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Coordinator: Welcome and thank you for standing by. At this time, all participants are in a 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, please disconnect at this time.

I'll now turn the call over to Jackie Glaze:. Thank you. You may begin.

Jackie Glaze: Thank you. And hi, everyone and welcome to today's All State Call. On today's call, we will provide information on two important issues. The first is on the vaccine coverage and the second is on CMS's Birthing-Friendly Hospital Designation. First off, Sara Harshman from the Division of Benefits and Coverage, and Mary Beth Hance from the Division of Quality will provide a brief update on the COVID-19 vaccine coverage, as a follow-up to questions raised on past All State Calls.

Second, Georgina Peacock and Alicia Hall from the Centers for Disease Control and Prevention will provide a brief overview of the respiratory syncytial, excuse me, the RSV vaccines. Our last presentation will be from Ellen Marie Whelan from our CMCS Center Director's Office and Tiffany Wiggins, the Medical Officer from the Center for Clinical Standards and Quality. They will provide an overview of the recent activities related to the

CMS Birthing-Friendly Hospital Designation.

Last year, CMS established a Birthing-Friendly Hospital Designation, a publicly reported public-facing hospital designation on the quality and safety of maternal care. This is the first-ever hospital quality designation by HHS that specifically focuses on maternal health. Last week, on November 8, CMS started displaying the Birthing-Friendly Designation icon on CMS's Care Compare online tool and released a new interactive map to display the Birthing-Friendly hospitals.

Before we get started, I want to let folks know that we will be using the webinar platform to share slides today. If you're not already logged in, I suggest that you do so now so that you can see the slides for today's presentation. You can also submit any questions you have into the chat any time during the presentation.

With that, I'm pleased to turn things over to Sara Harshman and Mary Beth Hance to provide an update on the COVID-19 vaccine.

Sara Harshman: Thanks, Jackie and hi, everyone. We wanted to come back to provide some more information on coverage of COVID-19 vaccinations after the verbal update we provided at the last All State Call. To help set the scene, there are a few federal programs and requirements currently in place for COVID-19 vaccinations.

First off, the American Rescue Plan requires coverage of COVID-19 vaccines and their administration without cost-sharing for CHIP and nearly all Medicaid beneficiaries until September 30, 2024. Under this provision, there is also a 100% federal match for COVID-19 vaccine doses and their

administration.

Next, the Vaccines for Children Program, or VFC, is a federal vaccine purchase and distribution program for pediatric vaccines recommended by the CDC's Advisory Committee on Immunization Practices or ACIP. For children through age 18 who are enrolled in Medicaid or are uninsured, underinsured, or American Indian, Alaska Native.

Children enrolled in a separate CHIP are not eligible for VFC vaccines. The ACIP recommendations make up the U.S. pediatric and adult immunization schedules, and vaccines on the pediatric schedule are generally provided by VFC for VFC eligible children. And with that, COVID-19 vaccine doses are currently distributed through the VFC program. Next slide, please.

And finally, as CMS explained in previous guidance, the HHS COVID-19 PREP Act declaration has Medicaid payment implications. While the declaration does not change Medicaid coverage rules, it does affect which providers are qualified to provide COVID-19 vaccinations for purposes of the Medicaid free choice of provider requirements. Through December 31, 2024, the COVID-19 PREP Act declaration authorizes pharmacies, pharmacists, pharmacy interns, and pharmacy technicians to administer COVID-19 vaccines to individuals age 3 and older as long as the provider meets the conditions stated in the declaration.

And as I mentioned on the previous slide, states are required to cover COVID-19 vaccines and their administration for nearly all Medicaid beneficiaries. And those vaccine doses are matched at 100% until September 30, 2024. Therefore, currently states must identify a pathway to providing payment to certain pharmacies and pharmacy professionals both for COVID-19 vaccine doses and their administration if the provider is qualified to administer the

COVID-19 vaccine, including if the provider is authorized under the HHS COVID-19 PREP Act declaration, and if Medicaid coverage of the vaccination is otherwise available for that beneficiary.

I should also note that states must meet all other applicable federal requirements for coverage, such as reimbursing only those providers that are enrolled as Medicaid providers and covering vaccinations only for eligible individuals. Next slide, please. As I mentioned earlier, pediatric vaccine doses for Medicaid beneficiaries under age 19 are provided through the VFC program. In cases where COVID-19 vaccine doses are available from the VFC program, the beneficiary could and would generally receive a VFC provided vaccine dose.

However, if a Medicaid beneficiary under age 19 receives a non-VFC provided COVID-19 vaccine dose from a pharmacy provider that is authorized to administer the vaccine under the COVID-19 PREP Act declaration, state Medicaid programs should ensure that the pharmacy provider can receive payment for both the non-VFC vaccine dose and its administration.

This is because the Medicaid payment policy related to COVID-19 PREP Act declaration applies regardless of whether a pharmacy provider is enrolled as a VFC provider.

And I just want to make it clear again this week. We are focusing today only on Medicaid payment policy implications applicable to certain pharmacy providers authorized to administer COVID-19 vaccines and are not discussing any other sites or providers in which children may receive a COVID-19 vaccination. And next slide, please.

During the last All-State call, we received a couple of questions related to the applicability of these provisions to the CHIP program. In CHIP, states may choose between a Medicaid Expansion CHIP program, a separate CHIP, or a combination of both programs. The type of program selected dictates whether beneficiaries enrolled in the state's CHIP program can receive vaccines through the VFC program.

Children under 19 years of age who are enrolled in Medicaid Expansion CHIP programs are eligible for the VFC program. However, children enrolled in separate CHIP programs are not eligible for vaccines through VFC, and states must cover vaccine doses for these children as they would any other benefit. And I'll remind folks again that under the ARP, there is 100% federal match for state separate CHIP and Medicaid Expansion CHIP expenditures for the COVID-19 vaccine in this administration through September 30, 2024. Next slide, please.

And there is also a slight difference in the application of the HHS COVID-19 PREP Act implications as separate CHIPs are not subject to Medicaid's free choice of willing and qualified provider requirements. Thus, states operating separate CHIPs generally have flexibility to determine which healthcare providers they would reimburse for providing covered services, including COVID-19 vaccinations. That said, as mentioned earlier, the COVID-19 PREP Act declaration authorizes certain pharmacy providers to order and or administer COVID-19 vaccinations if they do so consistently with the PREP Act declaration and authorizations.

Accordingly, states operating separate CHIPs may not deny CHIP payment to a CHIP provider for a covered COVID-19 vaccination on the basis that the provider is not licensed or authorized under state law to provide a COVID-19 vaccination as long as the PREP Act Declaration authorizes that provider to

do so. However, the HHS COVID-19 PREP Act declaration does not require the state's separate CHIP to pay providers or provider types they would not otherwise pay under the state plan. And states with Medicaid Expansion CHIP programs must follow guidance provided for Medicaid beneficiaries provided earlier in the slide.

All right. Next slide, please. With that information, we provided a couple of examples to help highlight how this may work for Medicaid and CHIP agencies covering pediatric vaccines in pharmacy settings. For the first example, if a family goes to a pharmacy for a Medicaid-covered pediatric COVID-19 vaccination, the state should identify a pathway to paying for the vaccination even if the vaccine dose is not provided through the VFC program, as long as the administering pharmacy provider meets the conditions of the HHS COVID-19 PREP Act, and that dose would be 100% federally matched.

In this example, if the provider is not enrolled in the Medicaid program, the state is not required to pay for the vaccination. In - our example for a separate CHIP, it's a bit different and doesn't have VFC vaccine dose availability. So, when a family goes to a pharmacy for a CHIP covered COVID-19 vaccination for a child under age 19, if the administering pharmacy provider meets the conditions in the PREP Act declaration, if the state pays pharmacy providers under the state plan and if the administering provider is an enrolled CHIP provider, the state should pay the provider for the vaccination.

State expenditures would also be matched at 100% until September 30, 2024. If the state does not pay pharmacy providers under the state plan or the provider is not an enrolled CHIP provider, the state is not required to pay for that vaccination. You can find more on the CHIP and Medicaid payment implications due to the HHS PREP Act on medicaid.gov in the materials from

the September 19, 2023 All State Call and in the Medicaid CHIP and BHP COVID-19 vaccine toolkit.

I'll now turn it over to my colleague, Marie Beth Hance, to provide some information on the RSV vaccine and introduce our guest speakers from the CDC.

Mary Hance: Great. Thank you so much, Sara. I appreciate it. I'm going to give a quick overview on Medicaid and CHIP coverage of the new RSV immunization products that are available this year. You may recall that we gave an update on seasonal vaccines, including RSV on September 12, 2023, and those slides are available as a resource as well. As Sara mentioned, after my update, our CDC colleagues will provide much more detail on these products.

Nirsevimab is one of the two products that are newly available, and it is an RSV immunization for infants, which has been shown to reduce the risk of hospitalizations and healthcare visits by about 80%. It was recommended by CDC's Advisory Committee on Immunization Practices, also known as ACIP, on August 3 and is included on CDC's Web site as an addendum to the Pediatric Immunization Schedule.

With this action, coverage is mandatory without cost sharing for EPSDT eligible children in Medicaid, in Medicaid Expansion CHIP programs, and for children enrolled in separate CHIPs. It is also included in the VFC program, which is for children enrolled in Medicaid and Medicaid Expansion CHIPs. And since it is included in VFC, the VFC administration fee ceiling applies. Due to supply issues, CDC has updated recommendations through a health alert, which CDC will address in the next presentation. Next slide, please.

There is also a new vaccine for pregnant people between 32 and 36 weeks gestation that was recommended by the ACIP on September 22, 2023, to prevent RSV infection in infants. Beginning on October 1, 2023, as mandated by Section 11405 of the Inflation Reduction Act. Coverage of this vaccine without cost sharing is required for nearly all full-benefit adult beneficiaries covered under Medicaid, if the CDC ACIP recommendations apply. Coverage is also mandatory for beneficiaries and alternative benefit plans in states that align ABP coverage with state plan coverage.

For non-alignment states, state ABPs' coverage of vaccinations must adhere to the essential health benefit rules, and coverage is mandatory for routine vaccinations on the adult immunization schedule. Additionally, beginning October 1, 2023, coverage is mandatory without cost sharing for Medicaid Expansion CHIPs and separate CHIP beneficiaries, if the CDC ACIP recommendations apply. And it is included in VFC for VFC eligible pregnant people through age 18.

I will now turn this over to our colleagues from CDC, Drs. Georgina Peacock and Alicia Hall, who will provide much more information on these new RSV products and recommendations.

Sara Harshman: Hi, Dr. Peacock and Alicia, are you ready for your presentation?

Alicia Hall: I can jump in if Dr. Peacock had to step away.

Sara Harshman: Okay.

Georgina Peacock: No. I'm sorry, I was talking, I just didn't unmute. I'm sorry. This is Dr. Peacock, I'm the Director of the Immunization Services Division, and I'm joined today by Alicia Hall, who is also in our division, and we're going to

talk to you mostly focused on the Nirsevimab supply shortage issues and the recommendations because of that. You'll have some other slides in your packet, but we're going to go through those fairly quickly so that we can get to an update on the changes that have been made in light of that shortage and then also I'll come back on at the end and provide some information on supply and distribution.

So, I'll turn it over to Alicia right now. Thanks.

Alicia Hall: Thank you, Dr. Peacock. Our next slide. And next slide again. All right. Thank you. So, as Dr. Peacock mentioned, I'm going to go through these very quickly, as I'm sure most of you are already familiar with the base recommendations. And most of this is really going to be focused on considerations with the limited supply. So, as you probably know, there are two options to protect infants, maternal immunization or Nirsevimab, and most infants are only going to need one of those. Next slide.

And I've included these slides primarily so you have all the recommendations in one place. But again, I really want to focus just on that limited supply of Nirsevimab. So you will have these available to print, but I am going to skip through them as I'm sure most of you are aware of these recommendations. So next slide. Next slide.

And I just want to mention, we will have highlighted these high-level Nirsevimab recommendations. Just as a reminder, those base recommendations are for infants entering or born during their first season younger than eight months. So, the two sort of steps here are those born during October 2023 through March 2024, and then all other infants younger than age 8 months would be eligible for Nirsevimab. But then it's going to get a little more complex when I go into those additional considerations. Next

slide.

And then we have the group of children ages 8 through 19 months that are at increased risk and entering their second RSV season that are also eligible for Nirsevimab and recommended assuming sufficient Nirsevimab availability. And this is where that is really going to narrow down with the additional considerations that I will go into. Next slide, please. And next slide again.

Okay. So now here's the real bulk of this presentation today. So first, I do want to just remind you of the two presentations of Nirsevimab because this is going to be really important here with the Nirsevimab supply and availability. So, first, sort of looking at that first row, there is a manufacturer-filled syringe that is in sort of, like, a purple box or a box with a purple ribbon on it. That's essentially the differing factor there. It is a 50-milligram Manufacturer-Filled Syringes, and this one is indicated for infants younger than age 8 months and weighing less than 5 kilograms born or entering their first season.

And then if you look on that second and third line there. The second presentation that is indicated for two populations is the 100 milligram Manufacturer-Filled Syringes. And that is for all other infants younger than 8 months that weigh 5 kilograms or greater, as well as the at-risk children ages 8 through 19 months, noting that for those at-risk children in their second season, they would be indicated for two 100 milligram pre-filled syringes. So, those are essentially the two presentations that we're working with here. Next slide.

So, going into the actual availability of each of these two presentations and then how that fits into the current recommendations and additional considerations. So in October, the manufacturer reported a limited supply of Nirsevimab, particularly that 100 milligram dose Manufacturer-Filled

Syringes used for infants weighing greater than 5 kilograms or those at-risk infants in their second season. Based on manufacturing capacity and currently available stock, there are not sufficient 100 milligram syringes of Nirsevimab to protect all eligible infants weighing more than 5 kilograms during the current RSV season.

Additionally, supply of the 50 milligram dose Manufacturer-Filled Syringes may be limited this season as well. And once I cover the breakdown of the recommendations and considerations here, Dr. Peacock will be talking more about supply availability at the end. Next slide.

So, following this manufacturer report on October 23, 2023, CDC released a health advisory describing the interim recommendations to provide options for clinicians to protect infants from RSV in this context of a limited supply of Nirsevimab. So, on the following slides, I'll cover recommendations from the HAN that apply to healthcare settings with limited Nirsevimab availability during the RSV season. Next slide.

So, first for the 50 milligram doses for infants weighing less than 5 kilograms. So, this is the easiest one. Recommendations for the 50 milligram doses remain unchanged at this time. So, this means for infants born before October 2023 administer a 50 milligram dose of Nirsevimab now for infants born during October 2023 and throughout the RSV season administer a 50 milligram dose of Nirsevimab in the first week of life.

Providers should also encourage pregnant people to receive Pfizer's RSV, maternal RSV vaccine, Abrysvo during 32 through 36 weeks gestation to prevent RSV associated lower respiratory tract infection. The potential for limited Nirsevimab availability should be considered when deciding on maternal vaccination or Nirsevimab. Next slide.

All right. And the 50 milligram doses, and I apologize if I have said microgram at any point in this presentation, I'm used to COVID. So the 50 milligram doses should be reserved only for infants weighing less than 5 kilograms. Avoid using two 50 milligram doses in place of a 100 milligram dose for infants weighing greater than 5 kilograms. You know, we want to reserve those doses for those youngest children. And follow AAP recommendations for palivizumab eligible infants ages less than 8 months when the appropriate dose of Nirsevimab is not available. Next slide.

All right. So now moving on to the 100 milligram doses for infants weighing 5 or more kilograms. So in healthcare settings with limited availability of the 100 milligram doses, prioritize infants at highest risk of severe RSV disease for receipt of these doses. This includes infants aged 6 or - excuse me, aged younger than 6 months, American Indian or Alaska Native infants ages less than 8 months, and infants ages 6 to younger than 8 months with conditions that place them at high risk for severe RSV disease. And I've listed those out on this slide. Next slide, please.

And then finally, for the 200 milligram doses, which again, are two shots of the 100, that this is for the children at risk ages 8 through 19 months. So, in healthcare facilities with limited availability of the 100 milligram doses, for palivizumab eligible children ages 8 through 19 months, providers should suspend the use of Nirsevimab for this season. These children should receive palivizumab per AAP recommendations.

The exception here is to continue offering Nirsevimab to American Indian and Alaska Native children ages 8 through 19 months who are not palivizumab eligible and who live in remote regions where transportation of children with

severe RSV for escalation of medical care is more challenging or in communities with known high rates of RSV among older infants and toddlers.

And we don't have a slide, Dr. Peacock is just going to give a verbal update, so I'm going to turn it back over to her to a verbal update on the supply and distribution.

Georgina Peacock: Hi, thank you. And I'm going to focus right now on the Vaccines for Children supply, however, the supply issues that are constrained within Vaccines for Children are similar on the commercial side. So currently, 50 and 100 milligram doses are available to VFC awardees, and those are - we are increasing those allocations as we get more doses within our depots. And that's happening about every two to three weeks as supplies become available. So, the most recent allocation was the 50 milligram doses and that was done on November 2.

Because of the supply constraints that became of - and the shortage that we became aware of, sort of as we had already started ordering for these doses, we had to put ordering controls into place to try to achieve some level of equity so that all of our VFC awardees or all of the states did get some supply. And early on in the ordering, there had been, you know, uneven ordering because we hadn't put any allocations or ordering controls there. And so what has happened because of that is some jurisdictions or some of our Vaccines for Children awardees have already ordered what would be expected to be their allocation for the season, either for the 50 milligrams, the 100 milligrams, or both.

We did recently notify all of the Vaccines for Children awardees about how much, what the - how many doses they're going to get for the season, so they are able to plan with what they have left. I wanted to give a little more detail

on that just because there is likely going to be some inequity in how that happened because the ordering started before any allocations were put into place, and we have a supply shortage, so we can't come back and sort of even everything out. But suffice it to say, we still have 50 and 100 milligram doses that are arriving from the depots and that will happen through likely the end of December.

In addition, we have added RSV vaccine to both our VFC availability or our VFC contract as well as for 317. So, for those individuals who might be pregnant and under the age of 19, there is availability now to order RSV vaccine for those pregnant persons. And then there is an ability also through the 317 ordering system to get doses both for pregnant people, and also those over age 60 years old through. Those are limited supplies, but those are through the 317 ordering process. And so I think with that, that was what I was going to update on the supply and distribution issues that we have, thanks.

Ellen Whelan: Thank you, Drs. Hall and Peacock. I hope everyone can hear me okay. That was really interesting and thanks for giving us the most recent updates from CDC. I appreciate that. I am Ellen Marie Whalen. I'm the Chief Population Health Officer here at CMCS. And today, we're going to be spending about 10 minutes with my colleague, Tiffany Wiggins, who's a Medical Officer at CCSQ, telling you about the next phase of our CMS Birthing-Friendly Designation for hospitals and health systems. Next slide, (Krista).

But before I turn to you - turn it over to Tiffany, I want to flag that we'll be coming back to you in a future call to tell you more about all of the work that CMS is doing to improve maternal health. Last year, CMS released a Maternal Health Action Plan in response to a call to action by Vice President Kamala Harris to improve maternal health. As I'm sure you're all well aware, in the

United States, we have an increasing rate of maternal mortality, higher than any other industrialized nation by far, and an increasing rate of infant mortality, a higher rate or worse than 32 of the 37 OECD countries.

Given that Medicaid and CHIP cover 41% of all births in the country and over 50% of all the children in the United States, we take this very seriously. This slide shows the six pillars of the CMS Maternal Health Action Plan. And again, I'm not going to go into detail about what we're doing in this action plan today. We'll cover that on another call. But as an example, in the coverage and access pillar, we're working with all of you to extend coverage for pregnant individuals for a full year and both states have responded and are currently providing this extended coverage.

In fact, just today, with the approval of Missouri SPA 40 states plus DC and the Virgin Islands now offer a full year of Medicaid coverage after pregnancy. In the quality pillar, all states have participated in some way over the years with our many quality improvement activities through our Maternal and Infant Health Initiative or MIHI. But today, we're going to spend time talking about a different CMS maternal health quality initiative. The Birthing-Friendly Designation, which aims to improve maternal health delivered by hospitals and health systems.

I'll hand this over to Tiffany to tell you more about the exciting next phase of this new designation. (Krista), you can switch the slide, and Dr. Wiggins?

Tiffany Wiggins: Great. Thank you so much, Ellen Marie, and good afternoon to everyone. As was mentioned, my name is Dr. Tiffany Wiggins, and I'm a Medical Officer at CMS. I have the honor of serving as a lead on maternity care quality as well as health equity measurement efforts. And so, as was mentioned, I'm really

excited because last week CMS launched the display of the Birthing-Friendly Designation on our Care Compare tool online.

And this is a designation that was created just last year to help identify hospitals and health systems that participate in various efforts to advance maternal health. And I'm going to go into more detail about this in subsequent slides, but the designation is based upon a measure that was finalized in a prior rule within CMS that essentially asks hospitals and health systems several questions around their participation in perinatal quality collaboratives, as well as their implementation of evidence-based best practices to advance maternal health.
And in addition to being able to utilize the Care Compare tool online to identify such facilities, consumers and patients and families are able to also use a new complementary interactive locator map that we also established, and I will show you various illustrations of that map as well. So, next slide, please.

Just to give you a bit of background around the Birthing-Friendly Designation. This was actually finalized in, as I mentioned, a prior rule. It was actually the Fiscal Year '23 Inpatient Prospective Payment System Rule, which updates Medicare fee-for-service payment rates and policies for both inpatient hospitals and long-term care hospitals. And the rule, specifically from Fiscal Year '23, was published in August 2022. And the policies that were established in that rule built upon CMS priorities to improve the safety and quality of maternity care, as Ellen Marie mentioned, as well as to better measure healthcare disparities to advance equity.

And so, as you'll hear throughout this presentation, we really do see the work that we're doing in this space and specifically with the Birthing-Friendly

Designation, as an opportunity to advance maternity care, quality, safety, and equity. And so in 2022, we established a designation, and that was in August.

And then in October, we actually were able to post the first round of data in support of the designation, which is based upon a structural measure that I mentioned in the prior slide. And for that first round of data that was published last year, it encompassed the reporting period that was for data from the end of Calendar Year 21, and so it would actually only come with three months of data.

Later on, we actually were able to capture data over the entire Calendar Year of 2022, and so the reporting that appeared just this fall on November 8, actually reflects data for that entire preceding Calendar Year. As is noted on this slide, future reporting is going to occur on an annual basis and will continue to include data that spans the preceding Calendar Year. Next slide, please.

As I have discussed previously, but I just want to drive home here, the designation initially, as we have constructed it, is based upon what is called the Maternal Morbidity Structural Measure, which was actually finalized even several years ago in the fiscal year 2022 to Inpatient Prospective Payment System Rule. And again, this has two parts.

It's a structural attestation measure. Asks first about participation in a perinatal quality collaborative, which could be at either the state or national level. And then second, asks whether or not there's an implementation of evidence-based patient safety practices, for example, maternal safety bundles that are related to reducing maternal morbidity and in turn, maternal mortality. Again, if a hospital health system is able to answer yes to both of these questions, then they are awarded the Birthing-Friendly Designation. Next slide, please.

On December 13, 2022, so again, this is after we had finalized the rule and then went on to - in October, to display the first round of data, we had a really wonderful event that was held downtown HHS with leaders from across government and industry where we had the first convening on maternal health since the agency launched the action plan. And that also was in the wake of the administration's release of the blueprint for addressing the maternal health crisis. And we brought together these leaders from across government and industry, one, to unveil the logo surrounding the birth and family designation, and you can see that in the pink and blue at the top right of the screen.

But we also wanted to unveil a commitment that commercial plans were making in support of this effort to also eventually post the designation with the hospitals and health systems affiliated with their networks on their relevant directories. And so we really saw this as a commitment from across the healthcare ecosystem to not only uplift the designation, but ultimately to really center maternal health and its care, quality, of course, and equity. And as is noted at the bottom of the screen, I think we're just really so excited and elated that this is the first ever designation that will go on to focus on maternal health by this administration agency. Next slide, please.

And so, again, driving home some of these key points around the data that the hospital data was, again, submitted first and displayed in 2022, and then the one that was submitted and displayed for 2023 is based upon the preceding year's data. I did want to highlight, for those who may not be aware, that the Hospital Inpatient Quality Reporting Program for which this data is submitted is one of more than 20 quality and value-based payment programs that CMS oversees. And through this program, acute care hospitals must meet certain eligibility criteria that are related to a number of factors, like geographic

location, as well as the patient population that is served.

And in terms of what was displayed on November 8, which was based upon the 2023 reporting year and, again, data spanning from the prior Calendar Year, just over 3,100 eligible hospitals ultimately were required to report data to the hospital IQR program. And could do so as either an individual hospital or a health system, which is why UCRF used both of those terms. And in this year - this Calendar Year of 2023, approximately 66% or two-thirds of those hospitals and health systems that reported received the Birthing-Friendly Designation.

Additionally, as is mentioned here, we released the interactive locator map, which was created to help facilitate consumer search for these hospitals or health systems in their communities to identify where they might seek to receive care in both the pregnant and postpartum phase. Next slide, please.

So, I think it's helpful to really be able to attach a visual to how one would actually navigate the tools that we are describing, so we're going to do that in this next part of the presentation. Next slide.

Here you'll see a visual of medicare.gov, which is the Care Compare site, where you can search for the Birthing-Friendly Designation. And you can see on the left-hand side there that there is a menu of different types of providers, doctors and clinicians, hospitals, nursing homes, home health services. In this case, you would select hospitals, and then you would enter your location or of the location that you're interested in searching. It could be by state, by city, by zip code, or you could even enter the hospital directly by name and then you would press Search. Next slide.

Based on the location that you entered, you will then be directed to a screen that will look like this. The screen includes a list of the hospitals and a map. Note that you can filter by distance and other factors. And on this screen, as you will see, hospitals and health systems that have the Birthing-Friendly designation. See the pink icon there of a mother and child, and it's kind of a heart shape. If the hospital has the designation, it will have that next to it. And I'll explain to you actually in a subsequent slide what it might mean if the hospital does not have it. But if you want more information about it, then you click on the hospital name. So next slide.

It will pop open on a screen with more information about that hospital. And under the Quality section, you can click Maternal Health. The page will display either one of these measures on the Maternal Health module, which is one of which measure is, you can see at the top, is based on early elective deliveries. And another measure, which is the Maternal Morbidity and Restructural Measure, is the one on which the designation is based. And here you can see that the answer for the hospital is yes, as to whether they are participating in a state or national program aimed at improving maternal and child health. Next slide, please.

The Care Compare tool also allows a user to compare more than one hospital at a time. So to get to this screen, you'd click on the Compare button for each hospital you want to compare. Blue bar will appear at the top of the screen, and you will click Compare on the upper right-hand button. You will then be brought to this page that shows the comparison of the hospitals you've selected.

And as you'll see here, there's a bubble, if you kind of hover your cursor over that area that says whether a hospital participated in a state or national program aimed at improving maternal and child health, you'll see this bubble

that offers a clarification on the absence of the designation, because this might mean one of two things, that the hospital does not actually qualify for the designation because it may not be eligible for the hospital inpatient quality reporting program based upon some of the criteria that I mentioned earlier. Or it may also be that the hospital does not provide inpatient labor and delivery services, and therefore there's no data submitted to that effect. Next slide.

Then pivoting over to the interactive locator map, you can see here is a snapshot of that map. And this is linked to CMS's Provider Data Catalog, which appears on cms.gov and allows users to view, filter, and or download various data sets. And in this case, users can view recipients of the Birthing-Friendly Designation as well as other data fields of interest. Next slide. Here is a look at the map by hospital name. And again, similar to the Care Compare tool that we showed on previous slides, users can search by city, state, or zip code. Next slide please.

And then having clicked on a given geography, here you can see a look at individual facilities in that community. And in this case, it's a snapshot of some of the Birthing-Friendly facilities in the city of Chicago and Illinois. So I wanted to give you just a really kind of brief overview of the designation, of some of the features, of the tools that are associated with this and really look forward to fielding any questions you have about this and or other efforts within our CMS Maternity Care Action Plan, again, with our focus on advancing maternal health quality, safety, and equity. Thank you again and I'll turn it back to the organizers of the webinar.

Mary Hance: Thank you so much, Tiffany and everyone, for the wonderful presentations today. At this point, we will open things up for an open Q&A session. So, if you have any questions for any of the presenters today or any questions in general, please go ahead and enter them into the chat. In a little bit, we will

open the phone lines, so folks can verbally ask, but for now, please just enter your questions in the chat. And I am seeing a few that are already here. These are enrollment-related questions.

The first one here is, we were reviewing the BFD document and notice that there is language to state that Ukrainian parolees can - that has been updated to parole grant date from on or between February 24, 2022 and September 30, 2023 to on February 24, 2024 or later. Are the grant dates for parolees indefinite based on this update? I'm not sure if we have anyone on the line who can help answer that. Otherwise, we might need to take this back.

Mark Steinberg: This is Mark Steinberg with (DMF). Let's take that one back. I know the right person to answer it is unavailable this afternoon.

Mary Hance: Great. Thank you so much for confirming. I will take note of this question and we can circle back with the person who asked it offline.

The second question here is around Former Foster Care. Are children eligible for Former Foster Care if enrolled in Medicaid when they age out of state custody if they do not have a satisfactory immigration status? An example would be that a child has a special immigrant juvenile status for less than 5 years when they age out of state custody but had IVE benefits while in custody, and therefore had Medicaid when they aged out.

Sarah de Lone: I think, this is Sarah de Lone, I think we should take that back to make sure our immigrant eligibility experts are able to weigh in, in terms of how their statuses work.

Mark Steinberg: Yes. Great. Yes. We're aware that we have this question with us. I'm happy to take it back again, but we're working on this one. This crosses several

different issue areas.

Mary Hance: Great. Thank you so much. Another one here, 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 de Lone: This sounds like the continuous eligibility question that I know is before our team and folks are working through. So that will be coming soon, hopefully, (unintelligible).

Mary Hance: Thank you. If private health insurance or payment of premiums are required under the waiver for the category and the household fails to enroll the child in private health insurance or pay premiums, would a state be required to keep the child enrolled in the waiver category for 12 months, considering the impact this would have on the premium assistance in the state.

Sarah de Lone: I'm not sure if that's the same question or just a variation, but it would be good to get that question, (Krista).

Mary Hance: Okay.

Sarah de Lone: I'm not sure that our continuous eligibility team is on the call right now.

Mary Hance: Great.

Sarah de Lone: Should we be able to take that question back.

Mary Hance: Okay. I'm seeing three more questions here about continuous eligibility, but I'm just given kind of the theme today. I will take note of all of the continuous

eligibility questions, and we'll make note of them. I know, and we'll be able to circle back offline on these.

Sarah de Lone: Yes. Thanks. I know the team is hard at work on a number of questions that come in. So, if these are new ones, definitely keep them coming. If you've already asked them, know that the team is working on them and trying to get you answers as soon as possible.

Mary Hance: Great. At this time, I don't see any other questions in the chat, so I'm wondering can we open the phone lines, (Ted)?

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. To withdraw your question, press star 2. Thank you. And I'm currently showing no phone questions at this time.

Mary Hance: Great. I am seeing an additional question or two here in the chat. The first one here is, what software is being used for the Care Compare system? Do we have anyone on the line familiar with the Care Compare system who can help answer? Otherwise, we can take that one back.

Jackie Glaze: Dr. Wiggins, are you still on the phone?

Tiffany Wiggins: I'm still on. I cannot answer that question. I'm not sure if it's asking about if one goes to the provider data catalog and is trying to download data. If that's the nature of the question, then one can download it in CSV format, but I don't know if that's answering the question.

Mary Hance: Okay. We can take that one back and follow up offline. The next question here I see is, are states required to pay pharmacy providers under the PREP

Act provision after the ARP COVID-19 coverage requirements end on September 30, 2024?

Sara Harshman: Hi. This is Sara. Yes. The HHS PREP Act declaration implications at this time run until December 31, 2024, so that will be beyond the ARP coverage period. And I will also note that COVID vaccines will be covered under the provisions of the Inflation Reduction Act for adult beneficiaries afterwards and we expect that the COVID-19 vaccines will be on the CDC ACIP, a pediatric immunization schedule, and would be covered for pediatric beneficiaries in Medicaid as well.

Mary Hance: Great. Thank you. At this time, I'm not seeing any additional questions in the chat. (Ted), are you seeing any on the phone line?

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

Mary Hance: Great. We can maybe give it another minute or so. I know we're close on time here.

Coordinator: Sure. And as a reminder to ask a question over the phone, please press star 1 and record your name.

Mary Hance: I'm still not seeing any additional questions in the chat. (Ted), are you seeing anything?

Coordinator: I'm showing no questions in the phone queue.

Mary Hance: Great. Jackie, maybe we should close things out.

Jackie Glaze: Yes. Thank you both. So in closing, I'd like to thank our presenters today for sharing the information. And looking forward, the topics and invitations for the next call will be forthcoming. If you do have questions that come up before the next call, please feel free to reach out to us, your state leads or bring your questions to the next call. We do thank you again for joining us today. We hope everyone has a great afternoon and thank you.

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

END