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Coordinator: Welcome and thank you for standing by. At this time, I'd like to inform all participants that today's call is being recorded. If you have any objections, you may disconnect at this time. All lines 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 Dan Tsai, our Center Director for opening remarks. Dan?

Daniel Tsai: Hi folks. Greetings. It was nice seeing many people -- was it really just last week? Last week -- last week and last week at NAMD. So in-person gatherings are just nice to see folks at. So for those of you that were there, thanks.

So jumping into today, I'll just give a brief kickoff. So we've got two items on for today. The first is as folks know, new federal statute that went into effect or was passed end of last year implements or mandates Continuous Eligibility for kids starting January 1, 2024. Many states have been in some of the various work group meetings. There have been some PowerPoint

presentations and such around how to implement. Half the states have implemented Continuous Eligibility for kids to date.

Last Friday -- I believe it was last Friday or the prior Friday, I forget which, very recently -- we released a State Health Official Letter walking through some additional guidance on how states should implement that statutory requirement for Continuous Eligibility for kids. So, Stacey Green, Kristin Pacek from our Child and Adult Health Programs Group will walk through that and be able to take any questions that folks have. And then Kirsten Baronio, our Senior Advisor for Behavioral Health here at CMCS, will then go through a Request for Comments, an RFI, if you will, that we recently put out on how best to implement MHPAEA, the Mental Health Parity and Addiction Equity Act. There's been a lot of discussion with states around that. We put out a call to a range of states and a range of stakeholders soliciting some very specific questions and comments from folks. And we're hoping folks will take a look at that and respond by December 4.

So, folks, you know we're using the webinar platform as usual to share any slides. If you're not already logged in, you can do that to see slides for today's presentation and also submit questions.

And with that, I'm going to turn it over to Stacey and Kristin. Thanks so much, everybody.

Stacey Green: Thank you, Dan. And good afternoon, everyone. And fairly close, not last Friday, but the Friday before. Very close. So, (unintelligible)...

Daniel Tsai: All the weeks blend together.

Stacey Green: I completely get it. It's so true. So before we discuss the guidance, I just want to say that we certainly recognize that there's a lot of information packed in the show letter and likely a lot to digest, particularly for states that will be doing CE for the first time come January. So there will be other opportunities for discussion. We'll be presenting on an upcoming ETAG call. And as always, we're available to provide individual TA to states.

Next slide please. I think we -- next slide as well. Thank you. One more shift.

So I'm going to start our presentation today with a quick overview of Continuous Eligibility for children under the CAA. Next, I'll spend a little bit of time talking about the pre-CAA CE state plan options. And then move on to some of the finer details of what CE will look like when it's mandatory in January. And lastly, I'll talk about submissions of CE-related Medicaid and CHIP SPAs.

The CAA makes amendments to Medicaid statute at 1902(e)(12) and CHIP statute at 2107(e)(1) to make it mandatory for all states to provide 12 months of CE for kids under age 19 with limited exceptions. And as Dan mentioned, the effective date is January 1, 2024. And we will be talking about the SPA admissions that they are required for all states that will be newly implementing CE and for some states that already have CE. Next slide please.

So CE for children has been a long-standing state plan option in both Medicaid and CHIP. The statutory and regulatory citations are listed on this slide just as a point of reference. But I do want to take a moment to flag an important point, which is that these regulations will continue to apply to mandatory CE in 2024 except where inconsistent with the CAA.

For example, we think it's important to note that under the existing state plan options, states may provide CE to a subset of the Medicaid and CHIP population, such as to kids that are under 19. States may also provide CE for a period of less than 12 months. These options will no longer be permissible under the CAA.

As of September 2023, we have about 22 states that have implemented CE in both Medicaid and CHIP, and additional nine states that have implemented in at least one program. So I think the fact that we have a little over 30 states that have experience with implementing CE means that in addition to CMS, these states can serve as a valuable resource for other states newly implementing the provision in 2024. Next slide please.

Under the pre-CAA state plan option, children determined eligible at application or during an annual renewal remain eligible for a 12-month period regardless of most changes and circumstances. Such as changes in income or household composition, loss of SSI for children eligible in Medicaid, or obtaining other health insurance for kids enrolled in CHIP. There are limited exceptions when a change in circumstance can result in termination of eligibility during a CE period under existing Medicaid and CHIP regulations, such as when a child turns age 19 or ceases to be a resident of the state.

In addition to the examples that you're viewing on this slide, our existing Medicaid and CHIP regs have exceptions for when there are requests for voluntary termination of eligibility, when the Agency determines that eligibility was erroneously granted or when a child dies. And for CHIP specifically, there are exceptions for when a child becomes eligible for Medicaid and update option when a family has not paid a premium. And I'll talk more about these exceptions relative to the CAA statute in a few minutes. Next slide please.

So now I want to turn just a moment to talk about the literature on CE. Since many states have experience with CE for kids, research on the impact of this policy is readily available. The research has shown that children who are disinvolved for all or part of the year are more likely to have fair or poor health care status compared to kids who have health insurance continuously throughout the year has been shown to reduce financial barriers to care for low-income families to promote improved health outcomes, and to provide states with better tools to hold health plans accountable for quality care and improved health outcomes.

Stable coverage also enables doctors to develop relationships with children and their parents, track their health and development, and to avoid expensive emergency room visits. It's also important to note that guaranteeing ongoing coverage helps ensure that children can receive appropriate preventive and primary care as well treatment for any health issues they experience. Next slide please.

Moving ahead to the CAA. We know that this legislation requires one year of CE for kids, but I want to take a moment to talk about who is eligible in a little bit more detail. For Medicaid, CE applies to all children under age 19 who are enrolled under the state plan in a mandatory or optional Medicaid eligibility group. And for CHIP, mandatory CE applies to all targeted low-income children enrolled in a separate CHIP under the state plan. This includes targeted low-income children covered from conception to end of pregnancy, which is also known as the on-board option. States are also required, the statute specifies that states are required to provide CE to children enrolled in Medicaid or CHIP under a Section 1115 Demonstration.

As you can see from the language under the second bullet of this slide, the CAA explicitly includes exceptions for children turning age 19 and those that are no longer a state resident. In addition, the legislation specifies that a child in CHIP who becomes Medicaid eligible and transfers to that program must remain in Medicaid for the duration of the 12-month period. Next slide please.

There are a few places where the CE statute enacted by Congress doesn't neatly line up with our existing regulations. If you take a look at this slide, you can see that the CAA does not explicitly include the voluntary termination, erroneous eligibility or death of child exceptions that are currently in Medicaid and CHIP regulations. But we clarify in the show that these regulatory exceptions will continue to apply as these are really considered program integrity measures.

In addition, and as many of you are aware, the CAA does not include the current state option to consider failure to pay premiums in CHIP as an exception to CE. And at an All State Meeting in June, we shared that states would likely not be able to terminate enrollment of children due to failure to pay premiums, but noted that the policy was still undergoing review. And as we speak, we're continuing to work through this issue and we'll be issuing a specific FAQ on this topic very soon. Next slide please.

Now let's talk a bit about how the effective date of CE works for new applicants and existing enrollees. So because the CE period is based on the effective date of the child's last eligibility determination -- and that can be as we know either initial application or last renewal -- children under age 19 currently enrolled in Medicaid and CHIP when a state first implements CE will receive CE for the remainder of their eligibility period based on the date of their last determination. And we know this is an important piece for the

states because it will likely require eligibility system changes for some states to go -- for some states. So let's go through an example.

Let's say that -- and we do have examples in the State Health Official Letter. I know it's sort of hard to talk it through in this sort of format. Let's say that (Mary)'s most recent determination of eligibility was completed in September 2023 and her current eligibility period began on October 1, 2023. Effective January 1, 2024, the state must provide (Mary) with CE for the remainder of her 12-month eligibility period. So in this example, that would be through September 30, 2024. And of course that's unless she experiences one of the required exceptions to CE that we discussed earlier, such as change in residency.

We also recognize that states are still in the process of unwinding and have some children whose eligibility was not renewed during the 12-month period preceding January 1, 2024. So states will need to conduct that renewal prior to the new CE period.

I'm now going to turn this over to Kristin, using the former last name, turn the presentation over to Kristin so she can talk a moment about two specific populations relative to the guidance provided in our show.

Kristin Pacek: Thanks, Stacey. Yes. So we unfortunately weren't able to make some slides for this. But we wanted to take a moment to talk about two particular populations that we discussed in further detail in the show. The first being incarcerated youth, and the second being From Conception to End of Pregnancy, the FCEP option.

So first, we're going to talk about incarcerated youth. And as you know, Medicaid and CHIP eligibility is impacted differently based on a child's

incarceration status. So first, we'll do an overview and refresher on Medicaid and then move to CHIP. So for Medicaid, incarceration status does not impact eligibility, but there is a payment exclusion that limits FFP to only inpatient services. Historically, states could either suspend or terminate an individual's eligibility while they were incarcerated to comply with this payment exclusion. However, the SUPPORT Act prohibited the termination of children from Medicaid. So states now must suspend coverage when a child who's enrolled in Medicaid becomes incarcerated. And as you'll see, we describe in more detail in the show, states may either adopt an eligibility suspension or a benefits suspension.

The current Medicaid CE regulations do not consider incarceration to be an exception to CE, and the CAA didn't change this. So that means that a child continues to retain their CE period even while they're incarcerated. So this is a little bit tricky, so just restating in a different way. Even if their Medicaid eligibility or their benefits are suspended, a child's CE period remains in place. But what exactly does that mean, that their CE period remains in place during a suspension? We talk a little bit more about this in the show.

For example, states that implement a benefit suspension generally will not be able to act on changes in circumstances like an increase in income during the child's CE period. However, they may be able to act on changes that are permissible exceptions to CE that Stacey was talking about earlier. But for states that may implement an eligibility suspension, the state has to determine if the child's still eligible for Medicaid before they can provide any inpatient services. So if it's been over 12 months since the child's last eligibility determination, the state needs to complete a redetermination to see if they are still eligible before turning their benefits back on to provide the inpatient services. However, if a child is still within their CE period, the state knows

that an eligibility determination was done within the last 12 months and the child is still eligible, so they can provide the inpatient services.

I know that was quite a bit packed in there. And so we're happy to take questions that you have and reach out to your Medicaid state lead to get more details on how this interacts with suspension strategies for Medicaid. But now we're going to turn to CHIP.

So unlike Medicaid, CHIP statute says that a child can't enroll in CHIP if they're incarcerated. The only exception to this eligibility exclusion is if a child is enrolled in CHIP and they then become incarcerated at some point within their CE period, they can stay in CHIP until the end of their CE period. However, if a child is still incarcerated at the end of their CE period, the child must be disenrolled from CHIP.

Since children remain eligible until the end of their CE period and CHIP doesn't have a payment exclusion like Medicaid, our policy to date has been to require states to pay for needed services under the CHIP state plan that are not otherwise covered by the carceral setting during a child's CE period. But as we discussed in the show, we're revising our policy to clarify that separate CHIPs must either continue to provide coverage of CHIP state plan services not otherwise paid for by the carceral setting while the child's incarcerated until the end of their CE period. Or states may implement an eligibility or benefit suspension similar to Medicaid while the child is incarcerated until the end of their CE period.

Regardless of whether the state elects to provide CHIP state plan services or to suspend coverage, we want to emphasize that during a CE period, states are not permitted to terminate eligibility for children who become incarcerated. And this is an important distinction. During this time, states can choose

whether or not they want to provide benefits, but they cannot terminate eligibility during a CE period. However, as we talked about a little earlier, when a child's CE period ends, the state must terminate a child's CHIP coverage if they remain incarcerated at that time. And this option is only available -- this suspension option that we just discussed -- is only available to states that provide CE currently prior to January 1, 2024. But all states will be able to elect the suspension option after January 1, 2024 when CE becomes mandatory for all states.

And finally, we wanted to note that there's another section of the CAA that will be making other changes to CHIP eligibility for this population effective January 1, 2025. Under Section 5121 of the CAA, states will no longer be permitted to terminate CHIP coverage even if their CE period ends and a child is still incarcerated at that time. But states may suspend their coverage. And we're working on additional guidance in that area. So stay tuned there.

And then finally, switching gears a little bit to the From Conception to End of Pregnancy option, otherwise known as the Unborn. And as you know states have this option to provide coverage beginning from conception to the end of pregnancy in order to provide prenatal care and other pregnancy related benefits to pregnant individuals if they're not otherwise eligible for Medicaid or CHIP. And as Stacey mentioned earlier, states must provide CE to the FCEP option in the same manner as CE for other target low-income children, except the duration of the CE period for the FCEP population will depend on how states pay for labor and delivery services.

If Emergency Medicaid pays for the labor and delivery, the newborn will be deemed eligible for Medicaid at birth. And so, the child is automatically eligible for continuous coverage in Medicaid until their first birthday. And because the newborn is eligible for Medicaid, the CE period that began in

CHIP, when they were found effective for their coverage under the FCEP option, that CE period ends at birth because now they're eligible for Medicaid. However, if CHIP pays for the labor and delivery, the state needs to screen that newborn for potential eligibility for CHIP now that they're born, because many of these infants will likely be eligible for Medicaid now that they're born.

If the screening identifies potential eligibility for Medicaid, the state must transition the newborn to Medicaid for the remainder of their 12-month CE period. And as we discussed in the show, states may also potentially choose to provide a new 12-month CE period in Medicaid from the date of that determination if the state has enough information available to it for all eligibility criteria without requiring additional information or documentation from the family. But if the screening does not indicate potential eligibility for Medicaid, the state must maintain the newborn's coverage in Medicaid for the duration of the 12-month CE period.

And similarly, if the state does the screening and it appears that the child remains eligible for CHIP, they can also choose to do a new 12-month eligibility period for CHIP if they have all the information that they need without reaching out to the family for more information. And I know that was also too, a lot of information that we packed in there. And we know that the unborn in particular is very specific state to state. And so we, you know, encourage you to reach out to your CHIP Project Officer as you kind of think through what impact this may have on your state, and we'd be happy to give you more TA on this as you think through this new policy.

But now I'm going to turn it back over to Stacey to talk a little bit more about the SPAs that states are going to need to submit for the new mandatory CE provision.

Stacey Green: Thanks, Kristin. So, as I mentioned earlier, all states that are newly implementing CE for children in Medicaid or CHIP will need to submit a SPA. In addition, states that currently have CE will need to submit a SPA if they impose restrictions that of course are no longer permissible under the CAA. Such as only applying CE to a subset of children, such as kids at an age younger than 19, or if the state has a CE period that is shorter than 12 months. And if you have any questions, if you do deviate from the new provision in the CAA, please just let us know. We're happy to take a look at that.

In order to meet the January 1, 2024 effective date, states will need to submit a SPA in Medicaid no later than March 31, 2024. And in CHIP, no later than the end of the state fiscal year in which January 1, 2024 falls.

We do plan to provide updated SPA templates soon. If the state would like to submit now, we can certainly accept the submission on the existing template. We note that the new template, if the new template is released while your SPA is pending, we'll need to work with you now to transfer the information to the new template. We also encourage states just to submit draft SPAs in advance or to seek technical assistance in advance of the submission date. We think that will make the SPA process run more smoothly.

Next slide please. For some reason, I don't see the slide moving, but maybe it's just my screen. It looks like we're still on CAA 2023 CE effective date. Is it? Okay. And then next slide. Key takeaways please. Perfect.

So here are some of the key takeaways for states. Current CE regulations will continue to apply to CE after January 1, 2024 unless and consistent with the CAA 2023, states continue to have the option to implement CE prior to implementation of mandatory CE in 2024. SPA submission in Medicaid and

CHIP is required for all states that will be newly adopting and for some states that already have CE. So please do, as Kristin mentioned, reach out to your Medicaid Leader and CHIP Project Officer with any sort of questions about the SPA submission. And CMS will also release FAQs on the CAA 2023 CE requirement, including an FAQ on the non-payment of premium exceptions.

I think that covers it for this presentation. I am going to turn it over to Kirsten Beronio now to talk about MHPAEA. Thank you.

Kirsten Beronio: Thanks, Stacey. Yes, I'm going to talk to you this afternoon about Mental Health and Substance Use Disorder parity and our quest for comment that we issued on September 29, posted on to medicaid.gov. So we can go to the next slide, (Krista).

So, and I just did want to mention at the outset, we will add the link to the Request for Comments to the slides before we post them. But if you want to go directly to that document, which we posted on medicaid.gov, you can find it by going to our Behavioral Health page and then to the Parity section of medicaid.gov. Or it was also announced in the CMS Roundup that's in the Newsroom tab on cms.gov last Friday, so October 6.

But in general, you know, we've worked for many years now closely with our state partners on implementation of parity in Medicaid and CHIP. We view it as really essential for improving access to care for enrollees who need Mental Health or Substance Use Disorder treatment. As mentioned, the Mental Health Parity and Addiction Equity Act of 2008 is sort of the foundational statute. Most of those provisions do apply to certain portions of the Medicaid and CHIP, Medicaid enrollee population, all of the CHIP enrollee and all of the ABP populations are covered. But the way that MHPAEA is sort of carried over into Medicaid and CHIP varies depending on those different benefit

arrangements. So, for Medicaid MCOs, there's a provision in Section 1932 that's cited there of the Social Security Act that references MHPAEA. There's the parity requirements in Title 21 for CHIP. And then the Affordable Care Act included parity requirements for Medicaid Alternative Benefit Plans, adding a section, subsection entitled in Section 1937.

And you know, we did want to point out that because of these various ways that MHPAEA has been sort of brought over into Medicaid and CHIP, there is a gap. So, for beneficiaries who are just receiving fee-for-service, non-ABP fee-for-service benefits, there is not a parity requirement. Although we have, you know, tried to encourage states to provide protections to all enrollees. So next slide please.

So I just wanted to provide a brief overview of the parity requirements. These aren't -- we're not proposing to change these. This is just a reminder kind of an overview that was included in the Request for Comment as a reminder. So in general, the federal parity law requires that financial requirements, which includes things like co-insurance and co-pays and treatment limitations, which includes any limits on the number of outpatient visits or inpatient days et cetera, that those kinds of requirements and limits that are imposed on Mental Health or Substance Use Disorder benefits cannot be more restrictive than the predominant requirements or limits that apply to substantially all medical and surgical benefits in the same classification of benefits. So that's a lot of words and a complicated standard. You know, some of the, you know, things like predominant and substantially all are very specifically defined in the regulations, so have very important meaning. And we're not proposing to change any of that. It's just that's the basic standard.

And then in terms of the classifications, how you apply that standard, it's you look at you don't just apply it across the board to behavioral health versus

medical, it's kind of broken down into different types of benefits. And the ones that we specifically look at, Medicaid and CHIP, are inpatient, outpatient, emergency care, and prescription drugs. The treatment limitations were further specified in regulations to include both quantitative and non-quantitative treatment limits. Those are the types of treatment limits that parity does apply to.

And some of the more common non-quantitative treatment limits include things like prior authorization and concurrent review requirements, formulary design, standards for provider admission, et cetera. And there is a specific standard specified in the regulations around non-quantitative treatment limits that basically focuses on the strategies, processes, evidentiary standards or other factors that are used in determining how to manage, you know, Mental Health and SUD benefits as compared to medical-surgical benefits in the same classification. So next slide please.

So what we are kind of focusing in on with this Request for Comment has to do with the processes we use for working with states on ensuring compliance and parity in Medicaid and CHIP. We did issue regulations, our final rule in 2016, that really specified how the parity requirements apply to Medicaid Managed Care Organizations, CHIP, and Medicaid Alternative Benefit Plans. That included some requirements around how states have to demonstrate compliance with Medicaid, particularly with regard to the Managed Care enrollees. So specifically, when benefits are split between a Managed Care arrangement, an MCO and some other Managed Care plan, or between a Managed Care organization and some part of the benefits are in fee-for-service, there is a requirement that the state provide documentation of compliance. And that has to be updated whenever there's a change that might affect compliance. Similarly, in CHIP, states are required to provide documentation demonstrating compliance with parity as part of a state plan

amendment process. And with the Medicaid Alternative Benefit Plans, there is also a requirement to demonstrate parity compliance as part of a state plan amendment process.

So, you know, as you may be aware, there were some changes to MHPAEA in the Consolidated Appropriations Act of 2021 that specified some documentation requirements for the private insurance plans. Those don't directly carry over. There are exceptions made for Medicaid and CHIP in part because I think we already have these requirements that we put in place through regulation. And we do have, you know, there is a regulatory process underway whereby the agencies involved in regulating private insurance have proposed how to implement those new requirements in the CAA of 2021. That is an ongoing process. And as I mentioned, we have separate CHIP and Medicaid regulations that we are implementing and that this Request for Comment is specifically tied to. So next slide please.

So, in light of this activity, you know, kind of examining how to implement these new CAA of 2021 regulations for private insurance, as well as in light of concerns that we've heard from certain stakeholders about challenges and continued challenges in accessing Mental Health and Substance Use Disorder treatment for Medicaid and CHIP enrollees, and also from state agencies about administrative burden related to the processes in place. We did put out this Request for Comment at the end of September. And I'm just going to provide a quick overview of those questions that we are hoping to receive some input from you all on.

So, the first question, we're looking for information around what kinds of model format, for example, a template, key questions, some way to really improve the efficiency of gathering the information we need, and the effectiveness of reviewing documentation around compliance with parity. And

we've gotten some suggestions in the past about ways to do that, but looking for ideas along those lines.

Similarly, we're looking for input and information on processes states and Managed Care plans are already using to determine compliance with parity to see if there's, you know, lessons learned there. We're also looking for information on key issues related to, you know, reviewing documentation of compliance with parity, particularly around the non-quantitative treatment limits and how to best review documentation of compliance with parity requirements for those kinds of treatment limitations. We are wondering if there are particular NQTLs that people think it's important to really prioritize for review. And what criteria we should use for identifying those high-priority NQTLs for review. Next slide please.

Really importantly, looking for input on how we might look to data, quality measures, other kinds of performance measures that would help us identify if there's a potential parity violation in a Managed Care Arrangement or Medicaid ABP or CHIP. In the Request for Comment, we included this list of examples primarily to really encourage some thinking and some good feedback on this particular topic. So some ideas that have been, you know, suggested in other -- with regard to other issues similar, but other arenas include comparison of rates of coverage being denied for Mental Health and SUD versus med-surg. Comparison of average and median appointment wait times between Mental Health and SUD versus medical and surgical. Comparison of payment rates for providers, Mental Health and SUD compared to medical and surgical. Comparison of prevalence of Mental Health and SUD among certain groups of enrollees. And then looking at the percent of those groups who receive mental health concessions compared to how that particular comparison plays out on the medical-surgical side. And comparison of the average time from the receipt of a claim to payment for

Mental Health and SUD versus medical and surgical benefits. And finally percent of Mental Health and SUD network providers who are actively submitting claims compared to medical and surgical providers to try to get at the issue of, you know, whether the network adequacy issues. So next slide please.

We also just wanted to kind of open it up for any other kinds of suggestions around measures to be thinking about for really identifying when there is a problem with compliance with parity and when we might really focus in on, you know, very comprehensive analysis. Some areas of interest include, again, the reimbursement rate issue and whether a comparison of the methods used for determining rates could be helpful. Credentialing standards, if there's a way to compare what's required in terms of credentials for the different Mental Health and SUD versus med-surg, or if there's a way -- procedures for ensuring that the network is adequate first, you know, different approaches being used for Mental Health and SUD versus med-surg, if that's problematic and should be looked at.

So, you know, we also wanted input on whether there's specific terms that should be defined to really make clear how collection and evaluation of data would be carried out. And then also looking for mechanisms for collecting the data, what stakeholders think would be the best approach to actually, if there are existing requirements that we have in place that should be looked to, or other ways to really examine this data and identify issues if there are any. So next slide please.

And these are the final set of questions we included in that request for input. If there's recommendations around particular approaches to following up when data or measures indicate there may be a problem with parity compliance, and whether there's other ways to think about this whole endeavor. It's perhaps

random audits might be a better way, a more efficient way to find whether or not there are issues with compliance.

And then some other important considerations that we would love to get input on have to do with whether there are particular Mental Health or SUD conditions that are more prevalent among enrollees of Medicaid MCOs, ABPs or CHIP, and what are the barriers to accessing treatment among enrollees with those conditions, as well as whether there are any particular types of treatment or conditions where there's at risk of being, you know, they're not being in compliance with parity.

So those are sort of the general topic areas we listed out in the Request for Information. We are collecting comments, as you can see on that slide, via a dedicated email inbox, medicaidchip-parity@cms.hss.gov, and would ask that you submit those comments by December 4 in order to receive full consideration.

So I think that concludes my presentation. And I will turn it back over to (Krista) or Jackie.

Jackie Glaze: Thank you. Thank you. Thank you, Kirsten. So, appreciate your presentation. We're ready to take state questions at this point. So please ask questions about today's presentation or if you have other general questions that you may have questions about. We'll start by taking questions through the chat function. So you may begin submitting your questions at this point. And then we'll follow by taking your questions over the phone line.

So, (Krista), I'll turn to you.

(Krista): Great. Thanks so much, Jackie. I do have a couple of questions in here right now about Continuous Eligibility. So, the first question here is, are states required to provide Continuous Eligibility to children in waiver categories that have a limited number of slots for a given category or that have a level of care or other requirement as part of the waiver?

Stacey: This is Stacey. I think the answer to that question is, no. But maybe we need to look into that just to be certain.

((Crosstalk))

Sarah deLone: Yeah, I think...

Stacey: What do you think?

Sarah deLone: I think we should take that back, Stacey.

Stacey: Okay, Sarah.

Sarah deLone: There may be some extra complications that we should think through.

Stacey: Sounds good.

Sarah deLone: Thank you for that question.

(Krista): I have one other question or a few other questions actually here. But the next one is, if a child no longer meets the level of care requirements for the waiver category, would a state be required to keep the child enrolled in the category for 12 months?

Sarah deLone: This sounds like a very similar question. And I think the answer is going to be sort of parsing out retaining coverage under the eligibility group to which the waiver service is attach versus actually having to continue the waiver services. And I think we need to be consulting with our waiver experts, our HCBS waiver experts to make sure we're pulling those things together accurately. So, and what implications there may or may not be for the waiting list. So it sounds like, (Krista), I get this similar question, and we'll take that back.

(Krista): Great. Sounds good. Another one here around the CE show is if the pregnant individual is a minor, does she get CE or is the coverage for the unborn baby and not for the pregnant minor? Thank you.

Sarah deLone: Sounding like we may need a little more information. Stacey, it's sounding to me -- this is Sarah deLone, by the way. It's sounding to me like there may be a little bit of confusion about whether we're talking about, you know, if a child is, if the coverage is through the unborn child option, you know, technically the enrolled individual is the unborn child, wouldn't matter whether the pregnant individual is a minor or not, or whether the question is getting at, you know, where you have an individual under age 19 who's pregnant, and they're both entitled to Continuous Eligibility. And then also it's a state that has picked up the ARP option to provide 12 months of continuous postpartum coverage, how those two interact. So I'm going to suggest that the questioner reach out to their state lead so we can connect with you and get more specifically about what exactly you're asking about.

(Krista): All right. Thank you so much. The next question here is, when will the new MA SPA template be available?

Sarah deLone: I don't think we have anybody on our team. I don't think we have an exact date yet. We are working on that and appreciate that you need that in order to

submit your state plan amendment, which will be due the end of the first quarter for the calendar year for Medicaid, by the end of your fiscal year for your separate CHIP SPAs. But if you have, we can certainly, you know, work with any state that's ready to get going offline. So reach out to your state lead if you are ready to sort of get rolling with your SPA and we can provide some Technical Assistance. Even pending the publication of the SPA template.

(Krista): Great. Thank you so much. At this point, I don't see any other questions in the chat. So if anyone else has any additional questions, please feel free to drop them in the chat. But Jackie, maybe we want to open this online.

Jackie Glaze: Yes. That sounds great. Thank you. So I'll ask the operator to provide instructions for registering the questions. And then if you could please open the phone lines. Thank you.

Coordinator: Yes, ma'am. If you would like to ask a question over the phone, please press Star followed by One. Please make sure your phone is unmuted and record your name when prompted. If you wish to withdraw your question, you can press Star Two. Please allow a moment for questions to come in. Thank you.

I'm not seeing any questions coming in the phone yet.

Jackie Glaze: Thank you. And I'm not seeing any additional questions through the chat function. So we'll give it another few minutes to see if we have and additional questions. (Missy), are you receiving any questions come through.

Coordinator: No, ma'am. I'm not. I'm not seeing any on the phone.

Jackie Glaze: Okay, thank you. (Krista), I'm not seeing any either. Are you through the chat?

(Krista): No. No additional questions through the chat. Thanks.

Jackie Glaze: Okay. I think we'll go ahead and close early today. So, in closing, I'd like to thank our team, Stacey Green, Kristin Pacek, and Kirsten Beronio for their presentations. Looking forward, we will provide the topics and the invitations for the next call. If you do have questions that come up before we speak again, please feel free to reach out to us, your state leads, or bring your questions to the next call. So, we do thank you for joining us today. 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