HHS-CMS-CMCS

February 21, 2023

2:00 pm CT

Coordinator: Welcome and thank you for standing by. At this time I'd like to inform all participants that you have been placed in a listen-only mode for the duration of today's conference. I would now like to turn the call over to Ms. (Jackie Glaze). Thank you, ma'am. You may begin.

(Jackie Glaze): Thank you and good afternoon and welcome everyone to today's all state call-in webinar. I'll now turn to Ann Marie Costello, our Deputy Center Director, for opening remarks. Ann Marie?

Anne Marie Costello: Thanks, Jackie, and hi, everyone, and welcome to today's all state call. First up today, Melissa Harris from our Disabled and Elderly Health Programs Group, will provide an overview of options for states to continue the use of family members as paid caregivers after the COVID-19 public health emergency ends in May and PHE flexibilities expire. Then Annie Hollis from our Children and Adult Health Programs Group, will provide an overview of a new tool CMS created laying out accessibility requirements in Medicaid and CHIP.

After Annie's presentation, Mark Steinberg and (Cassie Ligorio), also from our Children and Adult Health Programs Group, will answer some frequently

asked questions that we've received around restarting premiums for individuals. Finally, we'll open the lines for your questions. With that, I'll turn things over to Melissa. Melissa?

Melissa Harris: Thank you very much, Anne Marie. This is Melissa Harris. And I'm going to walk through some slides that talk about a flexibility that many states have requested to implement during the public health emergency. And while they could be implemented across different authorities, generally give states the flexibility to allow family members, including parents sometimes, to be paid caregivers. And states have been coming to us asking how they can continue these arrangements once the public health emergency ends. And so we wanted to provide you with some options depending on the various authorities today.

So we can go to the next slide, please. So I'll first start with the 1905(a) authority. And we're talking about 1905(a) personal care service. And right off the bat, we have a legislative prohibition in 1905(a)-24. And that prohibition says that family members cannot be paid as providers of personal care service. And as we defined the personal care benefit and regulations, we indicated that family member is defined as legally responsible relative.

So in the example of states wanting to pay parents, for example, outside of the public health emergency, and outside of an 1135 waiver, this would not be permissible. During the PHE, we did use the authority in Section 1135, to allow for a waiver of the prohibition against legally responsible relatives. And so several states do have today, 1135 waiver authority, to allow payment for 1905(a) personal care services rendered by legally responsible individuals, including parents.

The only threshold that states had to do under this 1135 waiver, was to make a reasonable assessment that this caregiver, this family member, is capable of

rendering these 1905(a) personal care services. Next slide, please. And then as we move to the 1915 authorities, the 1915(c) waivers and 1915(i) state plan programs, what is typically the case is that family members and legally responsible individuals can only be paid for services under these two authorities and when they provide "extraordinary care."

And again, under the PHE, states were using either the Appendix K for the 1915(c) waiver, or the Disaster Relief State Plan Amendment for the 1915(i) program, to temporarily permit legally responsible individuals, including parents, to render 1915(c) waiver services and 1915(i) benefits. And again, here the only thing the State had to do was to tell us the services to which this flexibility applied, that parents and other legally responsible individuals were going to be providing services; the safeguards the state would use to ensure that the services that were authorized in the service plan were actually provided; and the procedures that the state used, you know, to make sure that the payments were actually for services that were rendered.

Next slide, please. So as we now know, when the public health emergency is ending and we can look to the unwinding of these various PHE flexibilities, states have come to us with questions about how to extend the use of legally responsible individuals, including parents, once these PHE authorities have ended. And it really requires an authority by authority conversation. So that is what we are going to walk through in these next slides.

And you'll see in the sub-bullet here that flexibilities implemented under the 1135 waivers and the disaster relief state plan amendments will end on the 11th of May when the PHE designation expires. Flexibilities that were authorized under an Appendix K for 1915(c) waivers, have the ability to extend until 6 months after the end of the PHE, which would be November 11, 2023. Or states could have picked an end date earlier than that, but states have

the option to have those Appendix K flexibilities in place through 6 months after the end of the PHE. Next slide, please.

So let's talk about where we go next. And I'll start again with 1905(a) services. So once the 1135 waivers expire, states cannot continue to use 1905(a) personal care services to authorize family members, including parents, to deliver those services. It once again, reverts to the statutory prohibition. But we can look to other benefit categories in 1905(a) that do not carry that same prohibition. And the benefit that comes closest to the services delivered under the personal care benefit, is the home health benefit, and specifically, as you'll see in the sub-bullet at the bottom of the slide, the home health aid component of the home health benefit.

That home health aid provision authorizes assistance with activities of daily living and activities with instrumental, excuse me, it authorizes assistance with activities of daily living and assistance with instrumental activities of daily living. And that's about as close as we're going to get to personal care services under the 1905(a) package. And so how can we use the home health benefit to stand in for personal care in terms of states tapping parents and other legally responsible relatives as caregivers?

You'll see here in that second bullet that states will need to establish some sort of employment relationship or have some other kind of arrangement where the parents or the other legally responsible relatives have a formal arrangement with the home health agency such that they are formally delivering home health aid services. And the services would then be billed under the home health line item on the CMS-64. So this requires a pivot away from the personal care line item in the 1905(a) menu, and landing instead on the home health line item.

Home health is a more formal benefit, if you will. It requires conditions of participation, alignment, you know, with Medicare COPs. And it includes requirements for home health aids. There is no prohibition on a family member serving as a home health aid. But that family member needs to have, as we indicate here, a formal employment relationship or other kind of arrangement with the home health agency, to green light the billing and claiming of those services as home health.

We have had these conversations with a couple of states, and are very available to other states who want to kind of unpack this and think about how applicable this could be to your state, to use home health as the 1905(a) benefit for the continued use of paid family caregivers. Next slide, please. So going back to the 1915(c), the 1915(i), and introducing 1115 demonstrations. So states will be able to continue to use this extraordinary care option in the 1915(c) waiver authority, and the 1915(i) authority.

And we are certainly available for technical assistance to describe really what that extraordinary care looks like. When we're talking about using parents specifically as paid caregivers under the 1915 authorities, we need to understand what the extra responsibilities are that parents have for individuals enrolled in a C waiver or individuals enrolled in a 1915(i), that require parental duties above and beyond what a parent would ordinarily be doing for their child.

And because of the populations that we're dealing with, either individuals under the C waiver that meet an institutional level of care, or individuals under the 1915(i) state plan program that meet needs-based criteria, there is opportunity there for a state to describe the extra parenting responsibilities that parents would be reimbursed for under these authorities. But it needs to

be couched in the extraordinary care vernacular to be in compliance with existing guidance.

There are also states that have 1915(c)-like and 1915(i)-like services authorized in a section 1115 demonstration. And we would encourage those states to contact their project officer and talk about what kind of next steps might be available for them. Next slide, please. I wanted to touch briefly on 1915(j). This is another authority in the HCBS rubric that does allow beneficiaries to hire family members. This is one of the self-directed benefits. And so individuals can hire family members, including legally responsible individuals, to be their service providers. And so there was no PHE flexibility that was necessary for the 1915(j) program.

So states that are operating a program under 1915(j) or are interested in operating a program under 1915(j), it's just kind of business as usual based on the existing framework for this authority. 1915(j) allows self-direction of 1905(a) personal care services, I'll note - and 1915(c) waiver services. But this authority becomes the line item on the CMS-64 that states bill for these services when they are self-directed. And again, we are available to provide technical assistance on a state that might want to implement 1915(j) for self-direction of relevant services. Next slide, please.

And wrapping up with 1915(k), which is the community first choice state plan option, this is a program that provides home and community-based attendant services and support, with 6 percentage points of enhanced FMAP for the duration of the state plan program. Here, again, there is no prohibition. So individuals can hire under the self-direction delivery option of community first choice, individuals can hire legally responsible individuals to be their providers of services. And if a state is implementing the agency delivery model, which is a state decision, states can choose to allow legally responsible

family members to again, have some kind of employment relationship with the agency that is providing services. Next slide, please.

So, you know, to end, you know, there are paths forward to continue these flexibilities. We know that far more states started using paid family caregivers during the public health emergency than were using them before. And now, as we are talking about unwinding these flexibilities, we're hearing from family members themselves; beneficiaries themselves; provider agencies, states, really across the board in our stakeholder community, to see how we can continue to allow these individuals, you know, to provide services.

So take a look at the information that was on the slide deck. In all cases moving forward, there need to be safeguards included, so states are aware that the services that individuals have been assessed to need, are actually being provided. And so in all cases, a state can expect to outline for us how you're going to meet those safeguards in whatever authority we have going forward. But we are available for technical assistance.

Pay particular attention to this last bullet because as part of any unwinding conversation where we're talking about dates certain when existing flexibilities end, it is very important to understand the authority that you might be requesting to use to continue this flexibility and the effective date and the timing implications of those authorities. If we're talking about using a 1905(a) authority like home health, those state plan amendments can be submitted with a retroactive effective date back to the first day of the calendar quarter in which the SPA was submitted.

But 1915(i) state plan options, 1915(c) waivers, and 1115 authorities carry with them prospective effective dates, in which case you need to allow time at the state level to develop those submissions and send them to CMS with

enough time for us to adjudicate and approve those authorities, so they can stand up as soon as your PHE flexibility expires. So if you have any questions about that and how it impacts your state and your situation, please reach out either to your state lead or your 1115 project officer, and we will set up individual state TA calls for you.

I think that's it for me. So I am - we can go to the next slide, but I think I'm going to send it back to Jackie.

(Jackie Glaze): Thank you, Melissa. So next up is Annie Hollis from our Children and Adult Health Programs Group, and she's going to provide an overview of the tools for the accessibility requirements. So, Annie, I'll turn it to you.

Annie Hollis: Thanks so much, (Jackie). Again, I'm here to discuss language and disability access requirements in Medicaid and CHIP. Today's presentation will focus on the requirements for accessibility in the Medicaid and CHIP programs, regulatory requirements under Section 1557 of the Affordable Care Act, and how states can claim for language access services expenditures under Medicaid and CHIP. Next slide, please.

So some quick background on the different requirements that do apply to Medicaid and CHIP agencies - Medicaid and CHIP agencies must take reasonable steps to ensure meaningful access to the Medicaid and CHIP programs, by individuals with limited English proficiency, or LEP, and take appropriate steps to ensure communications are as effective for individuals with disabilities as they are for other individuals accessing the Medicaid and CHIP programs.

There are several laws and regulations that apply around language access and effective communication. They include, for Medicaid and CHIP, in federal

Medicaid and CHIP regulations under Section 1557 of the Affordable Care Act, Title VI of the Civil Rights Act, the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, and implementing regulations. This doc provides guidance for Medicaid and CHIP agencies on federal requirements and flexibilities in providing language services to individuals with LEP and effective communication to individuals with disabilities, to ensure compliance. Next slide, please.

So, under our federal statutes of Medicaid and CHIP rules, Medicaid and CHIP agencies are required to provide program information in plain language, timely, and in a manner that is accessible to applicants and beneficiaries with LEP, or a disability, at no cost to the individual. Agencies must provide language services, including oral interpretation and written translations. They must inform individuals that language services are available, and how individuals can access those services through, at minimum, providing taglines in non-English languages.

Medicaid and CHIP information must also be provided accessibly to individuals with disabilities through the provision of auxiliary aids and services at no cost to the individual. Finally, they must provide applications, renewal forms, notices, such as an eligibility notice or an adverse action notice, and the fair hearing process, in a format that is accessible to individuals with LEP or disabilities. Next slide, please.

So, when we're looking at the Section 1557 regs, and we'll go into those in a little bit more detail on the further slide, but we wanted to start with what does meaningful access mean? So, as states are developing or reviewing their language access plans, the HHS Office for Civil Rights, or OCR, uses these four factors to determine whether or not entities have taken reasonable steps to ensure individuals with LEP have meaningful access to programs.

The first being the number or proportion of individuals with LEP who are eligible to be served or likely to be encountered in the eligible population; the frequency with which individuals with LEP come in contact with the entity's health program, activity, or service; the nature and importance of the entity's health program, activity, or service; and the resources available to the entity and costs. Next slide, please.

So, on the previous slide, we just discussed the four factors that OCR uses to determine how meaningful access is being provided. On this slide we'll discuss the requirements under Section 1557 of the Affordable Care Act, starting with the basics of language access. So, what Section 1557 does is it prohibits discrimination under any health program or activity receiving federal financial assistance on the grounds of race, color, national origin, sex, age, or disability. Under Section 1557, Medicaid and CHIP agencies are considered covered entities and are subject to language access requirements established by the HHS Office for Civil Rights, or OCR, as well as the program-specific requirements identified earlier on slide 4.

Specifically, Section 1557 requires that states provide language services to individuals with LEP, which are required to be free of charge, accurate and timely, and protect the privacy and independence of the LEP individual. Language access services may include oral language assistance, including interpretation in non-English languages provided in person or remotely by a qualified interpreter, and the use of qualified bilingual or multilingual staff to communicate directly with individuals with LEP, and written translation performed by a qualified translator of written content in paper or an electronic form into languages other than English. Next slide, please.

On this slide, I want to spend some time discussing accessibility for individuals with disabilities. So states must take appropriate steps to ensure that communications with individuals with disabilities are as effective as communications with other individuals in their programs, including by providing information and communication technology accessible to individuals with disabilities, such as Web sites, or information kiosks. States must provide appropriate auxiliary aids and services to afford individuals with disabilities an equal opportunity to benefit from the service in question.

Auxiliary aids and services include interpreters, including onsite interpreters, or those that work through remote video interpreting services, methods to deliver oral information available to individuals who are deaf or hard of hearing, such as real-time computer-aided transcription services, written materials and notes, assistive listening devices and systems, open and closed captioning systems, including real time captioning, text telephones or TTYs, video phones and caption telephones, and materials that effectively provide visually-delivered materials accessible to individuals who are blind or who have low vision, such as audio recordings, braille materials and displays, screen reader software, and large print materials. Next slide, please.

There also are specific requirements for interpretation, which I'll cover on the next few slides. So if a covered entity is providing oral interpretation services to an individual with LEP, the interpreter must adhere to generally accepted interpreter ethics principles, including client confidentiality, have demonstrated proficiency in speaking and understanding both English and the non-English language to be interpreted, and to be able to interpret effectively, accurately, and impartially, including any necessary specialized vocabulary, terminology, and phraseology.

When providing interpretation for individuals with disabilities, an interpreter must adhere to those generally accepted interpreter ethics principles, including client confidentiality; and be able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary, terminology, and phraseology. If an oral interpretation is provided remotely, it must be in real-time audio over a dedicated high-speed audio, video, or wireless connection that delivers high-quality audio without lags. The entity must also provide adequate training to users of the technology and other involved individuals so that such remote interpreting services can be set up quickly and efficiently. Next slide, please.

When a state is providing oral interpretation services to an individual with an LEP, a state cannot require the individual with LEP to provide their own interpreter. The state cannot rely on an adult accompanying an individual with LEP to interpret or facilitate communication, except in an emergency involving an imminent threat to the safety or welfare of an individual or the public, where there is no qualified interpreter for the individual with LEP immediately available, or when the individual with LEP requests that the interpretation and accompanying adult agrees to assist, and assistance by that adult is appropriate under the circumstances.

The state cannot rely on a minor child to interpret or facilitate communication, except in an emergency. The state can also not rely on staff other than qualified bilingual or multilingual staff, to communicate directly with individuals with LEP. Next slide, please. So these go over some written translation requirements.

If a covered entity is providing written translation services for written content, whether that's in paper or electronic form, to an individual with LEP, they must be provided by a translator who must adhere to those generally accepted

translator ethics principles, including client confidentiality, have demonstrated proficiency in writing and understanding at least written English and the written language and native translation; and be able to translate effectively, accurately, and impartially, including any specialized vocabulary, terminology, and phraseology. Next slide, please.

We also want to note and call to your attention that Medicaid and CHIP agencies may claim for language access services. So there are a few different ways that that can happen. First, regular federal Medicaid administrative match is generally available for expenditures for language services, including translation and interpretation services. There also is an increased federal match option for certain translation or interpretation service expenditures. For Medicaid, 75% of allowable expenditures for translation or interpretation services in connection with the enrollment, retention, and receipt of covered services by children of families for whom English is not the primary language.

For CHIP, the higher of 75% are the state's enhanced FMAP plus 5% of allowable expenditures for translation or interpretation services in connection with the enrollment, retention, and receipt of covered services by an individual for whom English is not the primary language. In order to obtain the increased translation or interpretation match, states and providers may enter into a contract or employ staff that provides solely translation or interpretation functions and claim-related costs as administration and/or pay for translation or interpretation activities to assist the medical provider of record for the service separately as an administrative expenditure in addition to the rate paid for the medical service itself. Next slide, please.

So as states are preparing for unwinding, there are some important factors to consider when working with these populations - individuals with LEP, individuals with disabilities. We encourage you as you're making your

preparations, to consider the following items on this slide. These are some key items. - things like identification; how is the state identifying individuals who need accommodations or language services; how is the state identifying the need and capacity for language services based on known information using different data sources about the Medicaid population and the prevalence of language needs within the state; what follow-up or outreach needs to be done to provide appropriate accommodations for individuals with disabilities or LEP?

Another factor to look at would be a review of eligibility processes, including automation. So that could include things like how call centers or chat features are set up in order to ensure that individuals with LEP or a disability, can use automated or voice-prompting features, and how automations like QR codes, apps, or online systems impact individuals with an LEP or a disability and their ability to access benefits, and whether alternative methods of access or strategies are needed.

You can look at training, such as what training call center workers or other staff that interact with applicants and beneficiaries are receiving to recognize requests for accommodations or language services, complaints - whether there is a system to receive complaints from individuals with LEP or disabilities regarding accessibility and how individuals are informed about this process, and whether the system receiving complaints is accessible to individuals with LEP or disabilities.

Finally, monitoring - how the state will monitor that disability accommodations and language services are being provided adequately, and if individuals with disabilities or LEP, are being disparately impacted by procedural denials. Next slide, please. On this final slide we have some concrete examples to share that states can consider in order to ensure effective

communication with individuals with LEP and disabilities. Some examples of those steps to consider are ensuring that key documents are translated into multiple languages by qualified translators and reviewed for cultural competence.

Ensuring multilingual staff who speak frequently spoken languages within the state's population, such as Spanish, are available to communicate with applicants and beneficiaries, like in call centers, and conduct training on language and disability access requirements, confidentiality, ethics, terms, and phraseology to ensure oral interpreters are qualified. You could consider partnering with community-based organizations that offer interpretation services, updating Web sites with taglines, and non-English languages to inform individuals how to access language services that are available, and ensuring that information, including information provided through technology, like on Web sites or in information kiosks, is communicated to individuals with disabilities accessibly by providing auxiliary aids and services at no cost to the individual.

Of course, if states have additional questions or would like to discuss specific strategies to provide these services to beneficiaries and applicants, CMS can provide additional technical assistance, and you should contact your state lead for assistance. And then the final slide, next slide, please, is a resource slide that may be missing from this version. So we'll note that this slide deck did get posted on Medicaid.gov on the unwinding page, under other guidance and resources. So that should be there now if you all would like to go take a look at that. And with that, I will hand the presentation back to (Jackie). Thanks so much.

(Jackie Glaze): Thank you so much, Annie. Mark Steinberg and (Cassie Ligorio) from our Children and Adult Health Programs Group, will also provide some FAQs on premium assistance. So I'll now turn to you, Mark.

Mark Steinberg: Thank you, (Jackie). This is premium reinstatement and increasing premiums. Apologies for any vocal issues. I'm dealing with a respiratory bug. We have received a number of questions requesting clarification around what the changes to Section 6008(b)(2) of the FSTRA means for states that want to reinstate, resume premiums, or increase an individual's premium both in Medicaid and CHIP. So we're going to go through some questions that we've received and provide some answers to those right now.

The first question - this is a long one; has several parts. Beginning April 1, 2023, how may states that are - who are claiming the temporary FMAP increase resume - shall after April 1st, resume charging Medicaid premiums that have been suspended by a disaster relief SPA? And this answer has several parts because it depends on when states want to resume that. The first time period to consider is the period between April 1, 2023, when the changes under the CAA 2023 take effect and the end of the PHE on May 11th. We're expecting the COVID PHE to end on May 11, 2023, which means that disaster SPAs will generally sunset on that date.

So between April 1st and May 11th states may rescind premium suspensions under disaster SPAs, provided they meet certain conditions. It's important to remember that states resuming premiums can still claim the temporary FMAP increase from now until this - from April through December, as long as the resumed premium schedule amounts do not exceed the amounts in effect as of January 1, 2020.

States that choose to rescind their disaster SPAs between April 1st and May 11th need to ensure that the resumed premium schedules are - that the resumed premiums that are charged are consistent with the state's approved Medicaid premium schedule. Of course, you would be expected to do that. You should coordinate with your State lead to comply with all requirements for rescinding a disaster SPA. We had a discussion about those requirements at last week's all state call. As a reminder, this does include completing public notice. We consider a change to the end date of a disaster SPA to be a substantial modification of cost-sharing policy.

And for all of the changes we're talking about here, there are beneficiary protections that apply. I'm going to discuss all of those at the end of these questions. So what happens after May 11th, if you want to resume your premiums after May 11th? Unless a state takes a step to rescind or extend a disaster SPA, we expect that premium suspensions that were made under disaster SPAs, will sunset on May 11th. The state should resume Medicaid premiums at that time unless the state takes steps to delay the premium resumption.

And I'll discuss what those options are in a moment. Again, states can keep claiming a temporary FMAP from April through December as long as the amounts charged under the resumed premium schedules do not exceed the amounts in the state's premium schedule that were in place as of January 1, 2020. States also need to ensure, again, that resumed premiums that are charged are consistent with the state's approved premium schedule, that all the beneficiary protection measures that I've got to discuss are followed.

What are the options for delaying premiums after May 11th if states suspended under a disaster SPA? States can delay the resumption of premiums under several, at least two options. They can extend the disaster SPA authority

to delay resumption of all premiums for a specified time. As I mentioned, at CMS we discussed the requirements for extending a disaster SPA at last week's all state call, and we're happy to discuss those further. Another option is to submit a waiver request under Section 1902(d)-14(a). That request would be a request to delay resumption of premiums for individual beneficiaries until that individual's redetermination has been completed. States that are interested in either of these options should contact their state lead, and we're happy to discuss them.

Okay. The next question is a lot shorter. What about a state that wants to continue to claim the FMAP increase from April 1st to December 31st, and it wants to increase an individual beneficiary's Medicaid premium on or after April 1, 2023? So starting April 1, 2023, states can increase premiums charged to an individual under certain circumstances, such as when an individual's household composition or income have changed. This applies both to states that are resuming premiums in one of the ways we just discussed, and to states that never suspended Medicaid premiums during the PHE.

Again, in order to claim the temporary FMAP increase after April 1st, states should ensure that the resumed premium schedule amounts do not exceed the amounts in effect as of January 1, 2020. States should also ensure that, again, of course, the resumed premiums that are charged are consistent with the state's approved premium schedule, and that they follow all the beneficiary protections that I'm about to discuss. So what are these beneficiary protections that apply when a state resumes Medicaid premiums or if a state wants to increase Medicaid premiums imposed on a beneficiary?

They are the following - one, a state must meet redetermination requirements prior to resumption or increasing Medicaid premiums, and they must ensure

that the premium imposed on an individual is based on the state's most recent determination of income. Generally these redetermination requirements are what we discussed in our October 2022 FAQs. But we are here updating them to reflect the possibility that an individual's premium could increase from the period between April and December 2023.

Specifically, if a state has completed a renewal for the beneficiary in the last 12-months, the state may resume or increase Medicaid premiums for that beneficiary without completing a redetermination. However, if the state has not completed a renewal for the beneficiary in the last 12-months the state must complete a redetermination before resuming or increasing Medicaid premiums for that beneficiary. The other consumer or beneficiary protections that are relevant shouldn't come as any surprise, but again, the amount of any Medicaid premium imposed must be the amount that the beneficiary would be subject to under the state's approved Medicaid premium schedule, of course.

States must comply with all premium requirements and limitations in statute in the Act of Sections 1916 and 1916(a) and 42 CFR 447.50-57. This includes mandatory exemptions from premiums, household aggregate limits, and notice requirements. Specifically on notices, states must provide each beneficiary with a minimum of 10-days advance notice that includes the right to a fair hearing prior to resuming or increasing premium charges. That's in accordance with federal regulations.

This advance notice must provide the premium amount, a clear statement of the specific reasons that support the assessment of the premium, the basis, and the basis for the premium calculation. All right. Those are the key Medicaid components. And now (Cassie) is going to cover some considerations for CHIP. And I'll see you next time.

(Cassie Lagorio): Great. Thanks, Mark. I have two CHIP questions and answers to share today, related to resuming the collection of premiums in the separate CHIP programs. The first question is, if a state suspended the collection of premiums for separate CHIP enrollees during the PHE, must the state complete a renewal before resuming the collection of premiums during the unwinding period? And the answer is yes. States may resume the collection of premiums only for beneficiaries who have had a renewal within the last 12-months. The amount of the premium imposed should be based on the state's most recent determination of the beneficiary's household income.

If the beneficiary has not had a redetermination of household income in the last 12-months, the state must complete a redetermination before reimposing premiums. If the state has completed renewals for all beneficiaries within the last 12-months, the state may resume imposing the collection of premiums after providing timely and adequate written notice and information about the beneficiary's rights to the CHIP review process. A CHIP spot is not needed to resume the collection of premiums provided the state has completed renewals for all individuals in the last 12-months.

And question 2 - if a state has completed renewals for some but not all beneficiaries in the last 12-months, can the state resume the collection of premiums? If the state has completed renewals for some but not all beneficiaries within the last 12-months, the state may choose to resume collecting premiums only for the beneficiaries who have had a renewal. A SPA is required to resume the collection of premiums for only some beneficiaries, and the SPA submission requirements depend on the initial CHIP disaster relief SPA approved by CMS.

For states within approved Evergreen Disaster Relief SPA, the state must submit to CMS a disaster spa activation letter specifying the date on which the

state will begin collecting premiums from those beneficiaries who have completed a renewal within the last 12-months. For states with a disaster relief SPA that was specific to the COVID-19 PHE, the state must submit to CMS either one, a SPA specific to the unwinding period; or 2, a specific SPA specific to the unwinding period.

Stating that the state will begin collecting premiums from those beneficiaries who have completed a renewal within the last 12-months or two, in Evergreen Disaster Relief SPA. In the SPA cover letter, the state would describe how they will be resuming the collection of premiums during the unwinding period. And I highly recommend that states reach out to their CHIP project officer, so we can provide individualized technical assistance based on how the state has been handling CHIP renewals during the PHE, and the type of disaster relief SPA implemented by the state. And with that, I will turn it back to (Jackie).

(Jackie Glaze): Thank you, (Cassie). And thank you, Mark, for your updates. We're ready to take questions from the states, so we'll begin with the chat function. I do see a few questions, and then we'll follow by taking questions over the phone line. So, (Ashley), I'll turn to you.

(Ashley): Thanks, (Jackie). We have a few questions that have come in around today's personal care services presentation. The first one says, typically in a consumer-directed model family members are allowable if they are not legally responsible, correct?

Melissa Harris: Hi, (Ashley), this is Melissa. You know, typically that is correct. I want to preface my response by saying that as always, it's necessary to understand what authority we're talking about. But the point of self-direction is to give beneficiaries access to non-traditional providers. And so oftentimes, we see

states allowing individuals to select a family member, sometimes including, depending on the authority, a legally responsible individual. So typically, there are not any kind of statutory prohibitions about who in self-direction a beneficiary can reach as a provider.

As always, CMS would want to provide technical assistance to you on the specific authority that you're using to make sure we are on the right side of all these issues. And in a lot of cases, states have some discretion in terms of the type and extent of self-direction to utilize in a program and whether or not the ability to tap legally responsible individuals as providers exists under that self-direction. But typically there is not a federal prohibition, no.

(Ashley): Thanks, Melissa. The next question says, did you say that SPAs, specifically 1915(k)s, could be extended temporarily past the PHE?

Melissa Harris: Not for the 1915(k)s. I was probably talking about Appendix Ks that are associated with the 1915(c) waivers. Appendix Ks for C waivers have a lifespan at state option that can go up to 6-months post the public health emergency expiration. State plan amendments, the disaster relief state plan amendments that states have been submitting, and the 1135 flexibility, is associated with state plan services. Both of those will cut off definitively on the 11th of May.

(Ashley): Okay. The next question says, can you explain the interplay between the 1915(c) Extraordinary Care and Structure Family Caregiver benefit, that allows family members to be paid?

Melissa Harris: So I'll start by saying that I don't have familiarity with the structured family caregiver benefit. It could be something that is titled, a service has titled that in a particular state waiver. The extraordinary care piece comes in when a

state is requesting to have a legally responsible individual be a provider of services under a C or an I. And in that case, the state needs to distinguish the services that that individual would be providing and receiving reimbursement for from the services that individual would typically be providing absent the waiver.

A structured caregiver benefit, I imagine, could look very different depending on the types of people the state is defining as a family member in that case. They might be excluding legally liable individuals. But in that regard, we probably want to have a state-specific conversation with you. The extraordinary care standard applies really across the board, across the different waiver populations and different services that are rendered. So anything that's pretty state-specific, we would want to have a dedicated conversation with you to parse out. Thank you,

(Ashley): Thank you, Melissa. We'll transition to the phone lines at this point. So the other (Melissa), can you provide instructions to the states on how to register their question? And then if you could please open the phone lines.

Coordinator: Yes, ma'am. If you would like to ask a question over the phone, please press star followed by 1. Please make sure that your phone is unmuted and record your name clearly when prompted. If you wish to withdraw your question, you can press star 2. Please allow a moment for questions to come in. Thank you. Our first question comes from (Liz) over the phone. Your line is open.

(Liz): Hi. Thank you. Just a quick question, under the 1915(c) and (i) waivers. Could you give a few more examples of what constitutes extraordinary care, specifically some non-parent scenarios, or examples, thinking more along the lines of spouses, or adult children? Thank you.

Melissa Harris: That is a completely legitimate question that is going to pretty quickly exceed my well of knowledge. Do we have anybody from DLTSS who is on the line who could jump in? Hearing none, I would ask you to submit that question to us in writing. You know, I will say that, again, the extraordinary care is meant to reach the legally liable individuals, you know, that are in the life of a beneficiary. So if we're talking about a family member who is not legally responsible, like a cousin, you know, etc., an aunt or uncle, you know, that might not, you know, have to meet the parameters of extraordinary care.

But like I said, we are really getting outside my area of expertise. And so I'd like to bring in our subject-matter experts and would appreciate you sending that to us, so we can respond more formally.

(Liz): Sure. That would be great. What email should I send that to?

Melissa Harris: (Jackie), or (Ashley), what is the - I'm happy to give my own address, but is there one that you'd prefer for sending in an all state call follow-up?

(Ashley): I would suggest sending it to your state lead and then we'll make sure that we get it triaged to the right person.

(Liz): Okay. Thank you.

Coordinator: Thank you. Our next question over the phone comes from (Kathy). Your line is open. (Kathy), your line is open. (Kathy), are you muted?

Woman: (Melissa), I think we should move to the next question if we have one.

Operator; I'm showing no other questions at this time, ma'am.

Woman: Great. Thank you so much. So (Ashley), I'll send it back to you.

(Ashley): Sure. We have a couple of additional questions in the chat. The first one is about premiums. And it says, if the states continue to suspend premiums through a SPA extension during the unwinding period, is public notice required?

(Martha Meagher): Hi, this is (Martha Meagher). I can take that question. No. Public notice is not required to - oh, excuse me, I'm sorry. Public notice is required to extend a disaster SPA. And that is because a change in the sunset date of that disaster SPA is a substantial modification of cost-sharing policy. So prior to or during your process of submitting that disaster SPA extension, we can work with you to make sure that you have completed the appropriate cost-sharing public notice requirements.

For a disaster SPA extension, if the 1135 authority is available, then we can modify the public notice requirements to permit you to complete the public notice requirement after submission of that disaster SPA extension request and prior to the approval of it. But, it would still need to be completed prior to approval. No public notice is required for disaster SPAs that just sunset as they are currently scheduled to at the end of the PHE.

(Ashley): Thanks, (Martha). The next question says, on a prior call CMS stated that if returned mail is received after a case is closed at renewal, Medicaid must be reinstated if the state is able to confirm the address. CMS was going to provide additional guidance on the length of time after disenrollment that this would apply. Do you have the additional guidance that you can provide on this?

(Suzette): This is (Suzette). Can you all hear me?

(Ashley): Yes.

(Suzette): Thank you. So, we do not yet. We are working on that. We're working with just researching it more to understand return mail. But we hope to have a response to you all very, very soon.

(Ashley): Thanks, (Suzette). Looks like we have one more question and it says, regarding the 1915(k) and family caregivers who are legally responsible, did I hear correctly that there's no prohibition on this being allowed after the PHE?

Melissa Harris: So the 1915(k) is the Community First Choice program; the Community First Choice State Plan option. And you're correct that there is no prohibition on using legally responsible individuals as caregivers. Now, the state's got a couple of options for delivery system under that benefit. There's a self-directed option and an agency option. And states are in control of which or whether both of those options are used. So under the self-direction option, it's a pretty open runway to be able to access legally responsible individuals.

If the state has selected to use the agency option, those legally responsible individuals would need to have some kind of arrangement with that agency. But certainly we are available for technical assistance on both of those fronts.

(Ashley): Thank you, Melissa. We'll check the phone lines one additional time and we can take one more question. So can you, the other (Melissa), check to see if we have any questions and if you could provide instructions once again for registering the questions.

Coordinator: Yes, ma'am. Again, if you would like to ask a question over the phone, that is star followed by 1. Please make sure your phone is unmuted and record your

name when prompted. If you wish to withdraw your question, you can press star 2. Please allow a moment for questions to come in. Thank you. I'm showing no questions coming in.

(Ashley): Thank you very much. So in closing, I want to thank our team for their presentations today. Looking forward, the topics and the invitations for our next call will be forthcoming. If you do have questions that come up before the next call, please feel free to reach out to us, your state leads, or bring your question to the next call. So we thank you again for joining us. And we hope everyone has a great afternoon. Thank you.

Coordinator: Thank you. That does conclude today's conference. You may disconnect at this time and thank you for joining.

END