documentation could reduce processing lags due to facilities and postal mail, and use beneficiary and state burden. This will be particularly important for states as they begin to process pending applications, renewals, and pending changes in circumstances after the end of the COVID-19 public health emergency. We also remind states that for documentation purposes, renewal forms, applications, and signatures, along with other information supporting the state's determination must be retained in the case file consistent with 431.17, regardless of the modality through which the information was submitted.

Jessica Stephens: Great, thank you, Kirsten. And I'm sure there'll be some questions about some of these, but for now we're going to pass it off to Meg Barry to talk a little bit about CHIP.

Meg Barry: Thanks, Jessica. I'm here to remind states that the Medicaid continuous coverage requirements in section 6008(b)(3) of the FFCRA does not apply to separate CHIP programs. That means that states cannot maintain coverage for individuals enrolled in their separate CHIP if individuals have been determined ineligible for coverage. So if a state receives information from an enrollee, processes that information and determines the individual ineligible for a separate CHIP, the state would need to process the termination and transfer the individual to Medicaid or the exchange.

Meg Barry: So, some states have CHIP state plan amendments that acknowledge that the public health emergency may impact the state's ability to complete timely renewals. But an approved CHIP disaster SPA does not grant the authority to extend eligibility periods for separate CHIP enrollees who have been determined ineligible for coverage. And this isn't a new policy, it's described in the Medicaid and CHIP FAQs on Medicaid.gov. But as the public health emergency continues, we wanted to remind states about it. So I will hand it over to Sarah Spector now.

Sarah Spector: Great, thanks Meg. I'm going to provide a few updates on the new Compact of Free Association Migrants (COFA) migrant expansion in Medicaid. As a refresher, the Consolidated Appropriations Act 2021 restored Medicaid coverage for COFA migrants. And section 208 requires states and DC to cover COFA migrants in Medicaid without a five-year waiting period if they are otherwise eligible under the state plan or section 1115 demonstration.

Sarah Spector: As we've discussed before previous to the new legislation being enacted, Medicaid coverage for COFA migrants was limited to services necessary to treat an emergency medical condition, or full coverage, but limited to children under 21 or pregnant women if the state elected to cover lawfully residing individuals under what we call sometimes the CHIPRA 214 option. The extension to provide full Medicaid eligibility to COFA migrants who otherwise meet all eligibility requirements was effective on December 27th, 2020, the date the law was signed. And as you may know, the full coverage for otherwise eligible COFA migrants is an option for territories. Importantly for territories electing this option, the expenditures for COFA migrants will not count against the territory's expenditure cap. Further, the COFA expansion does not extend to separate CHIP programs.

Sarah Spector: We understand that all states and the FFE need to make changes to implement the expansion. We want to make sure you know that the FFE, the hub, and we are working diligently to ensure that COFA migrants can get enrolled as expeditiously as possible. To do that, we're taking the following steps here at CMS. We're continuing to work with The Center

for Consumer Information and Insurance Oversight (CCIIO) to make changes in the hub that will verify COFA migrants accurately as qualified non-citizens not subject to the five-year waiting period. In addition, we're working with CCIIO on logic changes at the FFE so that the FFE can correctly determine or assess Medicaid eligibility for COFA migrants.

Sarah Spector: While this work is happening, and to ensure COFA migrants have the fastest path to coverage, the FFE plans to encourage individuals to apply for coverage directly at their state Medicaid agency. We know that states will also need to implement system changes to correctly determine eligibility for COFA migrants, and that this may take a little time. Therefore, we're also developing workarounds that states can use while the hub, the FFE, and states are working on systems changes needed to expand eligibility to this new population. We will be holding a webinar for states later this month to discuss these work arounds, and recommend that states invite both their eligibility and systems staff. More coming soon on that.

Sarah Spector: We also want to remind States in DC that you do not need to submit a state plan amendment to include the expansion of eligibility to COFA migrants in your state Medicaid programs as your state plans already clearly cover qualified non-citizens, which now includes these particular COFA migrants. Territories interested in taking up the option should submit a state plan amendment, and we are happy to provide technical assistance for any state or territory who would like additional assistance as it is implementing the new expansion. So with that, I'm going to hand it back to Jackie Glaze.

Jackie Glaze: Thank you Sarah, and thank you team for sharing this guidance with us today. So we're ready now to take your questions, and we will begin by taking questions through the chat function. So I see that we received a couple already, so you can begin submitting those questions. And then we will follow with any questions by the phone, so we'll take your questions at this point.

Ashley Setala: Okay, so the first question that we have gotten in the chat says that section six of the SHO letter for planning to return to routine operations at the end of the PHE states that CMS will identify data elements to be used for reporting baseline data, and will provide a reporting template. When will this be available?

Jessica Stephens: Sure, this is Jessica. I can jump in on that. We are in the process of finalizing that template for states, and recognize that it will take planning for all states to be able to report at the end of the public health emergency. We don't have a concrete date at the moment, but we are certainly working

to get it to you as soon as we can. And at the time, we'll also ensure that we have an opportunity to walk through it and answer any state's questions.

Ashley Setala: Okay, thanks Jessica. The next question is also for CAHPG, and it is related to the interim final rule that CMS published in November. And it says CMS's interim final rule provided states with updated guidance regarding transitioning individuals from one tier of coverage to another. In the scenario where an individual loses eligibility for a tier one coverage such as community Medicaid, but remains eligible for another type of tier one coverage such as the Medicare Savings Program, then states are permitted to terminate the Medicaid coverage. Can CMS elaborate on whether this is an option or a requirement for states?

Sarah deLone: Sure, this is Sarah deLone, I can handle that. If the person loses the eligibility, they no longer meet the requirements for the first group that was referenced. And so in the ordinary course of the program, that person would be terminated from that coverage. And they become eligible however for an MSP group. That's what would typically absence the PHE and 6008 b3, that's what would happen and that would be required. And under the IFC provision that was published and effective November 2nd, that is what should happen. So what the IFC does no longer precludes the state from making that shift. So it's under the state plan. If that's what would happen to that person ordinarily, that is what should happen under the IFC. I do hasten to add that we recognize that a number of states made systems changes to prevent that from happening under the prior interpretation, and so we understand that that may not be something that can happen again right away. This is going to take some time, but that is a policy under the IFC.

Ashley Setala: Okay, thanks Sarah. Then we have a question for DE on NEMT. And it says regarding non-emergency medical transportation, it is our understanding based on guidance from CMS's website that wait times and unloaded miles can be negotiated and factored into contractual, non-fee-for-service payment arrangements. Is this still accurate?

Kirstin Jensen: This is Kirstin. Would you mind writing that one down, or we can take this one back and get back with you? I'm not sure which state it's from, but I'd like to take that one offline please as possible?

Ashley Setala: Sure, we can do that.

Kirstin Jensen: Yep, thanks.

Ashley Setala: And then we have a question that says, we submitted our appendix k for an extension of the ending date almost six weeks ago. Do you have any insight on how long it will take to get it approved?

Ralph Lollar: This is Ralph, and what I can say about that is this. We have experienced a very significant volume of requests coming through at this time, so it is taking us some time to work through processing all of those activities. States have been offered technical assistance to ensure that the request in the Appendix K to expand the termination date is a single Appendix K without any additional requests inside of it. And what we can say to you is as we process them, the state should recognize that a simple request to extend the transition period to the amount permissible, which is six months post-PHE, can be approved and will be approved retrospective to cover any periods that the state is concerned about.

Ashley Setala: Okay. Thanks, Ralph. Then we have a question related to COFA and it says, is CMS working to implement the COFA code in the hub and Systematic Alien Verification for Entitlements (SAVE)?

Sarah Spector: This is Sarah. I can jump in with that. So CMS is working to implement the changes in the codes in the hub. They already exist, actually, in phase. So a state that has a direct connection, for example, with their human services programs would save outside the hub or any state with a connection outside of the hub, is already able to get those COFA codes and the verification codes from SAVE.

Ashley Setala: Okay, thank you. And then we have a question that says, is there any anticipation or expectation that the guidance issued for clean-up, which I assume means that our CMS Unwinding SHO, will be changed by the new administration?

Shannon Lovejoy: So this is Shannon again. So as of now, the guidance that's in the SHO is the guidance that we are working with and that's in effect. But we are intending to provide states with additional technical assistance. And as we continue to learn more from states and get additional information, we certainly are going to take that into consideration and share it with the new leadership.

Ashley Setala: Thanks, Shannon. And then we have one more question in the chat and it says, for renewals, the SHO letter states CMS is available to provide technical assistance to states and territories seeking to ensure renewals are distributed evenly over the course of the year to ensure a manageable and sustainable renewable workload in future years. Can you talk through this, as other guidance says renewals must be completed within six months of the end of the PHE?

Shannon Lovejoy: So this is Shannon again. We are looking at ways to help states. As we just mentioned, the guidance in the state health official letters is that states had six months after the month in which the public health emergency ends to complete any pending work that was not completed during the public health emergency. But this is certainly an area that we know states are concerned about and we want to work to find ways to provide additional technical assistance to help states as they're working through their backlogs to make sure that renewals are manageable in future years.

Ashley Setala: Thanks, Shannon. And that is everything that we have in the chat at this moment.

Jackie Glaze: Okay. Thanks Ashley. So, operator, will you give instructions to the participants on how to ask questions? And then we will take questions through the phone line.

Operator: Certainly. If you would like to register a question, please press the one followed by the 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 phone question, it is the one followed by the four on your telephone.

Operator: And there appear to be no questions on the phone lines at this time.

Jackie Glaze: Thank you. Ashley, I do see one additional question in the chat.

Ashley Setala: Yep. And it says, would CMS speak to their expectations for states to gather paper proofs from members who have reported changes and would ordinarily move to another Medicaid eligibility category, but need to provide proof of income or assets where electronic verification is not available or successful? Should the state hold up movement within a tier for that paper proof when eventually the member will need to renew eligibility at the end of the PHE and we cannot terminate the member regardless of whether they provide the proof?

Jessica Stephens: So firstly ... Hi, this is Jessica Stephens again, and I don't think that the process that the questioner was asking here would differ from the regular process, except for the fact that that state cannot terminate coverage for an individual if you're seeking the 6.2 percentage point match. Therefore, if an individual ... If there's a change that is identified and the state is acting upon that change, and through that process, request that the beneficiary provide additional documentation of the change, that the state would still

need to go through and complete that process before acting on any particular change in circumstances.

Jessica Stephens: And, I mean, that of course varies by the type of change that that exists in whether it's the person response reporting the change, or it's sort of changed that's identified through a data source. So if there are maybe follow-up specific questions, it would be great if you could follow up with a question there, but otherwise it would be normal processes. Let me pause for a sec and see if any of my colleagues have more to say. I'm thinking no, but if there are follow-up questions, kindly go ahead and ask.

Ashley Setala: Okay. And then we have one more question that has just come in around COFA and it says, for COFA migrants, just confirming, did you say that this eligibility was not to be applied to the extended CHIP program?

Sarah Spector: Hi, this is Sarah. That's correct. The statutory languages is quite clear and it applies to Medicaid programs, but does not extend to separate CHIPs.

Sarah deLone: But Sarah, just to add on, it does pertain to a Medicaid expansion of that population that's for which the state receives the Title XXI match, right? So your so-called Medicaid expansion CHIPs, it applies. That's Medicaid. You're just talking about your separate CHIPS, is that correct?

Sarah Spector: That's right.

Ashley Setala: Thanks, Sarah.

Operator: Sorry. Sorry, this is the operator. We do have a question on the phone line. That would be from Jason McGill. Please proceed with your question.

Jason McGill: Hi. Yes. Thank you. Good afternoon. Just to clarification of the NEMT, if it's a mass vax site without a drop-off location, we're okay paying for that time, including the wait time after the shot, is that correct?

Kirsten Jensen: If the beneficiary remains in the vehicle, yes.

Jason McGill: Thank you.

Operator: And there are no further questions on the phone lines.

Jackie Glaze: Thank you. I'll come back to you, Ashley.

Ashley Setala: Okay. We have one more question that just came in the chat for a CAPHG on the IFC, and it says, to clarify, the IFC rule regarding moving tiers is

required to be implemented in state systems even though we are already working towards changes for the end of the PHE?

Sarah deLone: I would say it would probably be helpful. I mean, we're giving what the policy requirement is under the IFC, if it's posing a operational complication for a state that's in conflict maybe with other work that you're trying to get into place, it would be helpful maybe to reach out through the state lead so we can provide one-on-one TA and help you figure out what is the best path forward.

Ashley Setala: Thanks, Sarah. And then that's all that we have in the chat right now.

Jackie Glaze: Can we check the phone lines one additional time, operator?

Operator: There are no questions at this time. But as a reminder, once again, to register a phone question, that is the one followed by the four on your telephone. And there appear to be no questions on the phone lines.

Jackie Glaze: Thank you very much. So, no questions on the phone line and no additional questions in the chat. So Karen, I will turn to you for closing.

Karen Shields: Okay. All right. Thank you, Jackie. And thank you, Ashley, and thank you, everyone. I want to thank all of our presenters for their excellent presentations, and I want to thank all of our participants for such an engaging Q&A session. We look forward to reaching out to you with the next topic and invitation for our next call that will be forthcoming. Of course, if you have any questions that come up in between the next call, please feel free to reach out to us or your state leads and bring the questions to our next call. Thanks again, and have a great day.

Operator: That does conclude the conference call for today. We thank you for your participation and ask that you please disconnect your lines.