

HHS-CMS-INSTANT MEETING

February 7, 2023

2:00 pm CT

Coordinator: Welcome and thank you for standing by. I'd like to inform all parties that your lines have been placed in a listen-only mode until the question and answer session of today's conference call.

I'd also like to inform you that this call is being recorded. If you have any objections, you may disconnect at this time. I would now like to turn the meeting over to your host, Jackie Glaze. Thank you. 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 Anne Marie Costello, our Deputy Center Director, for opening remarks. Anne Marie?

Anne Marie-Costello: Thanks, Jackie, and hi everyone. Welcome to today's All-State Call. We are keeping our presentations brief today to make sure that we have time to take your questions on our unwinding guidance. You can feel free to start submitting any questions you have about unwinding or other topics into the Webinar chat now.

But first up today, we have a quick update from our Disabled and Elderly Health Programs Group. Annese Abdullah-McLaughlin will share some information about a new EPSDT contract that CMS has awarded. Then we'll be joined by a guest, Kim Glaun, from the Medicare and Medicaid

Coordination Office, who'll share updates on new Medicare rules that have implications for Medicaid beneficiaries.

After Kim's presentation, we'll take your questions. We'll use the Webinar for today's call. So if you have not logged into the Webinar platform yet, I suggest you do so now. And with that, I'm going to turn things over to Annese.

Annese Abdullah-Mclaughlin: Thank you, Ann Marie. CMS is excited to announce the recent award of the Medicaid Benefits and Coverage Oversight Early and Periodic Screening, Diagnostic and Treatment Benefit Contract to the National Opinion Research Center team.

The mandatory EPSDT Medicaid benefit is to ensure that children under age 21 enrolled in Medicaid receive all medically necessary screening, preventive, diagnostic, and treatment services to correct or ameliorate any identified conditions as specified in Sections 1905(a) and 1905(r) of the Social Security Act, and sections 44040(b), 440250(b), and 441 Subpart B in Title 42 of the Code of Federal Regulations.

The goal of EPSDT is to ensure that children in Medicaid receive appropriate health care at the right time, in the right place, and in the right capacity. CMS is committed to ensuring state adherence to EPSDT requirements and currently supports states through policy guidance and technical assistance to understand and implement the scope of services covered under EPSDT.

This contract is a continuation of CMS's commitment to achieving the goal of EPSDT through research, assessment, and analysis of state EPSDT services. Under this contract, the contractor will conduct a national environmental scan and case studies to gather quantitative and qualitative data to assess and

analyze state availability, delivery, and provision of EPSDT benefit services in accordance with federal statute and regulations, identify service gaps, deficiencies, and challenges as well as service innovation and best practices, establish a nationwide EPSDT service baseline, provide education and outreach and technical assistance to states, conduct state performance oversight and monitoring activities, comply with all EPSDT requirements in accordance with Section 11004 of the Bipartisan Safer Communities Act, and utilize data to further drive CMS strategic planning efforts to encourage and increase state compliance with federal statute and regulations.

While all aspects of work in this contract are important CMS is particularly focused on behavioral health service provision as we understand that this service area is challenging due to the lack of prompt and accurate screening, diagnosis and treatment, as well as the lack of qualified providers and access amongst other issues. Our contractor team will be reaching out to states to obtain vital EPSDT information to effectively perform data gathering and analyses for this important project.

CMS thanks you in advance for your cooperation, and we value your participation and feedback. This is a large, groundbreaking undertaking, and we look forward to working with you as you play a significant role in the improvement of healthcare for one of our most vulnerable populations.

Jackie Glaze: Thank you, Annese, for your update. So next, Kim Glaun from the Medicare and Medicaid Coordination's Office will provide updates on the new Medicare rule. I'll turn now to you, Kim.

Kim Glaun: Hi, everyone. Thanks for tuning in today. Again, I'm Kim Glaun from the CMS Medicare Medicaid Coordination Office. And I'm really pleased to be

here today to discuss Medicare's new immunosuppressive drug benefit and what it means for states.

We refer to this new limited benefit as Part B-ID. As of January 1, 2023, it's available to people whose Medicare entitlement would otherwise end 36 months after a successful kidney transplant. Individuals with low income may be eligible for the Medicare savings programs to pay some or all of their Part B-ID premiums and cost sharing.

Next slide please. First, you may be wondering what the Part B-ID benefit is, and who it's for. As some background, individuals of any age can be entitled to Medicare solely based on having end-stage renal disease or ESRD. Today, I'll refer to that benefit as ESRD only Medicare.

If an ESRD only Medicare beneficiary has a kidney transplant, their Medicare coverage continues for 36 months after the month in which they had the transplant. After a transplant, individuals must take immunosuppressive drugs to prevent their bodies from rejecting the new kidney.

If an individual has Medicare, when they got the transplant, Medicare Part B will cover this critical immunosuppressive drug therapy for as long as they remain eligible for and enrolled in Medicare. However, 36 months after the transplant Medicare coverage will end unless the individual otherwise gets Medicare for another reason. For example, individuals can become eligible for Medicare based on age or disability.

So once ESRD only individuals exhaust their 36 months of Medicare eligibility they lose Part B coverage for immunosuppressive drugs. Continuing this drug therapy could be impossible for them if they don't have another source of healthcare coverage.

Section 402 of the Consolidated Appropriations Act of 2021 created the Part B-ID benefit to help individuals afford to continue these essential medications. The new benefit is for individuals whose full Medicare coverage is ending 36 months after transplant and who do not have certain other types of health coverage.

This includes Medicaid coverage of immunosuppressants, Marketplace coverage, employer coverage, and TRICARE coverage. The Part B-ID benefit is different because it's a Part B benefit, but it only covers immunosuppressive drugs, there's no coverage of other Part A or B items or services.

It isn't a substitute for comprehensive health coverage. That's important because kidney transplant patients generally have other healthcare needs.

The implementing regulations for Section 402 are found in the CMS November 2022 Medicare Eligibility and Enrollment Rule. The link to that regulation is in the resource slide you'll find at the end of this presentation.

Next slide please. So how can eligible people sign up for and disenroll from the Part B-ID benefit? The primary way to enroll and disenroll is through the Social Security Administration's toll-free number, which is listed on this slide.

Individuals can also enroll or disenroll by completing and mailing CMS forms that are posted on the CMS Web site. You can find links to these forms in the resource slide at the end of this presentation.

As part of enrollment, the individual must complete what's known as an attestation. First, individuals must certify that they do not have certain other types of health coverage, as I mentioned Medicaid, that covers

immunosuppressive drugs and others, and that they do not intend to enroll in such coverage.

Second, they must agree to notify the Social Security Administration within 60 days of enrolling in such other coverage. Importantly, Medicare enrollment periods do not apply to the Part B-ID benefit. This means that individuals can enroll and re-enroll in the Part B-ID benefit at any time.

Keep in mind that there are no late enrollment penalties if individuals do not sign up when they first become eligible for the benefit. Coverage will start the first day of the month after they sign up.

Next slide please. Now, like other Medicare coverage, the Part B-ID benefit has associated premiums and cost sharing. In 2023, the Part B-ID premium is \$97.10 a month and the annual deductible is \$226. After the deductible, individuals pay 20% of the Medicare approved amount for their immunosuppressive drugs.

To help low-income individuals afford these costs Section 402 of the Consolidated Appropriations Act of 2021 expanded Medicare Savings Program eligibility to include individuals enrolled in Part B-ID. We refer to this benefit as MSP Part B-ID.

To qualify for it individuals must meet the income and resource requirements of the particular MSP eligibility group while also enrolling in Part B-ID. These MSP groups include the Qualified Medicare Beneficiary, or QMB group, the Specified Low-Income Medicare Beneficiary, or SLIMB group, and the Qualifying Individuals or QI group.

States will cover the Part B-ID premiums for individuals in the SLIMB and QMB groups. States will pay the Part B-ID premiums, deductible and coinsurance for individuals in the QMB eligibility group. As a reminder, individuals who have full Medicaid coverage, that includes immunosuppressive drugs, are not eligible for Part B-ID.

Next slide please. So as I've indicated eligibility for Part B-ID itself is narrow. For that reason we expect a small number of individuals to enroll in it each year.

Specifically, we anticipate that most of the individuals who would enroll would reside in states that have not expanded Medicaid coverage and are in what's known as the coverage gap. The federal income limit for the QMB group is the poverty line which is about - which is above the Medicaid income limit for Medicaid - the Medicaid income limit in most non-expansion states, but below the minimum income limit for Marketplace assistance.

Therefore, if an individual in a non-expansion state has QMB only coverage, when ESRD only Medicare coverage ends, they may choose to sign up for Part B-ID if they don't have other coverage. They would likely be eligible for the QMB benefit that is absent other changes in their circumstances.

Most other individuals who are enrolled in an MSP, when they lose ESRD Medicare, will have access to comprehensive coverage through the adult group or Marketplace with subsidies. Therefore, we do not expect them to enroll in Part B-ID.

For example, after losing QMB, SLIMB, or QI coverage, in expansion states, most individuals will be eligible for the adult group and enroll in it. This will make them ineligible for Part B-ID.

We also expect SLIMB and QI individuals who lose ESRD Medicare in non-expansion states to enroll in Marketplace with subsidies rather than MSP Part B-ID due to the limited benefits Part B-ID provides.

Next slide please. There are two ways for people to enroll in the MSP Part B-ID benefit. First, CMS will take steps to automatically enroll or roll over individuals who are in MSP - into MSP Part B-ID if individuals are enrolled in an MSP program when they lose Medicare ESRD coverage.

This only applies to individuals who enroll in Part B-ID by the 36 months after their transplant. So again, individuals will be rolled over - such individuals will be rolled over into the MSP Part B-ID if they have enrolled in Part B-ID before their ESRD only coverage ends.

We will notify states of this action through the state CMS buy-in data exchange. Second, individuals can also apply for an MSP after they enroll in Part B-ID.

Next slide please. We are providing education and outreach to help individuals maintain coverage as they transition off ESRD only Medicare. Each month the Social Security Administration, and CMS, will mail separate letters to individuals losing ESRD only Medicare.

The letters explain available health coverage options and list resources for further assistance. States will learn about Medicare ESRD termination through the same SSA and CMS systems they currently use to learn about these changes and other changes in Medicare status for beneficiaries.

We remind states that an individual's loss of ESRD only Medicare constitutes a change in circumstance that may affect ongoing Medicaid eligibility. States must redetermine all individuals enrolled in an MSP only, also known as partial Medicaid, from all Medicaid eligibility groups prior to termination including MSP Part B-ID.

However, states would only enroll individuals in an MSP Part B-ID if they are enrolled in Part B-ID already and continue to meet the MSP eligibility criteria. If the individual is ineligible for any Medicaid eligibility group, but potentially eligible for subsidies in the Marketplace, states would need to refer them to Marketplace.

CMS highly recommends that states conduct Medicaid redeterminations as early as possible. This will help transition individuals who lose ESRD Medicare to other coverage or Part B-ID without harmful gaps. To assist states in identifying these individuals early CMS is currently sending, to non-expansion states, monthly lists of individuals enrolled in partial Medicaid or MSP only whose ESRD coverage will be ending.

Next slide please. This resource slide includes a link to the final rule that includes Part B-ID and the Social Security prompt instructions on Part B-ID.

Next slide. The last resource slide includes other resources that you may find helpful like the CMS notice to beneficiaries who are losing ESRD Medicare, the Part B-ID enrollment and disenrollment forms for those who choose not to contact SSA, and CMS information on the Part B-ID benefit.

Next slide please. This slide lists CMS contacts for more questions. We're working to publicly release FAQs for states that include answers to commonly asked questions specifically those relating to operations and systems. Certain

resources are already accessible through the CMS case management tool states use for state buy-in.

That concludes my presentation. I'm happy to take questions during the Q&A session. Now back to you, Jackie.

Jackie Glaze: Thank you so much, Kim, for your presentation. So we are ready to take the questions now. So we'll begin by taking your questions through the chat function, so you can begin submitting them now. We have received a few already. And then we will follow by taking questions over the phone line. So we will hand it back now to you, (Ashley).

(Ashley): Thanks, Jackie. First, we have a clarification question for Kim. And it says, "Can you repeat how Medicare will notify states that an individual has Part B-ID coverage?"

Kim Glaun: Sure. So there are different ways that individuals can be reflected in our systems. So one way is through our normal eligibility feeds that we provide to states.

And we have a Medicare enrollment database. So we have information in our - and it's known as the EDB. And those - and that interface is available to states through different vehicles. One is an ELMO vehicle. There's also a vehicle called the TBQ. And there's also a vehicle in the MMA file, the state phase down file.

And we're going to update the Medicare enrollment reason code to show a value of P associated with the effective date and termination if applicable. SSA, Social Security Administration, will also notify states of the Part B-ID benefit on the (FENDX) file with a supplement, like a code. It's called the

Supplemental Medical Insurance Basis Code Value of I. And it will list the associated entitlement effective date.

And then also we would have the termination date in there as well. So that information, again, we'll hopefully include in our FAQs that will be released to states. Some of that is - much of that is also in the information that's available to the buy-in units in states through their case management tool with CMS.

(Ashley): Thanks, Kim. One more question for you. It says, "I missed the connection between the new Part B-ID benefits and Medicaid. Can you re-explain?"

Kim Glaun: Sure. So individuals who are eligible, or actually enrolled in Medicaid and that it covers immunosuppressive drugs, would be ineligible for the Part B-ID benefit. So it's not available to them.

However, individuals could qualify for what is known as partial Medicaid coverage, the Medicare Savings Program, to help cover their Part B-ID premiums and in some cases cost sharing if the individual qualifies for the Medicare Savings Program and has enrolled in Part B-ID.

(Ashley): Okay, then we have a question that says, this might be a little bit for you and for CAP. "The Consolidated Appropriations Act specifies that individuals must be determined eligible under all basis. This would include unmet spend down, correct? If an individual is eligible for an unmet spend down, are they still eligible for MSP B-ID coverage or would we need to grant both the unmet spend down and MSP B-ID?"

Kim Glaun: So I can take the - I can take some of the first bit and then maybe if CAP team colleagues want to jump in. The standard that states have to follow is what they would do for any redetermination.

So they have to determine eligibility on all basis. And that would include spend down for the individual. If the individual does qualify with the spend down, individual would be enrolled in that program - in the Medicaid program with the spend down.

When they have met their spend down they are not eligible for Part B-ID coverage. It's preferable and what we're trying to - the Part B-ID benefit is, you know, one way to think about it. It's not trying to replace comprehensive sources of coverage that people have, it's a coverage of last resort.

So if an individual has an opportunity to obtain full coverage through Medicaid that's what the state should enroll them in. The benefit under Part B-ID is for people who don't have or are ineligible, really, you know, ineligible for other forms of coverage. That's who it's intended for.

(Ashley): Okay, thank you. Then we have a question that says, "For a state that did not suspend premium beginning April 1, 2023, is it allowable to increase the premium for an individual who's being maintained eligible for Medicaid due to the continuous coverage requirement prior to their full renewal as long as the increase is consistent with the state's Medicaid premium schedule, and the premium schedule amounts must - did not increase over the amounts in effect as of January 1, 2020, or would doing this conflict with the maintenance of effort condition in effect through December 31, 2023?"

(Mark): This...

Woman: Hi. This is...

(Mark): ...is...

Woman: Oh, good. (Mark), are you on? Great.

(Mark): I am on, yes. I can give a - we are working on - we know this is a hot question for states, and we are working feverishly on getting specific guidance. I would refer you back to our October FAQs which talk about, in that context, they're about reinstating the - reinstating premiums at the end of the PHE and using recent income information for adjusting someone's premium.

And so I would encourage you to review those. Those obviously the context is a little different now because those were not - those were written before the CAA was enacted, but the same principles do apply which is a state will need to use - have recent income information to reinstate - should be using income information from the last 12 months to reinstate premiums.

And we're going to be providing further guidance in that area really soon, we hope. We are working very hard on that.

Woman: So (Mark), is it a fair statement to say if a state were to look at those October FAQs, and replace where it says end of the Public Health Emergency, what would that look like on March 31, 2020?

(Mark): Well I would - unless this was - and this is a state that did not suspend premiums, so they did not have a suspension of premiums then yes. I mean I think I would encourage them to look at those questions and send us a specific - reach out to their state lead, and we can help you sort of translate it.

But that's the basic principle that yes in a state that has not suspended premiums you're right. I agree. Yes you can substitute - you should be able to substitute - well yes I think so. But I would love - I would recommend reaching out look at those October questions and reach out to us for an individual TA I think is probably the most prudent way.

(Ashley): Okay, thanks (Mark). The next question says, "What is CMS guidance for situations when returned mail is received after the renewal due date and the state already closed Medicaid for failure to complete a renewal?"

(Suzette): Hi, (Ashley). This is (Suzette). Thank you so much for that question. I think we've heard it from a number of states and a number of forums, and we are working very hard to provide guidance about that question and a number of others in the return mail condition. So we hope to have an answer for you very soon.

(Ashley): Thanks, (Suzette). The next question says, "When we resend a renewal packet to the forwarding address, after returned mail is received, do we need to allow a new 30 day period to return the renewal or does the original due date stand? The renewal form may be for multiple benefits which may have different rules."

Sarah O'Connor: Thanks, (Ashley). So this is Sarah O'Connor with the enrollment team. And yes, if the renewal is sent again to the forwarding address, then the 30 days would start over again.

(Ashley): Thanks, Sarah. The next question says, "Does this pre-determination outreach via multiple modalities satisfy the needed outreach criteria for returned mail even before we know we have returned mail? The guidance doesn't say the modalities need to be used after the returned mail is received."

(Suzette): This is one of the other ones on our list that we are working to solidify guidance on and hope to have to states very soon.

(Ashley): Thank you, (Suzette). We're ready to transition to the phone lines. So, (Calvin), I'll ask that you provide instructions for registering their questions, and then if you could open the phone lines please.

Coordinator: Thank you. At this time if you would like to ask a question please press Star 1 on your telephone keypad. Please ensure your line is unmuted and record your name at the prompt. Again, that is Star 1 if you would like to ask a question.

Please stand by for our first question to come in. And our first question comes from (Jessica Pearson). Please ensure your line is open.

(Jessica Pearson): Hi, thank you so much. This is (Jessica Pearson) with Kansas. And I had asked a question about the unmet spend down in determining eligibility under all basis.

My question, I was going to ask for further clarification regarding the unmet spend down, understanding that this B-ID coverage is the coverage of last, you know, coverage of last resort. My question was, because an individual on an unmet spend down there's no - I'm wondering if we are also supposed to do this MSP B-ID at the same time, so concurrently with that.

Because if there's an unmet spend down then there's no benefit. They have to meet their spend down before there's a benefit to them, including payment of premiums. So how does the unmet spend down play into eligibility with the MSP B-ID?

Kim Glaun: So thank you. This is actually, this is Kim Glaun, and I appreciate the question and the opportunity to discuss it a little further.

So the question of spend down, in Part B-ID, is a little bit tricky when the person hasn't yet met the spend down. But what we know is just to think before the Part B-ID benefit individuals, who have ESRD Medicare - I mean and lose it, and then need a spend down probably would be using their - the cost of their health care which is usually very high to meet the spend down. And so we sort of would gather that that would probably be the best course for people to continue.

If an individual - but technically speaking, if an individual has not met their spend down they technically would be eligible to enroll in Part B-ID because they - their Medicaid - they do not have coverage of immunosuppressive drugs at that very moment. However, it is somewhat - it probably would not be in their best, you know, the best course for them.

It could not, you know, if they enroll in Part B-ID because they need, you know, they're using their Medicaid or they need to meet their Medicaid spend down using their health care cost. So I guess we wouldn't expect that to change.

And as long as the person hasn't enrolled in Part B-ID then you wouldn't refer them over to Part B-ID and say, "Hey, we see you've met spend down but right now go enroll in Part B-ID in the interim, and then we'll qualify you for an MSP." We wouldn't expect states to be taking that action.

But if you do see a case where you see an individual who has met their - who has not met their spend down, and you see that they've also enrolled in Part B-ID, we encourage you to contact us, CMS. You can send that individual, that

case, through the CMS case management tool that your state would - All-States are using for their state buy-in inquiries. And we can try to take a look at that case and try to help you analyze it further.

(Jessica Pearson): Okay, Thank you.

Kim Glaun: Was that helpful?

(Jessica Pearson): Yes. And it's really because, you know, if they're applying, and we're determining under all basis, we would have to include a spend down even if it's unmet. And there's just no benefit to them per se because we would have to determine that spend down before this MSP B-ID.

And the benefit would be the B-ID because they would get help with those premium costs unless they have excess expenses that would make them meet their spend down faster. So it just kind of seems circumstantial so I do appreciate the response and we will be sure to refer anyone who comes - we don't have any referrals yet, but if we do we'll be sure to reach out if we need guidance.

Kim Glaun: Thank you.

Coordinator: I'm showing no further questions. Again, if you would like to ask a question, please press Star 1 on your telephone keypad.

Jackie Glaze: Thanks, (Calvin). We'll transition back to the chat, and we'll circle back around to the phone lines. So, (Ashley), I'll turn to you.

(Ashley): Okay, the next question says, "Pre-CAA states were told they could not change asset test policies in disaster SPAs for some eligibility groups prior to

the end of the PHE due to the ARP HCBS MOE. Is that still the case post-CAA? And if so it will mean that people will be redetermined with different asset standards during the unwinding period."

Woman: Is anyone from the HCBS team on that can speak to this?

Melissa Harris: Hi, Ann Marie. It's Melissa Harris. And so I'll start and then maybe ask a CAP colleague to weigh in on the eligibility piece and the assets, the asset test.

So generally speaking, nothing in the CAA impacted the maintenance of effort implementation associated with 9817 of the American Rescue Plan. And I think we spoke to this in the most recently issued unwinding informational bulletin. There was some language in there that said that the MOE implications of the HCBS provision at ARP was not impacted by the CAA.

Your specific reference to reassessing people for Medicaid eligibility, and the fact that it might be a more restrictive standard, is where I'm going to need to hand you off to my CAP colleagues for advice on how that eligibility technicality fits in with the overall implementation. But generally speaking, the HCBS MOE provisions stand even as you undertake your eligibility unwinding activities. But Sarah or others in CAP I'm wondering if you can pick up on the eligibility piece. Thank you.

Sarah deLone: So this is Sarah deLone. Let me ask, is anybody from the Division of Medicaid Eligibility Policy on that can field otherwise, we may need to take that back.

(Ashley): Yes, it sounds like we'll...

Woman: Sarah, I think we're here, but I think it would be good to take it back.

Sarah deLone: Oh, great.

Woman: I think we should.

Sarah deLone: Thanks.

(Ashley): Okay, the next question says, "Can states maintain the suspension of premiums, and loss of coverage for nonpayment, through the redetermination slash renewal unwind period or would that be limited to September 30, 2024, through use of the temporary SPA extension process?"

(Mark): That is a good - this is (Mark) from (unintelligible) project. That is a good question. I mean it is certainly available through - you can extend your disaster SPA, as discussed.

And you can - there is the E14 option as well, which an E14 option would be available throughout the unwinding period. So that should not - that would not - both those options are - do remain available to states. And that should not be - I'm not sure I'm following the question about where - why it would end prior to the unwinding period.

(Ashley): Okay, thanks, (Mark). The next question says, "If the state wants to extend a disaster SPA past the end of the Public Health Emergency the state needs to submit the disaster SPA and the streamlined disaster SPA, correct?"

Jackie Glaze: This is Jackie, and I'll start. I'll start by saying that we will be providing some - a follow-up refresher on an All-State upcoming call, but I will say it depends

on what the state wants to do. So I would ask that you reach out to your state lead.

But if the state does want to extend provisions temporarily without modifications we do have a streamlined submission process and review process for these SPAs, but we have added a new section to the state plan for this. So just ask that you reach out to your state lead and we can get those instructions to you depending on what you'd like to do.

(Ashley): Thanks, Jackie. The next question says, "Can the MCO conduct outreach on a customer's returned mail on behalf of the state agency?"

(Suzette): Thank you. That was the third big question we are working on for states and hope to provide a response to very soon.

(Ashley): Okay, the next question says, "To tag on to the question about sending renewal packets to a forwarding address, if returned mail is received as a result of a request for additional information notice, and the additional information notice is sent to the forwarding address, are states required to give a new ten day due date for the additional information notice?"

(Suzette): (Ashley), could you repeat the question, please?

(Ashley): Sure, it says, "If returned mail is received as a result of an additional information notice, and the additional information notice is sent to the forwarding address, are states required to give a new ten day due date for the additional information notice?"

(Suzette): I think the answer is yes. I think that would assume that they sent the renewal form. The renewal form was received. If they provided 30 days for the

renewal form, they received information, and now they are reaching out again for additional information and receive return mail based on that correspondence.

And the state should allow for another ten days when they send to the new address or whatever the timeline is for that state in their own policy 10, 12, 15 whatever the state's policy is on providing the individual with a reasonable time period to return that information.

(Ashley): Thanks (Suzette). Then we have a question that says, "Is a person who is maintained eligible only because of their continuous - for a person who is maintained eligible only because of their continuous coverage requirement, does the state need to do a full renewal for that person prior to increasing their premium?"

(Mark): (Ashley), can you repeat that question?

(Ashley): Sure. "For a person who is maintained eligible only because of the continuous coverage requirement does the state need to do a full renewal for that person prior to increasing their premium?"

(Mark): I - yes. Yes you do. You need to follow all the usual processes. And again I would refer us back to our - the October FAQs on our Website. But all the normal processes must be applied including notice - before increasing someone's premium.

(Ashley): Thank you, (Mark). (Calvin), we'll transition back to the phone lines. Would you please provide instructions once again for registering the questions and then open from the phone lines, please?

Coordinator: Thank you. Once again if you would like to ask a question, please press Star 1 on your telephone keypad. Please record your name at the prompt, so I may introduce you. Again, that is Star 1 if you would like to ask a question.

One moment please for our first question to come in. And I'm showing no questions at this time. And I'm showing no questions at this time.

Jackie Glaze: Thank you, (Calvin), (Ashley), do I see another question.

(Ashley): Yes, it looks like we have one more. It says, "Any further guidance or information regarding the Carr case?"

Sarah de Lone: Hi. Yes, (Ashley), this is Sarah de Lone. Perfect timing because I just got cut off, but back in time. So I think if this person has heard, and others may or may not have heard, I can share a court order was issued on January 31, 2023, in Carr versus Becerra.

This is a case concerning the interim final rule that was issued by HHS in November 2020 which interprets Section 6008(b)(3) of the Families First Coronavirus Response Act. In the order the court certified a class consisting of all individuals who enrolled in Medicaid in any state on March 18, 2020, or later.

And as a result of the adoption of the interim final rule on November 6, 2020, either had their Medicaid eligibility reduced to a lower level of benefits, and were determined to be eligible for a Medicare Saving Program group, or will have their Medicaid eligibility reduced to a lower level of benefits and be determined to be eligible for a Medicare Savings Program prior to a redetermination conducted after March 31, 2023.

The court also ordered HHS to refrain from enforcing the challenge portion of the interim final rule with respect to members of the certified class through the close of business on March 31, 2023. The court also ordered HHS to reinstate its previous guidance with respect to the class members.

Finally, the court ordered HHS to inform state agencies of this revised position as to class members. On Monday, February 6, 2023, CMS sent a letter to each state Medicaid director to inform them of the court's order and the actions HHS is taking to comply with it.

Specifically, the letter explains that HHS will refrain from enforcing the challenged portion of the interim final rule with respect to the members of the certified class through the close of business on March 31, 2023, and that HHS reinstates its previous guidance with respect to the class members, so every state Medicaid Director should have one of those letters now.

Jackie Glaze: Thank you, Sarah. (Ashley), I see one additional question.

(Ashley): Looks like there's a follow-up. Well it looks like two questions that have just come in. First, again for Kim, there's a question that says, "For MSP B-ID you specified that states must refer to the Marketplace. Is that meaning via exchange or the information in our written notices?"

Kim Glaun: Sorry, you got cut off a little bit at the end (Ashley). You said, does that mean through, sorry? Could you repeat the last bit of the question?

(Ashley): Yes, well I'll just repeat the question. It says, "For MSP B-ID"...

Kim Glaun: Okay. Thank you.

(Ashley): ..."you specified that states must refer to the Marketplace. Is that meaning via exchange or providing the information in our written notices?"

Kim Glaun: So the current requirements to refer individuals to the exchange apply, so that's not a change. So basically states would need to affirmatively refer the individual to an exchange to determine whether that individual is eligible for the QHP. I would defer to CAHPG on what those specific parameters are.

(Suzette): It would be through the account transfer process for...

Kim Glaun: Thank you.

(Suzette): ...states and then however a state based exchange is set up whether it's a seamless in your system or whether you make an account transfer.

(Ashley): Okay, thank you. Then we have one more clarifying question on premiums. And it says, "For a state that did not suspend premium, for a person who is maintained eligible because of the continuous coverage requirement, does the state need to do a full annual renewal for that person prior to increasing their premium or can they increase the premium based on a reported change or semi-annual review in which income was recently verified?"

(Mark): Let me take that back. I - let's take that - I want to thank you for that question. That's a very specific question that we are - I want to make sure we are all in agreement on. And we'll get an answer to you as quickly as we can.

(Ashley): Thanks, (Mark). Thank you.

Jackie Glaze: I don't - yes, I don't see any other chat questions at this time.

(Ashley): I don't either.

Jackie Glaze: So, okay well, thank you. Okay, in closing, we want to thank the team for their presentations today. Looking forward the topics and invitations for the next call will be forthcoming.

If you do have questions before the next call please feel free to reach out to us, your state leads, or bring your questions to the next call. So we thank you again for joining us, and we hope everyone has a great afternoon. Thank you.

[End]