HHS-CMS-CMCS

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2:00 pm CT

Coordinator: Welcome and thank you for standing by. At this time, all participants are in listen only mode. During the Q&A session, if you'd like to ask a question, you may press star 1 on your phone. Today's call is being recorded. If you have any objections, you may disconnect at this time. I will now turn the call over to (Jackie Glaze). Thank you. You may begin.

Jackie Glaze: Good afternoon and welcome everyone, to today's all state call and webinar. I'll now turn to Dan Tsai, our Center Director, for opening remarks. Dan?

Dan Tsai: Thanks. Good afternoon. Good noon. Good morning, everybody. Welcome to today's all state call. We're going to touch on two topics, two important topics, and then open up for Q&A, and a whole range of things. The first - I'll give a quick update for folks on what you may all have seen an announcement on a proposed DACA ruling that folks are putting forward; that we're putting forward. And then second, we'll cover a justice involved reentry SMDL that was released yesterday.

And Nancy Kirchner from our Disabled and Elderly Health Policy Group and Danielle Daly from our State Demonstration Group, will together, walk through that SMDL, of which we've been engaged with our range of states, and we're quite excited about. And then we'll go to open Q&A. So first, DACA folks may have seen last Thursday, April 13, we submitted a proposed

rule to OMD, and that rule has got a long title. I'll read it formally. It's called Clarifying Eligibility for a Qualified Health Plan Through an Exchange Advanced Payments of PTCs, Cost Sharing Reductions, BHP and for Medicaid and CHIP.

That is procedurally the next step and the standard regulatory review process. And we expect the proposed rule to be released in the coming weeks. The proposed rule, if it's finalized, would amend the definition of lawfully present, to include recipients of the deferred action for childhood (unintelligible) program, which we know as DACA, or DACA recipients, for purposes of the marketplace, the basic health program, or BHP, or Medicaid and CHIP, in states that have elected the CHIP Section 14 option.

And under marketplace coverage, DACA recipients may be eligible for financial assistance like the advanced premium tax credits. So that's the core of what we've noted would be in the proposed rule. The effect of it, if finalized, is that it would provide uninsured DACA recipients through these healthcare coverage programs for the very first time. We have nearly 580,000 DACA recipients who arrived in this country as children. We certainly have DACA protections and roughly, a third have reported that they do not have health insurance coverage.

On the Medicaid CHIP side of the house, I think as most folks know, the CHIP 214 option covers lawfully residing children and pregnant individuals. In currently 34 states and the District of Columbia and three territories have elected the CHIP 214 option to cover lawfully residing kids, children. And 25 states, DC, and three territories, have elected the CHIP 214 option to cover lawfully residing, pregnant individuals, all of which would be subject to the 5-day waiting period. So, once the proposed rule is released in the coming weeks, we would welcome and ask for public comments.

If you have questions, or you have more questions about what the CHIP 214 option is for your state, just to reach out to your CMS state lead. So we're excited about that. I'm sure folks will have a range of comments for us on that. And we wanted to make a note of that on the call today. With that, I'm going to turn it to Nancy and Danielle to start the discussion on the justice involved 1115 general opportunity that we just put the State Medicaid Director Letter out about yesterday. So, Nancy and Danielle, I'll turn it to you. Thanks.

Nancy Kirchner: Thank you very much, Dan. And hello, everyone. My name is Nancy Kirchner. And I first want to start with please advance the slide. As Dan mentioned, we are going to be going over the State Medicaid Director Letter that was just released yesterday, about the Section 1115 demonstration opportunity that focuses on reentry for individuals. Next slide, please. So let's go ahead and start off with Medicaid and the inmates of a public institution, or for incarcerated individuals.

So in Medicaid, there is a longstanding statutory exclusion for payment for services to individuals who are incarcerated. This is often referred to as the inmate exclusion or the inmate payment exclusion. Next slide, please. And so while incarcerated individuals may be eligible for Medicaid and enrolled in Medicaid while they're incarcerated, no services may be paid for, with the exception of inpatient services in a medical institution. Next slide, please.

So in Section 5032 of the Support Act, there is a provision called the Medicaid Reentry Act. And in that provision, it directed the Secretary of Health and Human Services to convene a stakeholder group to look at best practices for transition for individuals who are incarcerated, to develop those best practices and then submit a report to Congress on those best practices.

And then the third component from that provision directed the Secretary through the Administrator of CMS, to issue a State Medicaid Director Letter based on those best practices, about a Section 1115 demonstration opportunity to help individuals who are incarcerated transition back to the community. And at the bottom of the slide you can see the progression where we landed yesterday, with the release of the State Medicaid Director Letter on this opportunity. Next slide, please.

So looking a little bit at the demographics and some research about individuals who are incarcerated, numerous studies all demonstrate that incarcerated individuals have very high rates of physical and behavioral healthcare conditions. Some of the demographics and statistics that we have on individuals in prisons and jails, show in the 30% and 40% of those individuals with mental illness. The rates for substance use disorders of incarcerated individuals, are even higher than that; a national average around 65%.

And individuals with physical health conditions have this similar high proportion in the incarcerated population, with hypertension, asthma, tuberculosis, HIV, arthritis, and hepatitis among some of those physical health chronic conditions. So clearly improving healthcare transitions for incarcerated individuals is critically important. And many of these individuals who are incarcerated, are Medicaid eligible. Access to services on both a pre and post-release basis from incarceration, may provide these individuals with more stability. Next slide, please.

So in this 1115 demonstration opportunity, CMS has established some goals that we expect states to address. It is important that states look at increasing coverage, continuity of coverage, and appropriate service uptake through assessment of individuals' eligibility. Second, improving access to services,

both prior to release and to improve transitions upon release. Third, to improve coordination and communication between carceral systems, correction systems, Medicaid systems, and all of our providers on that side, systems that have not historically communicated well with each other.

Fourth, increasing additional investments in healthcare and related services that will help improve the quality of care in both carceral settings and in the community once individuals are released. Fifth, improving connections between carceral settings and community services upon release to help with addressing physical, behavioral health, and health-related social needs. And six, reducing all cause deaths in the near term post-release. Data shows us that individuals released from incarceration, particularly in the first two weeks, experience very, very high rates of death, some studies showing as much as 40 times higher than the general population.

And finally, reducing the number of emergency department visits and inpatient hospitalizations, through better preventive and routine healthcare services. Next slide, please. Considering quality and health equity, states should look at how to advance the quality of care and close health disparity gaps, by promoting access to coverage, care, assisting with transitions to the community, and improving quality of services. And also, as I mentioned before in one of our goals, addressing the health-related social needs of this population.

CMS strongly encourages states to engage individuals who have lived experience with incarceration, in both their demonstration design and implementation. This is echoing a recommendation from the stakeholder group, research that we went through in writing the SMD letter, and also echoed in the report to Congress. Next slide, please. So who's eligible for this

demonstration? This is for Medicaid eligible individuals who are currently incarcerated and close to release.

This could include current Medicaid beneficiaries, and it also could include individuals who are not currently enrolled, but may be eligible. States have the flexibility to choose from either all eligible Medicaid, Medicaid eligible individuals who are incarcerated, or to target the population further. And if they target, they should establish identification criteria. So some states may choose to target the population to individuals who have specific conditions, such as substance use disorder, serious mental illnesses, chronic physical healthcare conditions, or some combination.

And also as states develop the identification criteria and processes to identify individuals, if they target the population, should be mindful to establish criteria in ways that don't overlook individuals who have undiagnosed health conditions. Next slide, please. Medicaid eligibility and enrollment - very important. As I mentioned earlier, this is for Medicaid eligible individuals or for individuals who are not currently enrolled, but could be Medicaid eligible.

So states should work with correctional facility partners to start the application process and assist already incarcerated individuals to apply for Medicaid. A state should assist with applications upon incarceration and no later than 45-days before the individual's expected date of release. Once enrolled, states are expected to suspend and not terminate eligibility. There are a couple of reasons for that. Suspending rather than terminating eligibility, supports the goals to ensure that states limit coverage and payment to authorize Medicaid benefits and services during incarceration.

And to make coverage and payment for the full Medicaid benefits to which an individual would otherwise be entitled upon release, to be available as soon as

possible after that individual is released from incarceration. Now we recognize that some states may not be able to do suspension now. They may be terminating eligibility, and they may propose alternative policies and procedures while they implement suspension. And CMS is willing to provide up to a 2-year glide path to fully implement suspension. Next slide, please.

Continuing in Medicaid eligibility and enrollment, states may utilize presumptive eligibility to connect individuals to coverage. Permitting local jails and prisons to serve as qualified entities, allows them to make determinations of presumptive eligibility prior to a person's release, providing immediate access to health coverage upon reentry, while the individual applies for Medicaid, or waits to learn if they qualify. And CMS encourages states to consider utilizing presumptive eligibility for individuals who are anticipated to have short-term stays.

That would most likely be individuals in jails where the national average is only about 33 days. And to enroll individuals who are likely eligible under a state's Medicaid eligibility guidelines for that temporary period of time. And we want to note the importance of individuals being informed that filing a full Medicaid application is necessary for coverage to continue. And states may require jails or prisons that serve as qualified entities, to assist individuals in completing a full Medicaid application during that presumptive eligibility period, prior to the date of release. Next slide, please.

So what types of settings can these services be provided in? States may include individuals in state prisons, local jails, and/or youth correctional facilities, for provision of pre-release services. States have the discretion to propose the types of carceral settings and also to designate individual carceral facilities for participation. States may also propose a phased approach to adding specific carceral facilities or facility types. And participating states

will need to conduct a readiness assessment of the various carceral facilities or settings, before implementing the demonstration in those locations.

States may include individuals in federal prisons for the purpose of helping them submit a Medicaid application in the state in which they are expected to reside upon release. However, federal prisons are not included in the demonstration as a setting in which pre-release services could be provided. Next slide, please. The scope of healthcare services - so CMS is proposing that states will be expected to include the following three services as the minimum pre-release benefit package.

The first is case management, which is truly a linchpin between the experience of the individual pre-release and their experiences of obtaining and accessing services upon release. So the case manager will need to assess the person for their physical health needs, their behavioral health needs, and those really critical health-related social needs such as housing and employment, access to nutrition, but really looking at that whole person.

The second service is medication assisted treatment as clinically appropriate. And that would include not just the medications, but also any accompanying counseling. And this would be for all types of substance use disorder, not just opioid use disorder. And then the third benefit would be a 30-day supply of all prescription medications again, as clinically appropriate for the individual, provided to that individual immediately upon release from the correctional facility. And that would actually be the medications, not just a script to get those medications.

And we will discuss pharmacy rebates and the applicability a little later in the presentation. Next slide, please. Continuing with the scope of healthcare services - in addition to those minimum services, CMS encourages states to

consider covering additional services on a pre-release basis. Some examples may be family planning services and supplies, peer support or community health workers who have lived experience with incarceration, various kinds of behavioral health services that may be covered under the rehabilitative or preventive services benefit or the other licensed practitioner benefit, and treatment for Hepatitis C.

Individual services should be based on the needs of the carceral populations that a state is proposing to include in their demonstration. And states should provide justification for these services, including capturing those services in their demonstrations, monitoring and evaluation. Next slide, please. Continuing to dig in a little bit more about the scope of the healthcare services - so case management services include the activities that are coverable under the targeted case management services benefit, which is described in Medicaid regulations.

Pre-release case management should build that bridge between what is going on for the person on a pre-release basis to post-release, really looking at the whole person and all of their needs. And that while the case manager may be different on a pre-release basis from that case manager that the person has post-release, it is critically important that there is a warm handoff, so that as part of that person-centered care plan that's developed pre-release, those appointments that are set up on a pre-release basis, that someone is ensuring that continuity of services and that the person upon release is getting those services, and those services are helping them to accomplish their goals, and that plans are adjusted as appropriate.

The next point about the scope of healthcare services is that in order for states to be permitted under this demonstration, to seek pharmacy rebates, all covered outpatient drugs have to be provided pre-release and meet the

Medicaid Drug Rebate Program Section 1927 requirements. So to the extent a state provides less than the full outpatient drug coverage, which was in - would include only providing that minimum of the medication assisted treatment drugs, the state may not seek rebates for any of the pre-release drugs provided under the demonstration. Next slide, please.

Providers for these pre-release services - so states have the ability to cover services in person and/or via telehealth. And certainly (in reach) pre-release services to individuals, settings by community providers, is preferred by CMS. But we recognize that there are significant provider shortages. We've heard particularly, that's the case in rural areas. So states may use pre-release carceral and/or community providers. Generally for states that do rely on any carceral healthcare providers to furnish pre-release services, they will be expected to ensure the providers comply with Medicaid provider participation requirements set by the state. Next slide, please.

The pre-release timeframe for services - consistent with the Support Act, states generally will be expected to cover demonstration services that begin 30-days immediately prior to the individual's expected date of release. However, CMS will consider approving demonstration authority to begin coverage of pre-release services up to 90-days prior to the expected release date. For states that request a pre-release service timeframe that is longer than that 30-days, and up to 90-days, the state should incorporate into its demonstration purpose, one or more elements to be tested for that additional time period. Next slide, please.

Administrative IT systems costs - so we recognize that state Medicaid agency IT systems costs are important to states. And they may be eligible for enhanced FFP that meets required criteria through an advanced planning document or APD. This may include IT systems that support data sharing

between Medicaid agencies, correctional agencies, carceral facilities, Medicaid providers, and other systems that provide resources and care in community, like housing, nutrition, assistance, other HRSN data systems.

The enhanced FFP through an advanced planning document, may be claimed for either new systems or improvements to existing systems. And for states that have any questions related to these IT topics or to IT systems expenditures, we encourage you to contact your Medicaid enterprise system's state officer. Next slide, please. We recognize that then in addition to the pre-release services, states may want to request transitional non-service expenditures. And they may request time limited support in the form of FFP for certain new expenditures that are required by states.

It could be correctional facilities, healthcare providers to implement and expand service provision and coordination with community providers. Some examples of these types of transitional non-service expenditures could be development of new business, or operational practices or processes, the necessary workforce development and outreach, including education and training, as well as various types of stakeholder convening. Next slide, please.

So all states will be expected to do a reinvestment plan. CMS does not expect to approve state proposals for any existing carceral healthcare services that are currently funded with state and/or local dollars, unless the state agrees to reinvest the total amount of the federal matching funds received for these services under the demonstration, into activities and/or initiatives that increase access to, or improve the quality of healthcare services for individuals who are currently incarcerated or were recently released from incarceration, or for health-related social services that may help divert individuals from criminal justice involvement on the front end.

States are expected to include their reinvestment plan in their implementation plan that's submitted to CMS. And the implementation plan will be discussed a little later in the presentation. In the reinvestment plan states will be outlining the aggregate amount of federal matching funds for carceral healthcare services that are currently funded with state and/or local dollars that's being requested, and where reinvestments will be made. Next slide, please.

Any investment in carceral healthcare, is expected to add to, or improve the quality of healthcare services and resources for individuals who are incarcerated, and to supplement and not supplant the existing state or local spending on these services and resources.

Some examples of reinvestment may include improved access to behavioral and physical healthcare services in the community, improved health information technology, and data sharing, increased community based provider capacity. And I want to emphasize that the state's share of expenditures for new, enhanced, or expanded pre-release services that are approved under the demonstration, can be considered an allowable reinvestment.

CMS will not approve a reinvestment plan through which funds are used to build prisons jails or any other types of carceral facilities used for non-health-related improvements to such carceral facilities, or to increase the profits of private carceral facilities. Thank you very much. And I am going to turn things over to my colleague, Danielle Daly, to continue with the rest of our presentation.

Danielle Daly: Thank you so much, Nancy. And if we could go to the next slide, please. Thank you. So I am going to take a few minutes to talk about implementation

plan monitoring and evaluation requirements, and highlight what is described in further detail in the SMDL that was released yesterday. So all states who are approved for this demonstration opportunity, will be required to submit an implementation plan for CMS approval. This implementation plan will need to be approved by CMS prior to the state being able to receive the FSP for the demonstration activities.

And as Nancy mentioned previously, the reinvestment plan will be one component of this implementation plan. CMS is working to develop a template for states to use, to help guide the information that CMS will need in order to be able to approve the implementation plan. So now I'll also talk a little bit about the monitoring expectations as well. Consistent with all section 1115 demonstrations, both systematic monitoring and robust evaluation will be required for this demonstration opportunity. For monitoring, CMS will identify a set of monitoring metrics.

Those monitoring metrics will align with the goals and/or milestones that are outlined in the State Medicaid Director Letter. Additionally, as the state identifies demonstration features beyond what is listed as the minimum in the State Medicaid Director Letter, CMS and the state will collaborate and will consider state-specific monitoring metrics as applicable. States will be expected to describe their plans for monitoring in a monitoring protocol, and to report on a quarterly and annual basis.

The monitoring metrics will also support a midpoint assessment, which will be conducted by the state between years two and three of the demonstration authority. And here again, CMS will provide templates and resources, first dates to leverage for both the monitoring protocol and the monitoring reporting requirements. Next slide, please.

So as noted on the prior slide, robust evaluation of the demonstration is required. The evaluation should be mixed methods and might include how the state will test whether the demonstration improved care transitions for individuals who are released from incarceration, including but not limited to, whether and how the demonstration improves coverage and quality of care. Evaluation requirements will include an evaluation design, which is subject to CMS approval, and an interim and summative evaluation report.

The evaluation reports must align with the methodology and the approved evaluation design. CMS will provide evaluation design guidance to states who have approved reentry demonstration. So the outcomes of interests are listed on the slide here for the evaluation. And could include, but are not limited to, measurements of cross system communication and collaboration, connections between carceral settings and community services, provision of preventative and routine physical and behavioral healthcare, avoidable ED visits, and inpatient hospitalizations, and all cause death. Next slide, please.

Now just a quick note about budget neutrality - so as noted in the State Medicaid Director Letter, the services CMS is likely to approve as coverage for Medicaid enrollees, during their pre-release period, are otherwise state plan covered services. This means that budget neutrality savings would not be needed. Next slide, please. We wanted to also share with you some of the emerging interest for this demonstration opportunity. As you are likely to have seen CMS approved the first reentry Section 1115 demonstration in January. We also have a long list of states who have applied for this demonstration opportunity as also listed on the slide here.

For more information about this demonstration opportunity, please reach out to your Section 1115 demonstration project officer. All right. And thank you very much. I will turn it over to (Jackie Glaze) to take us through questions.

Jackie Glaze: Thank you so much, Danielle and Nancy, for your presentations. So we are ready to take the state questions at this point. So you may ask questions about the presentations that you just heard, or any other questions that you may have. So we will begin with the chat function, and then we'll follow by taking your questions over the phone line. So I do see a couple questions now on the chat. So I'll turn to you, (Krista), so that you can begin those questions.

(Krista): Great. Our first question here is, is the text of DACA rule available yet, or do we need to wait until OMB releases it and signs off on it?

Sarah Spector: This is Sarah Spector. I can take that one. It will be issued in the federal register. I'm sure there'll be a widespread notification when it's available.

(Krista): Great. Thank you, Sarah. Our second question here is, so the approval of the expenditure authority isn't actually authority of expended funds, meaning states must have a separate implementation plan approved as well? Why is it a 2-step process?

Woman: Danielle, do you want to go ahead and take that, or someone in FTT?

Danielle Daly: Sure. Yes. I can get us started. And I'd welcome my colleagues as well, to add additional information. I think it's not necessarily intended to be a 2-step process. I think the goal is for the implementation plan to provide further details that were not available to CMS at the time of the approval. And I think, you know, part of what we're trying to do is incorporate all of the necessary information into one document. Hence, the reinvestment plan will be incorporated into the implementation plan as well, to help streamline these efforts.

And this is definitely something, you know, we are very much looking forward to our continued coordination and collaboration with states around this. But I'd welcome any of my other colleagues to share additional information as well.

(Krista): Thank you, Danielle. I'm not seeing any additional questions in the chat. So we will move to the phone lines. So (Ted), if you could provide instructions to the participants on how to register their questions and open the phone lines, please.

Coordinator: Yes. The phone lines are now open for questions. If you would like to ask a question over the phone, please press star 1 and record your name. If you'd like to withdraw your question, press star 2. Thank you. And as a reminder, if you would like to ask a question over the phone, please press star 1 and record your name. There is one question in queue from (Henry Lipman). Your line is now open.

(Henry Lipman): Yes. Thank you. Thank you for the presentation. A quick question - I want to make sure I heard correctly. In terms of the services that are provided under the required services, did I hear correctly or incorrectly, that they couldn't be provided in the setting of the correction facility, or they had to be provided elsewhere?

Nancy Kirchner: Hi, this is Nancy. I'll take that question. So the pre-release services that we talked about, the minimum pre-release would be provided while the individual was incarcerated. And what we had also talked about was that those services might be provided by a community provider going into that carceral facility to provide those services either in person or through telehealth, or that a state might choose to have carceral healthcare providers provide some or all of those pre-release services. Does that respond to your question?

(Henry Lipman): Yes. I must have been distracted for a second. So that's exactly what I hoped to hear. And just a follow up question if I could, to that, is would a managed care delivery system be an option to deliver that as you described?

Nancy Kirchner: Yes. And I think the letter goes into more detail about whether - how services would be de delivered. But I think that would be something that you could certainly talk about in terms of how those pre-release services might be delivered to an individual while they're incarcerated.

(Henry Lipman): Thank you.

Coordinator: And I'm showing no further phone questions at this time.

(Krista): Thank you. I'm not seeing any additional questions in the chat function, so we'll give folks another minute or two to see if they would like to submit a question.

Coordinator: And as a reminder, to ask a question over the phone, please press star 1.

(Krista): Ted, are you seeing any additional questions?

Coordinator: I'm showing no questions at this time.

(Krista): Okay. And I'm not seeing any questions either through the chat function. So I think we will close early today. So in closing, I want to thank our team for their presentations today. Looking forward, the topic and invitation for our 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 do thank you again for joining us today and hope you all have a great afternoon. Thank you.

Coordinator: This concludes today's call. Thank you for your participation. You may disconnect at this time.

[End]