

Centers for Medicare & Medicaid Services
COVID-19 Medicaid & CHIP All State Call

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3:00 pm ET

Operator: Greetings and thank you for standing by. Welcome to the CMCS All-State Medicaid and CHIP Call Webinar. During the presentation all participants will be in a listen-only mode, and afterwards, we'll 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, and at that time, your line will be accessed from the conference, to obtain information.

Operator: If at any time during the conference, you need to reach an operator, please press star, zero. This call is being recorded, Tuesday, March 16, 2021 and now I'd 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 to Anne Marie Costello, our Acting Center Director and she will share highlights for today's discussion. Anne Marie?

Anne Marie Costello: Thanks, Jackie and thanks to everybody for joining us today. First up today, Stephanie Bell and Martha Marr, from our Children and Adults Health Programs Group will present on the State Medicaid Director Letter that CMS issued in January, providing guidance to states on the implementation of new Medicaid eligibility requirements for at-risk youth who are inmates of public institutions.

Anne Marie Costello: The letter was created to help states implement Section 1001 of the SUPPORT Act. After the presentation, we'll take your questions. Then Jeff Galecki from our Data and Systems Group will present the 2018 T-MSIS Substance Use Disorder Data Book that CMS released in January. The Data Book reports the number of Medicaid beneficiaries treated for Substance Use Disorder (SUD) and the services they receive during the calendar year, and represents another innovative way CMS is using T-MSIS data to provide insights into the populations enrolled in Medicaid and CHIP. After that presentation, we'll also open up the line for your general questions. I'll note that we'll use a webinar for both of today's presentations. If you've not logged into the webinar platform, I suggest that you do so now.

Anne Marie Costello: But before we jump in, I wanted to make sure states are aware of two things. First, last week, the Department of Homeland Security changed its litigation posture in multiple cases affecting the Public Charge Final Rule that was published in 2019. The 2019 Rule had expanded the extent to which receiving Medicaid benefits may be considered in public charge inadmissibility determination.

Anne Marie Costello: As a result of the change in litigation posture and subsequent court action, the 2019 Public Charge Final Rule has been vacated and is no longer in effect. Effective March 9th of this year, DHS instead will apply the policy that was in place before the 2019 Public Charge Final Rule. This former policy is contained in the 1999 Interim Field Guidance under Deportability and Inadmissibility on Public Charge Grounds published by DHS in 1999.

Anne Marie Costello: Under the 1999 Interim Field Guidance, DHS will not consider a person's receipt of Medicaid benefits as part of the public charge determination with one exception. Under that exception, individuals who are institutionalized for long-term care, such as nursing facility residents, receiving Medicaid coverage for the institutional services may have those services considered by DHS in a public charge determination.

Anne Marie Costello: CHIP benefits are not considered a public charge determination under any circumstances. For additional information on the 1999 Interim Field Guidance, you can refer to the May 26, 1999, CMS State Health Official Letter, which includes a fact sheet and frequently asked questions on this topic. It's available on Medicaid.gov.

Anne Marie Costello: You can also obtain more information on DHS's public charge policies on the U.S. Citizenship and Immigration Services webpage. We're working on CMCS Informational Bulletin for states on this issue. In the meantime, if you have any questions regarding the interaction of Medicaid or CHIP with public charge, inadmissibility determination, please reach out to your state lead. We're happy to provide technical assistance.

Anne Marie Costello: Second, as I'm sure many of you have seen on March 11th, President Biden signed the American Rescue Plan Act (ARPA). This legislation represents the largest expansion of health coverage for the American people since the Affordable Care Act in 2010, and has a significant and immediate impact on State Medicaid and CHIP programs and beneficiaries.

Anne Marie Costello: Some of these provisions included 100% FMAP for COVID-19 vaccines and their administration, as well as an expansion of individuals eligible for COVID-19 vaccine administration coverage. We recognize the states will need guidance on these provisions and other provisions quite quickly.

We've begun working expeditiously on these documents and hope to have more for you in the coming weeks.

Anne Marie Costello: I also want to recognize that yesterday, CMS released an update on the vaccine administration rates for Medicare beneficiaries. We recognize that Medicare's announcement, combined with the new temporary 100% FMAP, may have implications for states with approved or pending state plan amendments. States with questions on the impact of these changes on their program should contact CMS for technical assistance.

Anne Marie Costello: CMS also intends to provide additional guidance to states on implementation of 100% FMAP available for payment to providers for administration of the COVID-19 vaccine. While we updated our Medicaid vaccine toolkit to reflect the changes in Medicare rates, it does not yet reflect all changes made by the ARPA. We're working on updates and will post relevant updates shortly. With that, I'll turn things over to Stephanie to start her presentation. Thank you, Stephanie, take it away.

Stephanie Bell: Thanks, Anne Marie. Hi everyone. I'm Stephanie Bell. I'm a Senior Policy Advisor in the Children and Adults Health Programs Group. And as Anne Marie said, I'm here to talk today about a State Medicaid Director Letter that we released earlier this year on implementing Section 1001 of the SUPPORT Act. This is a provision that established Medicaid protections for youth who are inmates of a public institution.

Stephanie Bell: Today we're going to touch on -- we're not going to go through every detail in the State Medicaid Director Letter, but hopefully give you enough information to get you interested and go check it out and dig in further. We'll talk briefly about the requirements, strategies to implement the requirements, and then considerations for operationalizing them.

Stephanie Bell: Before jumping into the requirements themselves, I wanted to spend a moment orienting everyone to who exactly it is we're talking about here. Section 1001 of the SUPPORT Act applies specifically to eligible juveniles--that's determined in the legislation or the law now--and they're defined as juveniles who are under age 21 or individuals who are enrolled in the mandatory eligibility groups for former foster care youth.

Stephanie Bell: Those folks must be under age 26. Now most eligible juveniles are placed in a juvenile residential setting, but a small number of these folks will be incarcerated in adult jails and prisons, more likely those in the former foster youth group. And you can see here that about 45,000 individuals were held in residential placement in 2016.

- Stephanie Bell: That's a pretty small number when you're looking at the whole Medicaid population, but it's definitely not insignificant. And most of those placements were less than six months. This population is likely to be moving in and out. And it's not on this slide, but about 70% of those in residential placement have at least one diagnosable mental health or Substance Use Disorder, so access to healthcare is really important, especially as they're transitioning in and out of the system.
- Stephanie Bell: Now I want to introduce Martha Marr. She's one of our subject matter experts on justice-involved populations and she is going to walk us through some additional background on the requirements.
- Martha Marr: Thank you, Stephanie. I'm more than happy to do that. Section 1001 of the SUPPORT Act, which was signed in October 2018, prohibits states from terminating Medicaid for eligible juveniles. Some mandatory protections for this population include redetermination prior to release, eligible individuals must have benefits restored upon release, and states must process new applications in a timely manner.
- Martha Marr: It is important to note that the inmate payment exclusion does still apply for this population. Stephanie, where can states find additional information regarding that?
- Stephanie Bell: State Health Official Letter, 16-007, which was issued in 2016, provides a lot more detail on the definition of a public institution and an inmate of a public institution. And you can find that on Medicaid.gov under the Federal Guidance section.
- Martha Marr: Great, thank you. Now we hope this presentation will help you determine the best ways states can meet these requirements. Also to help these operationalize, CMS did issue a State Medicaid Director Letter in January of this year with additional guidance regarding these requirements [SMD #21-002]. These requirements are now in effect for all states. Stephanie, I'll turn it over to you to discuss an implementation strategy.
- Stephanie Bell: Great. As Martha said, the SUPPORT Act prohibits states from terminating the Medicaid eligibility of eligible juveniles, but states may suspend Medicaid. And in the State Medicaid Director Letter (SMDL), we described two different strategies you could use for suspension. The first pathway, pathway one here, is "eligibility suspension." And in this case, an individual's eligibility isn't terminated, but it's effectively paused so that they can't receive Medicaid coverage for services.
- Stephanie Bell: In this case, when an individual is hospitalized, the state Medicaid agency must take an action to lift the suspension and that would then enable the

hospital to claim for reimbursement and the state to claim FFP. Under the second pathway, the "benefits suspension" option, the eligible juvenile continues to be enrolled in Medicaid, but Medicaid coverage is limited to those inpatient services that are not subject to the payment exclusion.

Stephanie Bell: In this case, when an individual is hospitalized, the hospital can immediately claim for reimbursement for those services and the state can claim for FFP. We will go into a little more detail on each of these in the next couple of slides. Here's more on pathway one. States established an eligibility suspension by marking the individual's case in the MMIS system as "no pay," or another MMIS status that indicates no benefits are available, and/or marking the case as suspended in the state's eligibility system so that redeterminations aren't triggered.

Stephanie Bell: When eligibility is suspended, household composition generally isn't affected. Martha does it make a difference if the individual was eligible on a MAGI versus a non-MAGI basis?

Martha Marr: That's a really great question. Yes, and I will go into that in more detail in later slides.

Stephanie Bell: Great, thanks. In an eligibility suspension case, annual renewal is not required while the individual is incarcerated, although they are prohibited from doing renewals, and in some cases may want to. And as I mentioned, when the individual is hospitalized, the state needs to take an action to lift the suspension. And if it's been more than 12 months since the last renewal or the state notes that the person has experienced a change in circumstances, they would need to do a redetermination before reactivating coverage.

Stephanie Bell: What's different with the benefits suspension? Well, states generally effectuate a benefit suspension by limiting payable benefits to inpatient services, through an MMIS edit typically. But the real differences are, first that annual renewals are required if a benefit suspension occurs, and the state doesn't need to take any actions to lift the suspension if an individual is hospitalized, because they still remain eligible. Their eligibility is continuing, there's just a payment limitation in place.

Stephanie Bell: This slide [Slide 12], I know it's got a lot going on and I'm not going to walk through the whole thing. But it basically takes you through each step in the process. And we'll go into a little bit more detail in some of these points here in just a minute. Martha, what are the key components that we're gonna touch on?

- Martha Marr: Thank you, Stephanie. We'll talk through some of those now. There are several key components of the Medicaid eligibility life cycle for states to consider when they're implementing these requirements. The main areas for States to consider are household composition, processing application, annual renewal, redetermination, and issuing notices.
- Martha Marr: Unfortunately we do not have enough time during this presentation to cover all of the details. Make sure to use the following slides as a resource, but we also urge states to take a careful look at the January SMDL, which does include additional information, including information regarding determining a residency and coordination with MCOs.
- Martha Marr: The first area is regarding household composition. As Stephanie mentioned earlier, household composition is generally not impacted by incarceration for eligible juveniles who are eligible on a MAGI basis. Household composition generally remains unchanged for the length of incarceration in light of the IRS's temporary absence policies.
- Martha Marr: That IRS policy defines a stay in a juvenile facility as a temporary absence that does not impact household composition for tax filing purposes. If it is reasonable to assume the eligible juvenile will return to the home after their incarceration, the home is maintained during the absence. However, there's an exception for non-MAGI eligibility. Household composition in non-MAGI eligibility is determined by who is living with the applicant or the beneficiary.
- Martha Marr: The states should redetermine eligibility carefully, both for the eligible juvenile and for others in the household for any potential changes to the household composition. Stephanie, is there anything in particular that states should keep in mind regarding former foster care youth?
- Stephanie Bell: Yes, good reminder. There is no income standard for the former foster care group. Individuals in that group, you don't have to worry about financial eligibility changes.
- Martha Marr: Great, thank you. And I'll turn it over to you to discuss new applications.
- Stephanie Bell: All right. The requirement for processing a new application is the same, whether an individual is incarcerated or not incarcerated. And per our regulations, states must process new applications upon receipt promptly, and without delay. There are a number of things that Medicaid agencies can do in collaboration with your state's justice agency to facilitate application processing.

- Stephanie Bell: And you probably know these even better than we do, but just a few ideas on this slide to get the thinking going around Medicaid agencies, dedicating staff to eligibility and enrollment of justice-involved populations. You could assign eligibility workers to correctional facilities, or process those applications by phone, but having specific staff has often worked well for some states.
- Stephanie Bell: On the other side of the equation, a justice agency can take actions on its end that will really help to facilitate the process, and things like establishing a routine schedule, or making Medicaid enrollment a specific part of their intake or discharge process. Annual renewal--so if utilizing benefits suspension, you do need to renew your Medicaid coverage annually during the length of incarceration, just as they would for any other Medicaid beneficiary, while states with the eligibility suspension option are not required to conduct annual renewal. States should observe their normal processes for conducting renewals, and this would include attempting to renew based on available information in the account, if it is reliable, as well as available electronic data sources. And if the state Medicaid agency can't renew based on available information, a pre-populated renewal form for MAGI eligible folks would need to be provided and may be provided for non-MAGI folks.
- Stephanie Bell: I do want to note that if the inmate is the only member of his or her Medicaid household, the agency should have all the information needed to complete a renewal, and hopefully it'll be pretty quick and easy process.
- Martha Marr: Stephanie, how does the pre-release redetermination differ from an annual renewal?
- Stephanie Bell: Excellent question. For individuals who were beneficiaries before they became incarcerated, the SUPPORT Act specifically requires states to conduct a redetermination of eligibility prior to their release. In addition, states must also conduct a pre-release redetermination if they suspended eligibility, and it has been more than 12 months since the beneficiary's last redetermination, or even if they know they've experienced the change in circumstances.
- Stephanie Bell: Again, as with the renewal, states will need to use available information, including information in the individual's account and any electronic data sources that are available. And in this case may request only the information necessary to make the redetermination. And two other quick things I want to flag here are if the individual remains eligible, the state must restore full benefits upon release, you want people to walk out the door with coverage. And if a redetermination can't be completed prior to release, such as because you've experienced administrative circumstances

beyond the agency's control--I'm sure you're pretty familiar with those points--the state would restore benefits and then must complete the redetermination as soon as possible after release. Martha, will you tell us how notices fit into all of this?

Martha Marr: Absolutely. Suspension is an adverse action, and therefore states must provide at least 10-day advanced notice to impacted individuals. The notice must inform individuals of the fair hearing rights. States are probably wondering where they should send the notice, and that depends on how many people are in the household. For a multi-member household, states should send that notice to the last known address versus for a household of one where the individual is incarcerated, states should send that notice to the justice setting address.

Martha Marr: But these should coordinate with the justice agencies and the Medicaid agencies to ensure that the case files for the individual is updated to reflect the new justice setting address so that consumer notices can be sent to the prison or the jail. It is important for Medicaid and justice agencies to collaborate throughout this process.

Martha Marr: I know this has been a lot of information, and I also know that we had to really race through. I definitely understand if there are any questions, I'll turn it over to Jackie to take any of those.

Jackie Glaze: Thank you, Martha, and thank you, Stephanie for your presentation. We would like to take a few questions from you now on the information that they shared with you today. We'll begin by asking that you submit your questions through the chat function, and then we'll follow them to see if there are any questions through the phone lines. We'll take those questions at this point.

Ashley Setala: And it looks like we have a couple of questions that have come in so far. And the first question is around the advance notice and fair hearing rights provisions in the letter. And it says, "The letter indicates that eligible juveniles must be provided with timely and adequate written notice at least 10 days in advance of the date of the adverse action in accordance with 42 CFR 431.211-214. However, using date-specific incarceration and suspension dates for Medicaid fraud mitigation, my state provides written notice to the beneficiary on the date it took action to suspend Medicaid coverage in accordance with the exception noted in 42 CFR 431.213(c) which says, "The beneficiary has been admitted to an institution where he is ineligible under the plan for further services." The question is, to operationalize this advance notice and fair hearing rights requirements, do we need to provide eligible juveniles written notice 10 days prior to suspension of Medicaid coverage? Or may we continue to notify the

eligible juvenile on the date of action in alignment with the exceptions noted?"

Martha Marr: This is Martha. I can address that. Under the regulations, the suspension of eligibility benefits and services would be considered the adverse action. And the regulations require that these provide written notice at least 10 days prior to that action. In this case, the state would be required to provide written notice to the beneficiaries at least 10 days prior to suspending their Medicaid coverage.

Ashley Setala: Thanks, Martha. And there was a follow-up to that question and it says "the State Medicaid Director Letter is specific to eligible juveniles. And so is there a federal comparability issue if a state chooses to notify the adult inmates on the date of action pursuant to 42 CFR 431.213(c) as opposed to 10 days prior to the action?"

Martha Marr: In this case the notice would also still need to be provided at least 10 days prior to the action. Although I will note that we are looking into providing some additional guidance in the future regarding adult inmates. And so if you have additional questions regarding that, we can follow up with you separately.

Jackie Glaze: Sorry. Ashley, we have time for one additional question. We'll check the phone lines. Operator, can you give instructions? And see if we have a question there, please.

Operator: Absolutely. If you'd like to register for a question, please press the one followed by the four on your telephone, and you will hear a three-tone-prompt to acknowledge your request and your line will 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.

Operator: Once again, that's one, four to register for a question. One brief moment for the first question. (silence). Once again, it's a one, four to register for a question. One brief moment. We do have one question.

Jackie Glaze: Can you ask the question please?

Operator: Sure, absolutely. They're just queuing up now with their name. We have a question from the line of Pat Curtis. Please go ahead. Your line is now open.

Pat Curtis: Yes, I heard there were some auditory problems. I'm assuming everybody can hear me. I know you've mentioned this, but I'm wondering if you

could walk through it just a little bit in more detail. This is the difference between assessing the suspension of eligibility between the inmate or the person who was incarcerated with MAGI budgeting, as opposed to non-MAGI budgeting and looking at the letter or the guidance.

Pat Curtis: It appears quite complicated because it affects both the household from where the person came and the person him or herself. And if you could just walk through that a little bit as to how states would handle that particular group that is not using MAGI budgeting.

Stephanie Bell: Martha, do you want to take a stab or shall I jump in?

Martha Marr: Why don't you jump in and I can add anything else later.

Stephanie Bell: This is Stephanie. I don't think it would be too different from the process you have in place today. I think the real difference is the MAGI population, in that we did work with the IRS and found that under their rules, they would consider that young person to continue to be in the household. And so, the state can keep them in there and keep everything consistent with the way it was before they were incarcerated.

Stephanie Bell: Whereas on the non-MAGI side, because it really is based on who you live with, when an individual becomes incarcerated, they're obviously no longer living with their spouse or parents. And it may change not only their eligibility, but others in the household. Does that help at all, Pat?

Pat Curtis: Yes. It does help a little bit. We were just trying to decide how we would handle the two different ones. The MAGI is much, much easier. We're just trying to figure it out. The other issue, and this is the second question. Maybe it's not fair. The letter addresses both incarceration in prisons and jails, and with jails because people are in and out much, much, much more frequently, it's a much different process to apply, especially since jails are different sizes. Some of them are huge. Some of them are little mom-and-pop operations, and we always refer to the Mayberry concept. It's a different process to apply to the county jail population.

Sarah DeLone: This is Sarah DeLone. If I can just jump in for a second, it may be possible, Pat, if part of the concern is the family members who are remaining in the community, that you might probably put a 1902(r)(2) disregard to keep a steady state for those family members. Little bit out on a ledge here, because I'm not 100% sure, but if that's something of interest to you or other states, we should both reach out. And Gene Coffey and his team could look into that.

Pat Curtis: Thank you. Thank you. I appreciate that. We will need to think about that. Thanks a lot.

Martha Marr: Great idea. Thanks, Sarah.

Jackie Glaze: Thanks for the questions. And we do have time at the end of the session to take more questions on this topic. But at this point, we're going to move on to the next presentation and Jeff Galecki, he will present on the 2018 T-MSIS SUD Data Book that was released in January. Jeff, I'll turn it over to you at this time.

Jeff Galecki: Thank you so much. My name's Jeff Galecki. I'm a Social Science Research Analyst in the Data and Systems Group, and it's really exciting for us to have spent so long with the states and everybody getting T-MSIS ready to start releasing some of these really interesting reports, one of which we'll go over. This is 2018 T-MSIS Substance Use Disorder Book. A little bit of background on what is a Substance Use Disorder.

Jeff Galecki: We took the DSM-5 definition of a Substance Use Disorder, which merged the abuse and dependence categories people used to use in DSM-4, and merged them into one, which they call a Substance Use Disorder. They're characterized by a problematic pattern of alcohol and/or drug use, leading to clinically significant impairment or distress as manifested by one or by more than one symptom, such as difficulty controlling use, risk of self-harm, withdrawal, social or interpersonal problems, or failure to meet major responsibilities at work, school, or home.

Jeff Galecki: And then we have basically each of the different categories we'll go over for Substance Use Disorder in a minute. In 2018 overall, an estimated 20.3 million Americans ages 12 and older had a Substance Use Disorder. We included that stat in there, so that it could give some measure by which all of the other stats can be measured against the general population at-large versus Medicaid.

Jeff Galecki: The background on the SUPPORT Act, which is a Congressionally-Mandated Act, that requires this report, which we're publishing every year and we're doing catch-up years right now. In October 2018, Congress passed a Substance Use Disorder prevention that promotes opioid recovery and treatment or SUPPORT Act for patients and communities act.

Jeff Galecki: It offers a range of Medicaid, CHIP, Medicare, and public health reforms intended to advance SUD treatment and recovery initiatives, and improve prevention efforts. Section 1015 directs the U.S. Department of Health and Human Services (HHS), to publish the Transformed Medicaid Statistical

Information System, or T-MSIS, Data Book. Everything contained in this data book will be based on that T-MSIS data that they have mandated.

Jeff Galecki: This contains comprehensive data on Medicaid beneficiaries treated for SUD and the services they received. It uses T-MSIS enrollment, claims, and encounter data to identify Medicaid beneficiaries with a Substance Use Disorder, ages 12 and older with full or comprehensive benefits, for at least one day in the calendar year. And these are the 10 different categories that we've used for each of the different SUDs. Alcohol, cannabis, opioids, stimulant, tobacco, polysubstance, and "other use disorders."

Jeff Galecki: And some of the "other Substance Use Disorders" category includes things like inhalants, where there wasn't enough of a quantity for us to justify having a wholly separate category. It ended up in "other use disorders." T-MSIS data represents the national data system for Medicaid and Children's Health Insurance Program. They've continued to improve the completeness and quality of their T-MSIS submissions, and have steadily done so since we started releasing these reports in 2017.

Jeff Galecki: And in 2019, which will be forthcoming this year, we'll include all states in there, having achieved good data quality being reported, so we're very happy about that. The 2018 data book is based on the T-MSIS analytic files, TAF Release 1. The 2018 TAF Release 1 data are nearly identical to the first publicly available 2018 TAF Research Identifiable Files or RIFs, which became available in 2020.

Jeff Galecki: Here's the findings that we found in this report and that we published in the 2018 data book that's available. Of the 55.9 million Medicaid beneficiaries with full or comprehensive benefits ages 12 and older, 4.6 million or 8% were treated for a SUD in 2018. Tobacco use was the most commonly treated SUD in the Medicaid program. Approximately 2.6 million Medicaid beneficiaries, or 4.7%, were treated for tobacco use disorder.

Jeff Galecki: Approximately 1.4 million beneficiaries were treated for an opioid use disorder representing 2.5% of beneficiaries and 30.5% of beneficiaries with a Substance Use Disorder. The highest proportion, 40%, of beneficiaries treated for SUD were eligible for Medicaid due to the expansion of benefits to adults. In states that did not expand coverage for adults, beneficiaries in the aged, blind, or disabled category made up the highest proportion of beneficiaries treated for a SUD.

Jeff Galecki: Across the major enrollment categories, beneficiaries in the ABD category had the highest treated prevalence of Substance Use Disorders at 11%.

Almost 15% of Medicaid beneficiaries treated for SUD were dually eligible for Medicare and Medicaid.

Jeff Galecki: There are many types of SUD services covered by Medicaid, and here's the breakdown of the ones that we categorized and counted. Case management, community support, consultation, counseling, detoxification, emergency services, inpatient care, intervention services, medication-assisted treatment (MAT) and other pharmacotherapy, medication management, observation care, partial hospitalization, peer supports, physical services, screening and assessment, and treatment programs.

Jeff Galecki: Most states have at least one Medicaid beneficiary who received each type of service. The exceptions are peer support and partial hospitalizations, which fewer states covered--37 and 35 states respectively. Acute care services were the most common SUD treatment service delivered to Medicaid beneficiaries. Nearly half of beneficiaries (46%) treated for SUD, received emergency services, the most common SUD treatment, and slightly fewer (42%) received inpatient care.

Jeff Galecki: And I think this is one of the findings as I've been speaking about the 2018 Data Book findings that I've really been highlighting, that the majority of SUD treatment services are at the likely most invasive and the highest cost level. And so this is something that I think would be a great goal that we want to reduce in this category. About one fourth (24%) of Medicaid beneficiaries treated for a SUD received MAT (medication-assisted treatment).

Jeff Galecki: The distribution treatment services vary substantially across states. The variation most likely reflects variation in state policies, service and provider availability, population characteristics, and possibly data quality. About 77% of Medicaid beneficiaries treated for a SUD received at least one service in an outpatient setting; 44% received at least one service in an inpatient setting.

Jeff Galecki: And this is another critical, I think, two findings we found. Very few beneficiaries received SUD services in residential or home and community-based settings at 6% and 2% respectively. Here's a breakdown of the average number of days of service among beneficiaries receiving that service across all states received. And we can see here that MAT had 130 days worth of medication (or four months), treatment programs 31 days, partial hospitalization 16 days, inpatient care 10 days, and observation care 4 days.

Jeff Galecki: Average number of visits among beneficiaries receiving that service across all states are counseling services at 10 visits, physician services at 4

visits, and immersion emergency care at 2 visits. About 72% of Medicaid beneficiaries treated for SUD received at least one service through a managed care organization. And in the 12 states listed there, 90% or more of the beneficiaries treated for SUD received at least one service through a managed care organization. About 45% of Medicaid beneficiaries treated for SUD received at least one service through a state's fee-for-service system.

Jeff Galecki: Here's another very critical finding that I'd like to highlight, especially given the context of what I said earlier about how most of the care has been in a higher level setting like inpatient emergency services. This finding is that among the Medicaid beneficiaries treated for SUD who received SUD services in an inpatient or residential setting, 26% received at least one service in an outpatient or home and community-based setting within 30 days of discharge.

Jeff Galecki: This would be like going into the emergency department for an acute overdose and then your follow-up care being at a home or community-based setting like an outpatient service, and a low number of 26% received at least one service within 30 days of discharge outside of that setting. This varied across states from a low of 13% in Arkansas, Colorado, and The Virgin Islands to a high of 44% in Massachusetts.

Jeff Galecki: Another important finding is 18% received two or more services in an outpatient, or home and community-based setting within 30 days of discharge. These would be the numbers we'd want to increase, whereas we want to decrease the earlier numbers of those receiving or needing the emergency inpatient services. All of this information is published in a static PDF report. That was the one published on our website, and then also sent to Congress.

Jeff Galecki: Also in the slides I've embedded--and this is a hyperlink that if you click on it, it will take you directly to the interactive data tool where you can go through all of the tables and all of the data that was included in the report, and you can filter by things like state, service categories, and then you can also download some of that aggregate data so that you can use it for your own means. That is the SUD Interactive Data Book link. It's also along with the report on the website, but I included it in the slides for ease of use, and those are our references. And now I guess we can go to questions.

Jackie Glaze: Thank you, Jeff, for your presentation. As Jeff indicated, we are ready to take your questions at this point. We'll follow the same process as we have before by taking your questions through the chat function. You can begin submitting those now, and then we'll take your calls over the lines. You

can begin sending your questions through the chat line at this point. Thank you.

Ashley Setala: And we have a few remaining questions related to our first presentation on Section 1001 of the SUPPORT Act that we can start with. The first question is, "Does Section 1001 of the SUPPORT Act relating to eligible juveniles apply to juveniles who are eligible for Medicaid through the 1915(c) waiver?"

Stephanie Bell: This is Stephanie. I'm trying to think about how that would impact their eligibility. We may need to follow up. There's no exclusion for individuals that are in (c) waivers, but if your eligibility is derived from your use of home and community-based services, then it might have an impact. But we can certainly follow up.

Ashley Setala: Thanks, Stephanie. Then we've gotten a couple of questions around the letter and CHIP. One of them says "the letter refers to Medicaid only. Is it also applicable to CHIP? And if not, is it an option for the state to expand to CHIP?"

Stephanie Bell: I can say the SUPPORT Act requirement section 1001, which we've been talking about specifically is limited to Medicaid and the rules in CHIP are somewhat different with respect to inmates of public institutions. And so I think we would have to follow up depending on what's happening in that state might impact the options. But we're happy to--we can certainly follow up or if folks want to reach out with specific questions about their state, we can definitely help there.

Ashley Setala: Great. And then we have one more question on the suspension letter around the advance notice and fair hearing rights provision. And it says, "Does a benefits suspension also require a 10-days-notice?"

Martha Marr: I can take this one. Yes, both of the strategies that we discussed today would fall within the definition of an action, which is defined at 42 CFR 431.201 to include a termination, reduction, or suspension of benefits and services. And so either pathway that the state chooses to utilize, at least 10 days advance notice to the individual is required. I hope that helps.

Ashley Setala: Thanks, Martha. Then we have a couple of other questions that we would like to address. One was raised on our call last week, and we needed to take it offline, but wanted to come back and provide a response. It is around the updates we gave on non-emergency medical transportation and says, "Regarding non-emergency medical transportation, it is our understanding based on guidance from CMS' website that wait times and

unloaded miles can be negotiated and factored into contractual, non-fee for service payment arrangements. Is this still accurate?"

John Giles: Hi, Ashley. This is John Giles. I can answer that question. Under a Medicaid managed care contract, non-emergency medical transportation can be included in a risk-based contract. Under that risk-based contract, the associated prepaid capitation payments must be actuarially sound in accordance with our regulations. And those can be found at 42 CFR 438.4 through 42 CFR 438.7.

John Giles: Actuarially sound capitation rates must be projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of that contract, and for the operation of the managed care plan for the time period and the population covered under the terms of the contract. We would expect that covered services, including wait times and mileage as appropriate, would be part of the actuarially sound capitation rates in accordance with our regulations at 42 CFR 438.3(c). And I would be happy to take any additional questions on that point.

Ashley Setala: Great. Thanks, John. And then we had a question that came in through our Medicaid COVID-19 email box this week, that we also wanted to address on today's call. And it is for our Children and Adult Health Programs Group (CAHPG). And it says, "Assuming the public health emergency extension continues through the end of the year, but expire around January 20th, 2022, can state take actions to terminate before the PHE expires with an effective date after the PHE expiration?"

Shannon Lovejoy: Hi, this is Shannon Lovejoy in CAHPG, and I can take that question. As we know, states claiming the temporary FMAP increase must keep Medicaid beneficiaries enrolled through the end of the month in which the public health emergency ends. And regardless of when the PHE will end, dates must follow certain requirements and expectations before they can terminate coverage for an individual, such as making sure they're following processes for a renewal potentially repeating certain redeterminations and providing any required advance notice.

Shannon Lovejoy: We do recognize that states are doing what they can to prepare for the end of the public health emergency, and many states are completing as many eligibility enrollment actions as possible now, so they can limit the amount of work that we'll need to complete once the public health emergency ends. With that, HHS has indicated that there's an attempt to provide states with 60 days advance notice of the end of the public health emergency.

Shannon Lovejoy: And this possibly could be sufficient time for states to align completion of some eligibility and enrollment actions, once the continuous enrollment

requirement is no longer in effect. But states will need to make sure that they're taking the appropriate steps, so they don't run the risk of inadvertently terminating coverage for some individuals before the end of the month in which the public health emergency ends. Or that they are otherwise failing to meet other federal requirements, and any attempts to better line up terminations with the end of a continuous enrollment requirement.

Shannon Lovejoy: And I'll just also remind states that the guidance that was in the December State Health Official Letter is still the guidance that's in effect. And in that guidance, states are provided up to six months after the month in which the public health emergency ends, to complete pending work. Hopefully that addresses the question.

Ashley Setala: Thanks, Shannon. And then we have one more question that's come in on today's presentation on the suspension State Medicaid Director Letter, again around the requirement to provide a 10-day-advance notice prior to suspension. And it says, "How does that work with claims and paying claims and federal match?"

Martha Marr: Stephanie, do you mind jumping in on this one?

Stephanie Bell: Yep. I was just going to say this guidance doesn't change anything about claiming for individuals who are inmates of a public institution. It really just sets up parameters for ensuring that they're suspended. That eligible juveniles are in a suspension status, and not terminated in order to effectuate the payment exclusion. But it doesn't change anything about the payment exclusion itself. John, I don't know if you want to say anything about what happens on the managed care end.

John Giles: No, I would have to take that back. I don't have an answer to that today.

Stephanie Bell: Okay.

Jackie Glaze: Thank you. If we can ask the operator to provide the instructions for submitting questions through the phone lines, and then we can take some questions there as well.

Operator: Thank you. If you like to register for a question, please press the one followed by the four on your telephone. We do have a question from the line of Pamela Winslow. Please go ahead. Your line is open.

Pamela Winslow: Great. Good afternoon. My question is about the FMAP increase related to HCBS services. I understand it's going to be for "select services." Is there

going to be any guidance coming out from CMS in the near future about what those services are going to be?

Alissa Deboy: Hi, this is Alissa Deboy from the Disabled and Elderly Health Programs Group. And the answer is yes, we do intend to provide them. But we're not able to really dive into that at this time. But please stand by and we are working on that. Thank you.

Operator: Thank you. We also have a question from Eve Lickers. Please, go ahead. Your line is open.

Eve Lickers: Yes, I have two questions. Thank you. The first question is in response to the recently signed American Rescue Plan Act. When does CMS anticipate issuing guidance to states regarding the option to extend the postpartum coverage period from 60 days to 12 months?

Anne Marie Costello: Hi, this is Anne Marie Costello. Maybe I'll jump in here. That provision is not effective until April 2022. We'll be putting guidance out in the coming months. But it will not be one of the first sets of guidance that we put out. I would like to let states know that if in the interim states are interested in considering Section 1115 demonstration related to postpartum coverage, and addressing maternal morbidity mortality, we'd be happy to talk to states if they want to consider that in the interim.

Eve Lickers: Thank you very much for that feedback. We were aware of the April 2022 date. However, we're getting a number of questions already from a number of our stakeholders. And they're very eager to move forward. We just want to be able to provide that guidance. And we had already considered 1115, but the budget neutrality provision or requirement would probably be an issue.

Anne Marie Costello: Thank you. Thank you.

Eve Lickers: Yes, ma'am and then the second thing and we may not be prepared to comment on it today because we have asked about this previously, and we also have asked our regional reps, as well. But can CMS advise what options they've had in paying FQHCs and RHCs for the administration of COVID-19 vaccines? Essentially, can they pay as an example, a fee schedule rate such as what would be paid to other practitioners under the program like physicians or CRMP, instead of their PPS rates, if we submit a state plan amendment for disaster SPA to do so?

Rory Howe: Hi, good afternoon. This is Rory Howe with the Financial Management Group. And this is a common question we've heard from a lot of states and that there are some limited flexibilities that are available regarding state

payment options for vaccine administration in FQHCs. And what we're asking you to do at this time is to reach out through your state lead, and we can work to provide you technical assistance in a one-on-one basis. The policy is pretty nuanced and we realized that states are in different situations and we really want to be able to provide you that individual TA.

Eve Lickers: Very good. Thank you very much.

Rory Howe: Sure.

Operator: And there are no further questions at this time.

Jackie Glaze: Thank you. Ashley, do you have one additional question before we close?

Ashley Setala: Yes, it looks like there was one last chat question and it says, "Recognizing that more guidance is forthcoming, is the following a correct statement on ARPA coverage provision? COVID-19 testing groups for the uninsured is eligible for the full mandatory benefit, including testing, vaccine, vaccine administration, and treatment. Other limited benefit groups, including family planning, tuberculosis, and breast and cervical cancer receive coverage for testing, and vaccine, and vaccine administration, but not treatment."

Stephanie Bell: This is Stephanie Bell. I would say I think it's more nuanced than that. COVID-19 testing group that definitely has expanded coverage, but not to the full mandatory benefit. And I believe the limited benefit groups get just vaccine administration. Can anyone else [crosstalk]-

Sarah DeLone: Yes, I believe that's the case. Yep.

Jackie Glaze: Thank you everyone. And in closing, I'd like to thank the presenters today for their excellent presentations. We will be meeting with all of you again soon, and the invitation and agendas will be forthcoming. As always, if you do have questions before our next call, please reach out to us, reach out to your state leads and we'll be sure to answer your questions. We hope everyone has a great afternoon. And thank you again for your attendance today.

Operator: That concludes the call for today. We thank you for your participation, and ask that you please disconnect your line.