Centers for Medicare & Medicaid Services

COVID-19 Medicaid & CHIP All State Call

February 9, 2021

3:00 pm ET

Operator: Greetings and welcome to the CMCS All-State Medicaid and CHIP Call webinar. During the presentation, all participants will be in a listen-only mode. Afterwards, we will conduct a question and answer session. If you have a question, please press the one followed by the four on your telephone at any time during the presentation. At that time, your line will be briefly accessed from the conference to obtain information. You may also submit a written question using the chat feature located on the bottom left of your screen. If any time during the conference, you need to reach an operator, please press *0. As a reminder, this conference is being recorded Tuesday, February 9th, 2021. I would now like to turn the conference over to Jackie Glaze, please go ahead.

Jackie Glaze: Thank you and good afternoon and welcome everyone to today's all-state call and webinar. I will now turn it to Judith Cash, our Acting Deputy Center Director, and she will share highlights for today's discussion, Judith?

Judith Cash: Thanks Jackie. And welcome everyone to today's call. Thanks so much for joining us. First up today, we'll be joined by a special guest from CMS's Center for Consumer Information and Insurance Oversight. We know that as the CCIIO and that's Alex Bates. Alex and Suzette Seng from our very own Children and Adult Health Programs Group will discuss the implications of a new federally facilitated exchange Special Enrollment Period for Medicaid and CHIP. That Special Enrollment Period was authorized in an executive order issued by the president last month and is set to begin on February the 15th. After Alex and Suzette's presentation, we'll certainly take some time for your questions on that Special Enrollment Period.

Judith Cash: And then Kim Proctor, from our Data and Systems Group will present new preliminary Medicaid and CHIP COVID-19 data snapshot that was released on January the 15th. This snapshot includes data from the beginning of the public health emergency through the end of July 2020, and provides a variety of information on COVID-19 related to utilization by beneficiaries, including data on treatment and outcome, service use among Medicaid and CHIP beneficiaries who are 18 or under, services delivered via telehealth during the public health emergency, and services

for mental health and substance use disorder during the public health emergency.

Judith Cash: Again, after Kim's presentation, we'll open the line for more questions, including any general questions you might have. I also want to note that we are using a webinar for both of today's presentations, so if you're not already logged into the webinar platform, I suggest that you do that now. And with that, I'll turn it over to Alex and Suzette to start their presentation. Alex?

Alex Bates: Hey, thank you. So I'll give just a quick highlight of what we'll cover here. So we'll provide an overview of the 2021 Special Enrollment Period and Suzette will discuss the key implications there for Medicaid and CHIP along with some reminders on AT processing and considerations for planning ahead. So with that, we can move into the 2021 SEP overview. In accordance with the executive order issued on January 28th by President Biden, CMS determined that the COVID-19 emergency presents exceptional circumstances for consumers in accessing health insurance. And because of these exceptional circumstances, CMS will provide a Special Enrollment Period to give individuals and families an opportunity to apply and enroll in coverage.

Alex Bates: So from February 15th, through May 15th, the SEP will be available to marketplace eligible consumers, submitting new applications or updating existing applications in the 36 states that use the healthcare.gov platform. These consumers can access the SEP in a few different ways such as by going directly to healthcare.gov, by calling the marketplace call center, or through direct enrollment channels. And moving on to the next slide, CMS will conduct an outreach campaign using a mix of paid advertising, such as broadcast and digital media and it will include direct outreach to consumers as well, all aimed at building awareness and encouraging the uninsured as well as those exploring coverage options on healthcare.gov to continue the process and enroll in coverage. And with that, I'll hand it over to Suzette.

Suzette Seng: Thank you so much Alex and thank you for that important information. So now we'd like to focus on the key implications for Medicaid and CHIP agencies, regarding this Special Enrollment Period. So the SEP is likely to cause an increase in application volume for both state submitted applications and account transfers. Due to the outreach efforts that Alex just described, states may experience a potential increase in applicant and beneficiary inquiries and state call center volumes, part of this call volume increase maybe as a result of consumer confusion about the need to take any action as a result of the SEP. This may be particularly the case for beneficiaries who are continuously involved in Medicaid under the

FFCRA continuous enrollment department. And we'll touch upon that a little more in the presentation.

Suzette Seng: So, we'll start with some general reminders and an overview of the account transfer process and some reminders on how to handle specific scenarios always and especially during this Special Enrollment Period. So states who are served by the federally facilitated exchange will continue to receive outbound account transfers as we do throughout the year. And as a reminder, when we refer to an outbound account transfer, it is a transfer from the federally facilitated exchange through the states. So states will continue to receive these, and the different types of account transfers states receive are in the assessment work and determination states through account transfers, for eligibility for MAGI-based Medicaid and CHIP, states select whether they are an assessment or determination state.

Suzette Seng: All states receive non-MAGI referrals, for individuals who answer yes to specific screening questions that indicate they may be eligible on a basis other than MAGI for example, disability. All states also receive account transfers for inconsistency and pends, for individuals who attest to MAGI income and other factors that would make them potentially eligible for Medicaid or CHIP, but for whom the FFE cannot verify eligibility. And as a reminder, an inconsistency refers to a citizenship or immigration inconsistency and pends refers to income and residency inconsistencies. And again, both assessment and determination states receive account transfers and make the final determination for those inconsistencies.

Suzette Seng: States also receive full determination requests. In assessment states, if the FFE assesses an individual as ineligible, applicants may request a full determination from the state agency. The full determination requests are sent to the state for a final MAGI-based determination and also for a non-MAGI determination. In determination states, as the FFE has already made the final determination for MAGI-based coverage, a full determination request sent to states the determination states are only sent for completion of determinations for non-MAGI based coverage.

Suzette Seng: The next couple of slides will give an overview of state responsibilities, first in the assessment states, and then in determination states. So in an assessment state, the FFE transferred the accounts for individuals assessed as potentially eligible to the state regency for final determination. As we discussed in the slide, before the FFE also cancels accounts for individuals whose information was not verified by the FFE, individuals who have a pends inconsistency, and for those not assessed as eligible, but who have requested that their accounts be transferred to the state agency for full Medicaid CHIP determination and then in an assessment state, that is those for MAGI and non-MAGI coverage.

Suzette Seng: So once the state receives that account transfer, the state responsibilities are as follows. The first step in the process is to notify the FFE of receipt of the electronic accounts and this is called technically and acknowledgement that is sent from the state to the FFE. Again, acknowledging receipt of electronic accounts. States should not request information from the applicant if it's already included in the electronic accounts, except findings related to specific eligibility criteria made by the FFE without further verification. Based on the information sent to the account transfer, the state should promptly determine eligibility for MAGI-based coverage and non-MAGI-based coverage. If appropriate, without requiring a new application, the state should notify the applicants of the eligibility determination and enroll, if eligible. The state should then notify the FFE of the final determination of the individual eligibility or ineligibility and this is called an outbound response.

Jessica Stephens: This is Jessica Stephen's jumping in because it seems like Suzette was knocked off of the webinar. So I'm going to pick up from where she left off.

Suzette Seng: I'm here, can you hear me?

Jessica Stephens: Okay. Jumped back in. Yeah. I'm sorry, Suzette.

Suzette Seng: Thank you. Okay. So, picking up the process, the state responsibility for determination states. So in the determination states, the FFE is making the final determination for MAGI-based Medicaid. So the FFE transfers the electronic accounts for individuals who have been determined eligible for MAGI-based Medicaid, through the hub to the state agency and the state accepts that determination as final. Similarly, to assessment states, the FFE also cancels accounts individuals whose information is not verified by the FFE and for those not determined as eligible, but who have requested that their accounts be transferred to the state agency for full Medicaid state determination on a non-MAGI basis.

Suzette Seng: State agency responsibilities, when the state notifies the FFE of receipt of the electronic account, so they send an acknowledgement, the state promptly enroll individuals in Medicaid and CHIP, and sends notice as appropriate for individuals over pends or inconsistency that state collects additional information to resolve inconsistencies in pends and complete a final determination as needed and they notify the applicant's availability and determinations and eligibility. Determination states also determine eligibility on a non-MAGI basis if appropriate and send notice and they give coverage if they find eligible or ineligible. And they notify the FFE of the final determination of an individual's eligibility or ineligibility, again, an outbound response.

Suzette Seng: So the next slide, this was a reminder to states on processing real time outbound account transfers. Since the fall of 2019, the FFE has sent outbound account transfers to states in real time instead of nightly batches, because we have accounts sent in real time, multiple versions of an application may be sent to the state. In outbound account transfer, if an applicant returns to the FFE to update the application in the same day. So we wanted to highlight the guidance we provided to states on these same day versions of an application. States would only process the last version of an application submitted in a given day and states may identify the last version of an application in the day by using the date timestamp information provided in the account transfer statement.

Suzette Seng: States may also receive additional versions of an application in subsequent days after the initial submission date, the process fully processes those account transfers as they contain information that constitutes a change in circumstance that may affect eligibility and must be addressed consistent with our regulations at 42 C.F.R. § 42 CFR 435.916(d) and 457.343. Processing account transfers for beneficiaries already enrolled in Medicaid and CHIP. It is possible that existing Medicaid beneficiaries may end up applying at the federally facilitated exchange, during the 2021 SEP, especially if they are unsure of their enrollment status. This may be more likely in states where sending notices to ineligible individuals, informing them that they are ineligible to continue to be enrolled in Medicaid under the FFCRA.

Suzette Seng: If these individuals are assessed and determined eligible Medicaid or CHIP, the SEP will transfer these accounts for states to process. States will need to duplicate applications sent via the account transfer process to identify individuals that are known to the state, either as a transfer, enrollee, or applicants. States follow this process now but wanted to stress the importance of this to the patients of these accounts that may receive safe needs to process any updated information and the more recent account transfers as a change in the beneficiaries determination.

Suzette Seng: Similarly, an existing Medicaid or CHIP beneficiary may end up applying for coverage at the FFE during the 2021 SEP. And it's possible that he or she could be determined by the FFE as eligible for coverage in a QHP with APCC, this may result in dual enrollment in Medicaid CHIP and QHP APCC coverage for the individual. Individuals determined or assessed ineligible for Medicaid or CHIP by an exchange, to enroll in a QHP APCC will not be liable to pay back APCC according to the IRS status. And we've included some of those here for that IRS FAQ. The following slide is a little forward-thinking and helping states as we begin preparing for this 2021 Special Enrollment Period and the possible increase in applications, both from the FFE and from applications

submitted through the state, we wanted to provide some resources that may assist states address increased volume and strategies.

Suzette Seng: This first strategy, plan for increased application in call center volume, we wanted to provide a resource that was part of the coverage learning collaborative and ensuring timely and accurate eligibility determinations. This deck discusses policies and procedures that improve timeliness and may be a helpful resource for states as they plan for a possible increased volume due to the 2021 SEP. As states think through the strategies for addressing increased volume, states may also want to consider temporary policy operational changes to facilitate timely determinations of ineligibility, including updating the state verification plan and policies, and also temporarily accepting FFE assessments as determination.

Suzette Seng: So if a state is currently an assessment state, they may accept the assessment as a determination for a time-limited period without needing to submit a state plan amendment as the state would like to make some more permanent change, we would need to submit a state plan. This is more fully described in our Disaster Toolkit. States will also want to closely monitor systems regularly to identify issues and sending and receiving account transfers and states should report plan system outages to max.gov and contact with CCIIO IT project manager for assistance if needed. And I think we will take questions.

Jackie Glaze: Thank you, Suzette and thank you, Alex. So we're ready today to take your questions now on the FFE SEP. So we'll begin by taking your questions through the chat function first, and then we'll follow with taking questions over the phone line. So you can begin submitting your questions through the chat function at this time. While we're waiting to get your questions through the chat function, we'll open up the phone lines to see if you have any questions there. So operator, can you provide instructions and open up the phone lines at this time?

Operator: Thank you. If you'd like to register a question, please press the one followed by the four on your telephone. You'll hear a three tone prompt to acknowledge your request. Your line will then be accessed from the conference to obtain information. If your question has been answered and you would like to withdraw your registration, please press the one followed by the three. Once again, to register for a question over the phone lines, please press the one followed by the four.

Jackie Glaze: Are there any questions?

Operator: We have no questions over the phone lines at this time.

Jackie Glaze: Okay. So we'll just proceed with the agenda. Go ahead.

Ashley Setala: Jackie, it looks like we have one question that came in through the chat box.

Jackie Glaze: Okay.

Ashley Setala: And it is, where is the process to temporarily accept FFE assessments outlined and how quickly can the change be made?

Suzette Seng: Sure. So the process is outlined in the CMS Disaster Toolkit, which is on our Medicaid.gov website, and how quickly can that change be made, if the state is planning to use it again for a time limited period, the state has to let CMS know that we'll be accepting assessments as determinations and start doing that right away.

Jackie Glaze: Okay. So we'll now move on to the next part of the next part of the agenda and then we can certainly come back and take additional questions at the end of the session today. So now we'll transition to Kim Proctor and she'll provide an overview of the CMCS COVID data snapshot. So Kim, I'll turn it over to you.

Kim Proctor: Great. Thank you so much. And I'm Kim Proctor, I'm a Technical Director in the Data and Systems Group. And today I'm going to present the recent update that we published on the Medicaid and CHIP COVID-19 summaries. And I want to just start by saying that we're really excited to present this today, we have released a couple of these decks before, so two were updates and two have new content. So there are over 50 slides in this presentation, there won't be enough time to spend a lot of time on every single slide.

Kim Proctor: So I would definitely encourage you to go explore the publicly released tools through the link in the chat box and also what's available online so you can see all the extra detail that we have here. But we are really excited to release this because it is among the most real time we've ever been able to push data out at CMS on Medicaid and CHIP. That's really exciting, particularly in response to the public health emergency and it absolutely would not be possible without timely and accurate submissions from states. So I think this is just a great example of that federal state partnership, and we are very excited to present the results to you today. So to orient us in the product, I think everyone will have a good sense of the basics of Medicaid and CHIP. The only thing I really want to spend time highlighting here is that this is based on September T-MSIS submissions, those will include services through August.

Kim Proctor: And we have only presented results through July because of the claims lag or claims run out issues that I'll talk about on the next couple of slides. So basically, we know that it takes time for states to send claims to us. So we want to leave a little bit of a gap there to make sure that when we present results, if it's reflecting what's happening as accurately as possible and trying to account for that run out issue whenever possible. So basically, all the results will be focused on the period of March through July of 2020 and we'll compare that to the same time period in 2019.

Kim Proctor: So this is what I was referencing with the claim lag issue. So basically we know that there's a lag between when a service occurs and when we will see it at CMS, that's going to vary based on the submitting state, the claim type, and the delivery system. So this is going to show you the four different claim types, inpatient long-term care, other services and pharmacy. And then it's going to break it down by fee for service and managed care. And a really basic takeaway here is just that encounter records tend to take longer for CMS to see than fee for service records, and claims like out outpatient claims are going to come faster than something that's a long, complex inpatient claim. So just keep that in mind when you view the results.

Kim Proctor: And for people looking at this publicly online like stakeholders and other people, this is in a footnote on every single page, it's something that we really try to highlight when we present these results. And we break this down a little bit more here because in some parts of the presentation, there was some information on variation we see across states. There are lots of maps and charts and so we're trying to show people when they look at this presentation, that there's a lot of variation in terms of how fast states actually submit their claims. So some states submit really quickly, some states take longer and that can really change how you interpret the results.

Kim Proctor: So it's not always possible to know in a really short timeframe, if the variation you're seeing is the result of real variation or claims run out, that's another reason that we try to build in a little bit of buffer for that lag, but it is an important consideration to keep in mind when you review the results. Okay. I just ran to you if you want to go back and look at this presentation it's really long, so it'll make it much easier to kind of toggle between the different content areas. So the first area we'll spend a little bit of extra time on because it is a new release and this is our first release on COVID-19 treatment and outcomes. So throughout the course of 2020, we released information on services to beneficiaries 18 and under, and we released information on telehealth, so we did not actually release anything directly on COVID and the Medicaid and CHIP populations. So we were really excited to put this release out last month.

Kim Proctor: And then here, the main thing to highlight specifically for COVID outcomes and treatment. One of the things that we really tried to highlight also in many of our footnotes is that these estimates reflect only services covered by Medicaid and CHIP, a service covered by any other insurance program is not going to be reflected in these results. So if testing is covered via some other payment, you're not going to see that because we didn't pay for it, this is particularly relevant for duly eligible beneficiary. So you can see here there over 12.3 million duals who are enrolled in both Medicare and Medicaid. Medicare is often the primary payer for dual eligible beneficiaries and that means that we are not going to see claims related to that.

Kim Proctor: So I think that's a really important thing to keep in mind, if you are interested in the dual population specifically, or just what's happening with Medicare in general, Medicare also releases a variety of COVID-19 data snapshots, which you can also explore through this link. So I think the presentations for Medicare and Medicaid go really well together and I would also encourage you to explore that, but that is a really important thing to keep in mind as we do this, which is that this is only what is covered by Medicare.

Kim Proctor: So for our first slide here, we basically show that between March and July, there were over 730,000 beneficiaries treated for COVID-19, you can see the map on the left, that's going to show you that variation across space and take it two per 100,000 beneficiaries to just adjust for program size. And then that chart on the right is just going to show you how this is moving over time. So there's a lot of information on this slide about the number of beneficiaries, the variance across states, and the variance across time. And I think one of the encouraging things is that even though we're conducting analysis in relatively real time, we really do see, for example, increasing pieces reflecting what we know is happening from other data sources.

Kim Proctor: And then this slide is showing acute care use, so we're really focusing on hospitalizations. And here we show that there were nearly 80,000 hospitalizations between March and July of last year and you can see in the chart that we have broken that down apart by ICU stays, ICU stays with the ventilator use, and just general inpatient stays. So you can see a wealth of information about what was happening during those hospitalizations for the beneficiaries. And then same thing on the left, you can see those hospitalizations per 100,000 beneficiaries, and you can see that they appear to be concentrated in few key states. And then for this slide, we're showing how Medicaid and CHIP enrollment has changed relative to changes in the unemployment rates. And so we can see here that enrollment does continue to steadily increase.

Kim Proctor: So for this presentation, this is an update of a presentation that we publicly released before. So because we have presented this to this group before, I'll talk about this at a really high level to make sure that we have a lot of times to talk about some of our new content, particularly at the end. The key things to focus on here, this is particularly for service utilization for beneficiaries, age 18 and under. We cover over 41.5 million children, we cover many children living in poverty and many children that we require special health care services. We have focused this analysis on some key primary preventative and mental health services that children normally receive and the results are very similar to what we have seen before in the sense that we have seen services decline among many key areas that we're monitoring.

Kim Proctor: And we are starting to see services rebound, but there is a lot of variance not just across states in terms of that rebound, but actually across the different content areas. And that's one of the things that we've been able to see as we continue to monitor this as some areas of here to be rebounding quickly, more quickly than others. We have seen a drastic increase in service delivery via telehealth, but it is just not enough to offset the decline in services that we see for children, especially for mental health services. Of the services that we are examining in this analysis, it appears that mental health service rates are rebounding the least by the time we get to the end of July for our last period of analysis.

Kim Proctor: And as I mentioned and I will continue to mention throughout this presentation, there is a ton of state variation. Some states are returning to pre-pandemic levels, some states appear to be even surpassing free pandemic levels, and some states, appear to be taking a longer time to rebound in terms of giving care to children. So for the first slide here, we show this data on vaccinations. And so what you can see here is that for that period between March and July of 2020, we have about 1.5 million fewer vaccines, which is about 12%. So that decline really started in April, it does appear to have recovered by June, which is very encouraging but even with that recovery, we are still missing a significant number of vaccinations.

Kim Proctor: This slide shows some of the state variation, many states have started to rebound and some states are surpassing their pre-pandemic levels, which is very encouraging. So this slide is showing a very similar theme for child screening services. So in this case, the main thing to focus on here is on this bottom right. These charts were all at the same, the headlines will change slightly, but all these numbers will be updated. So you can see that the increase or the change in the number of services that are missing compared to the 2019 benchmark. So in this case, we are missing about 3.7 million child screening services, which is almost 30% fewer.

Kim Proctor: And we're seeing the same thing here. Very encouraging. Many states have started to rebound, which I think is great but that we still have many services that have been missed that we would want to close the gap for. And then dental services definitely shows a really significant decline. So I think when we originally made these slides, it was a 90% decline between March and April and it was just an astronomical decline. So the results are showing that there was a really substantial decline for March to April and that it has increased, but it is still very far below prior year rates and that does translate to a gap of over 9 million missing dental services, which is about 50% fewer. So this is a really sharp V-shape, so there's still a large gap between those prior year levels of prior year and the 2021 year.

Kim Proctor: And then we can see that V really reflected and with the state test submitted. So there's a really sharp drop with no states beginning to recover by the time that's July comes. And then I mentioned this slide on outpatient mental health services for children. So we saw these services start to decline in March and of the services that we're seeing, this is really one of the ones with that doesn't have as much as a V-shape in the sense that the decline started early in the pandemic and it appears to have really continued. The green line is showing the sharp increase in telehealth that we saw, but it's just not increased enough to offset that decline, particularly given the persistent nature of the decline. And so here, you can see that we are missing about 8.4 million mental health services even when we account for those telehealth visits.

Kim Proctor: So that's a lot of services, it's about 35% fewer services when you compare the same time period in 2020 to 2019. And you can see the same and this really reflected, I think this relationship is very consistent when we started to look at space. So here it's dropped, but it really hasn't recovered in most states. There absolutely is variance, but the general trend is that there has been a decline that has not started to rebound as much. And this is showing that relationship with telehealth and this will be reflected in the telehealth portion, which is that we saw this explosion of telehealth in April, but that explosion started to taper off by July even though, particularly for this issue, some of those in-person services haven't really resumed entirely yet. So this is showing that, telehealth information in greater detail, as you can see a map here on the left, which you're showing those services being telehealth, on the right, we're going to show the number of services. And so you can just see the general variance across states and the variance across time.

Kim Proctor: And then for the last few slides, we talked a little bit about the COVID specific outcomes, just updating what we had in our previous deck. So at this point, more than a million Medicaid and CHIP beneficiaries under age 19 have received a test that was covered by Medicaid or CHIP for

COVID-19 in 2020. Once again, you can see the variance here in the state map on the left, and you can see the actual count on the right. There were fewer than 130,000 beneficiaries treated for COVID-19 who were under age 19 in 2020. And once again, this is showing that treatment variance across states. And then similar to that general COVID information, here we're showing those hospitalizations and we find that through the end of July, there were fewer than 2,100 of beneficiaries under age 19 hospitalized for COVID-19.

Kim Proctor: And here you can see that variation the same way we showed it in the beginning across inpatient stays, ICU stays, and ICU stays with ventilator use. So this slide on telehealth is also an update of our other previous release, so we just updated everything with our more current data. And what you can see here is here, we just explain, what are we talking about? What are we measuring when we talk about services delivered via telehealth? And the key highlights here which even though we continue to get more and more months of submissions, it really appears that telehealth utilization spiked in April and then starting in May, it did start to decline through all age groups.

Kim Proctor: So we find that the number of services delivered via telehealth appears to be highest among adults age 19 to 64. And that rates for children under 19 and adults over 65 are about the same. I do want to re-emphasize that point in the beginning particularly for beneficiaries aged 65 and older, who are probably duly eligible, you will only receive those claims covered by Medicaid and CHIP. So we do note that on the slides and we do note that there is considerable variation across states in delivered via telehealth. So here you can see looking at this chart over time that there was a very large peak in April that does appear to be declining through July.

Kim Proctor: You can see at the top that there were almost 47 million services delivered via telehealth just between March and July, which was just an explosion on the 3000% more compared to the prior year. And then on the left, you can just see that variance across states, peg to that for 100,000 beneficiaries. Here you can see it broken down across month and age, and you can just see that there does appear to be some variance in terms of different age groups but that those relationships tend to be pretty consistent over time. And then on these next few slides, we just basically break it out by age group. So you can really see the number, if you're more interested in a specific age group, it allows you to break it apart by under 19, 19 to 64, and then 65 and older.

Kim Proctor: And then for this last section, we will spend a little more time here just because this is one of our new updates. So this presentation focuses on services for mental health and substance use disorders during the COVID-

19 public health emergency. And we want to ground this in the background. So one of the reasons this is so important is because Medicaid is the largest payer for behavioral health services, including both mental health and sub services in the United States. So we are a major payer and you can see from the last bullet that a substantial portion of our beneficiaries have mental health disorders or receive some services. And we know that they face multiple barriers to care during regular times, not even during a pandemic.

Kim Proctor: And so we think it's particularly important to examine what's happening in the face of the pandemic, especially given some of the trends that we had seen from our prior release related to children and mental health services. We also know based on preliminary evidence, it appears that there has been a large increase in the number of adults reporting adverse mental health conditions. So you know I sort of alluded to in the prior slides that for children, there's been a decline in the number of services children are receiving while simultaneously at least in the adults, there appears to be an increase in potential mental health conditions.

Kim Proctor: So we're sort of seeing, I think, the growing mental health crisis with the decline in services. So we really wanted to highlight that in the slides, particularly also for substance use disorders, we have seen that preliminary evidence suggests there's an increase in drug related mortalities, that is going back to the same thing, if there was an increase in drug abuse and drug related mortality that is coinciding with a decline in service utilization, that could be a potential issue that we would want to look into further.

Kim Proctor: And our preliminary results show the same thing across both topics that we sort of mentioned earlier for children which is just that for both adults and kids, we are seeing that mental health services have dropped substantially, that began in April and it has continued to decline through July in nearly all states. So there's a little bit less variance here than we see across some of the other topics. There's a notable gap compared to prior year levels. It is very encouraging that services continue to be delivered via telehealth, but that increase is not enough to offset the decline in in-person services, especially because for some of these services, they just can't be delivered via telehealth. They require an inpatient or a partial inpatient setting.

Kim Proctor: So it's very encouraging to see an increase in telehealth, but we know that that will not fully offset all the care that our beneficiaries need to receive. And this shows a similar slide for adults that we showed for children. So here, what you're seeing is that outpatient mental health services for adults age 19 to 64, started declining in March., and that decline has really

appeared to continue through July. Telehealth did increase but not enough to offset that decline. And so for adults, very similar to children, we see about almost 8 million fewer services even when we account for that drastic increase in telehealth. And that is a 25% decline, so the very significant drop that appears to be persisting throughout the pandemic.

Kim Proctor: And then this is just really showing that state variance and I think this is getting back to that prior point, which is that even though there's lots of variation in terms of how quickly they submit their claims, we really see that states appear to have a general decline across both the faster submitters and slower submitters. And this is just showing you a very similar relationship for telehealth. So even though telehealth really exploded in March and April, it appears to have tapered or leveled off somewhat throughout the summer, it is not enough to offset the decline that we've seen in his outpatient services.

Kim Proctor: And this shows that the slide for children, again, just to reorient it to this specific topic, and just highlighting the prior slide. It was about 8 million for adults, 19 to 64. It's about 8 million for kids under 19, that's over 16 million services, that is a lot of services, especially given the context in the beginning about what we're seeing from survey data and some preliminary substance use disorder data, that there is a growing need but there is also simultaneously a growing gap in service utilization. And this shows the same thing for states here that generally speaking, there was a decline that really hasn't started to rebound in most states. And this is one that is a little bit more consistent across states.

Kim Proctor: And we're seeing the same thing here about telehealth. So I think the story is very similar across age groups for the most part and across most topics, it seems that most states are tending to trend the same way. So states are starting to rebound while there is variance, many people start to rebound, in this case there's somewhat of an increase, but it is still very gradual and has not increased as much as we would want to see. And then this is just showing the same thing for SUD services. So we're seeing that, SUD services for adults 19 to 64 declined in March, and they're still below those COVID-19 levels in July. And here we see that's about a 17% decline almost 3 million services. So same thing, we're in the millions of services, there is a substantial decline particularly given what we're seeing surrounding drug related mortalities.

Kim Proctor: And we're seeing the same things here that it appears to be fairly consistent in terms of what's happening in states where there was that decline that really has not started going down. There's always variance when we're looking at what's happening across states but just generally speaking, we are not starting to see a very large increase in July back to

pre-pandemic levels. Okay. So that was a quick overview of all of the slides that we recently released for COVID-19 including the two new presentations. And I definitely want to make sure to leave time for questions.

Jackie Glaze: Thank you, Kim, for your presentation. So we're ready to take your questions now from the presenters that you heard today or any of your general questions. So let's begin by taking your questions through the chat function. I see we have several right now and then we'll follow with taking questions over the phone line.

Ashley Setala: Okay. Great. Well, the first question that's come in through the chat, is for Kim on the data presentation and it says, can you provide additional guidance on how we should interpret the map on COVID-19 treatment and COVID-19 hospitalizations on slide 23 and 24? For example, if a state falls in the two to three category on the COVID-19 treatment map, how should we interpret that?

Kim Proctor: Yeah, so I will say that generally speaking, I think we've displayed this information for informative purposes about what's happening to Medicaid and CHIP as much as we possibly can. And in terms of a narrative around what to take away from the slide, we really leave that to the individual analytic projects of the state or the researcher or the person that interests. So I think for us, it's more about aggregating this showing what's happening nationally and showing that there's variance.

Kim Proctor: I think the most simple explanation for this type of slide in that variance is just some places, if you're to have more significant COVID-19 outbreaks than others, I think that's very consistent with what you would see from other datasets from HHS and in news reports, for example. So it appears that the pandemic, it is variable in terms of how it has impacted different states in different mortalities. And we would expect to see that variation reflected in our data. And I think it's a positive sign in terms of timeliness and accuracy that it appears to reflect other datasets that we've seen publicly released.

Ashley Setala: Okay, thanks. The next question, this also came on the data and it says, do you think the decline in children's services is directly linked to school closure?

Kim Proctor: Yeah. So getting back to this one, I will say that we participated in a lot of meetings with stakeholders over the summer to talk about the forgone care, particularly for children. And I will say that in those meetings the key stakeholders definitely expressed a lot of concern about the relationship between school being closed and the services that kids

receive. I will highlight for example, on this slide for well-child visits, you'll see here, for example, that between July and September, we normally see an explosion in the number of filed screens that are probably related to kids getting seen before they start school, for example. So this is a time period that we really are interested in monitoring as data continues to come in, because we know that the services children receive are very heavily tied to school.

Kim Proctor: We can't establish causality with this information, that's certainly a possible explanation. And we did a lot of meetings with stakeholders over the summer to see what we could do in the face of schools being closed. And I think it's also very encouraging to look at this slide on destinations, there was a lot of concern about the staff over the summer, and I think the stakeholders and states have done an absolutely great job of working to tie kids back into getting care and getting vaccines. So they're probably definitely related, but it absolutely seems like there are things that can be done that help close this gap even in the face to school closures.

Ashley Setala: Okay. Thanks. And the next question on the data presentation is a three-part question, how are mental health services defined, do we use HEDIS definitions, and are services on the same day counted separately or as one visit?

Kim Proctor: So for the first one, mental health services, I could pull up the logic on that specifically. Hopefully, I think my contact information is in here and we could send you the actual methodology that we use, but here we're looking at basically anything that is a service related to a mental health condition. So it is broadly defined, it casts a wide net. So I do not think that we're using HEDIS definition, we're just using the administrative claims to look at mental health diagnoses and related procedures. In terms of that same day counting, I would have to dig into that a little bit further. Our goal is to look at distinct services, but I'd have to do a little bit more research on that one to make sure that I'm answering accurately.

Ashley Setala: Okay, thanks. And then we have a question that has come in for CAHPG related to our unwinding SHO that was released in December, January. And it says, that the SHO letter states, states must repeat redeterminations after the PHE for individuals determined ineligible during the PHE, if the beneficiary's initial redetermination is conducted more than six months prior to the scheduled termination date. Can you define repeat redetermination, does that mean we have to schedule and send a new renewal forms for these individuals?

Jessica Stephens: This is Jessica. I can take that one. It is starting the process from the beginning. So in a case where you've identified that the individual during

the public health emergency might potentially be ineligible you would need to first attempt an ex parte renewal again, or renewal based on available information based on updated data sources at that point. And if based on updated information at that point you find that the individual, you don't have sufficient information to redetermine the individual's eligibility, you would then send another renewal form. So in effect it is conducting the full renewal process at the end of the period that we're referring to.

Jackie Glaze: Okay. Thank you, Jessica. Should we check the phone lines operator to see if we have any questions there?

Operator: Of course, if you'd like to register a question, please press the one followed by the four. And I'm showing no questions at this time.

Jackie Glaze: Thank you. Judith, would you like to wait a few minutes to see if we receive additional questions or would you like to close at this point?

Judith Cash: Let's give everybody just 30 more seconds in case anybody's scrambling and is a slow typist like I am trying to get a question in, and then we'll close it out.

Jackie Glaze: Sure. Again, you can submit your questions through the chat line, or we have the phone lines open if you'd like to submit a question that way.

Judith Cash: All right. Last look, anything in the chat box?

Ashley Setala: It looks like we just got one more that came in, that came on the data presentation, it says, can you also share how you are identifying ICU and ICU with ventilator services.

Kim Proctor: So for that one, I'm working with collective methodology and obviously it's the same thing for all of these. We're just using either the claim type and the settings with procedure codes and diagnostic codes to identify all of this. So I believe in our fact sheet that corresponds with this, we talked specifically about, for example, how we're identifying COVID, how we're identifying all these treatments and so that's just that more detailed methodological underpinning so that you can absolutely understand exactly what you're looking at. So that is available with a fact sheet online for this release or you can always contact us and we can send you that more detailed methodology.

Jackie Glaze: Thanks. So we'll check the phone lines one additional time, operator?

Operator: And as a reminder to register for your question, please press the one followed by the four. And we have no questions.

Jackie Glaze: Thank you. Judith, I'll turn to you.

Judith Cash: Thanks Jackie. I'll say that's a wrap, so thanks so much everyone for joining us. I really want to especially thank all of our presenters for their really informative presentations and excellent information. Looking forward, we will meet you again soon. The topic and the invitation for our next call will be forthcoming and certainly if any questions come up between these calls, feel free to reach out to us, to your state lead, or bring the questions to our next call. Thanks again for joining us today and have a good rest of your day.

Operator: That does conclude the conference call for today. We thank you for your participation and ask that you please disconnect your lines.