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All-State Medicaid & CHIP Call

March 16, 2021

March 16, 2021 Agenda

- Youth Medicaid Protections for Inmates of Public Institutions: Implementing Section 1001 of the SUPPORT Act
- 2018 T-MSIS Substance Use Disorder Data Book
- Open Mic Q and A

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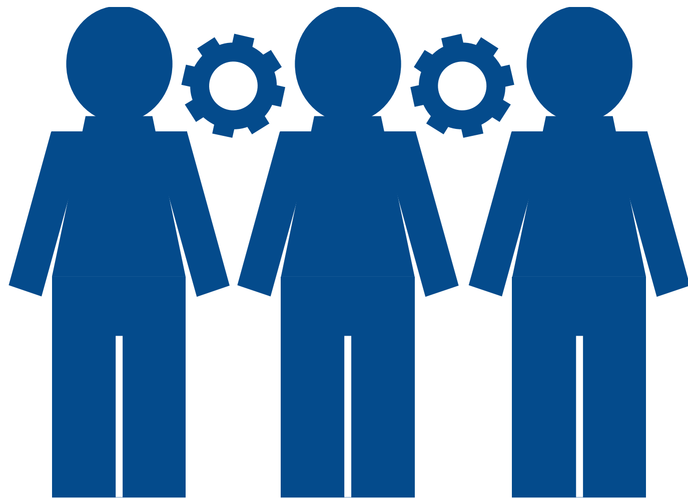
Youth Medicaid Protections for Inmates of Public Institutions



Implementing Section 1001 of the SUPPORT Act

and

SMD #21-002

Background on "Eligible Juvenile" Inmates

"Eligible juveniles" are defined in the SUPPORT Act as juveniles who are under age 21 or individuals enrolled in the eligibility group for former foster care youth (FFY).

Placement for Juvenile/FFY Justice-Involved Populations

- Juveniles in the justice system are most commonly placed in a juvenile residential setting. A smaller proportion are incarcerated in adult jails and prisons.
  - ~45,500 individuals under age 21 were held in residential placement. (2016)
  - ~3,700 individuals under age 18 were held in local jails. (2016)
  - ~1,200 individuals under age 18 were held in state prisons (2013)
- Due to their age, most FFY who are incarcerated are placed in adult jails and prisons, though data on the number of Medicaid-enrolled FFY who are incarcerated are not available.

Time in Residential Placement*

- Most juveniles remain in a residential placement for less than six months.
- 11% of committed juveniles remain in a residential placement after one year.**

Sources: https://www.acf.hhs.gov/sites/default/files/cb/afcarsreport25.pdf; https://www.ojjdp.gov/mpg/litreviews/Status_Offenders.pdf; https://www.ojjdp.gov/ojstatbb/corrections/faqs.asp.

*Data for duration of stay for juveniles in jail or prison is not available.

**Committed juveniles and FFY include those who are awaiting adjudication, disposition, or placement and those who are held as part of a court-ordered disposition.

Section 1001 of the SUPPORT Act's Medicaid Coverage Requirements

Medicaid Coverage Requirements Under Section 1001 of the SUPPORT Act: At-Risk Youth Medicaid Protections

Section 1001 of the SUPPORT Act, signed into law on October 24, 2018, prohibits states from terminating Medicaid eligibility when an eligible juvenile is an inmate of a public institution.

Sec. 1001: At-Risk Youth Medicaid Protections

- States shall not terminate Medicaid eligibility when eligible juveniles become inmates of a public institution. States may instead suspend Medicaid eligibility for the duration of incarceration.
- States must conduct a Medicaid redetermination of eligibility for juveniles and prior to their release, without requiring a new application.
- Coverage for juveniles and FFY who are found eligible for Medicaid during the pre-release redetermination must have their Medicaid benefits restored upon release.
- For juveniles and FFY who were not enrolled in Medicaid prior to becoming an inmate, states must process new applications submitted by them—or by someone on their behalf—in a timely enough manner to ensure Medicaid benefits are available to them upon release if they are determined eligible.
- The new requirements do not change the exclusion from medical assistance rules prohibiting Medicaid payment for services provided to inmates of public institutions, including correctional institutions. (*see* Sec. 1905(a)(30)(A) of the Social Security Act)

Source: Pub. L. 115-271, https://www.congress.gov/115/bills/hr6/BILLS-115hr6enr.pdf

Implementing Section 1001 of the SUPPORT Act

- On January 19, 2021, CMS issued State Medicaid Director letter #21-002: Implementation of At-Risk Youth Medicaid Protections for Inmates of Public Institutions.
- The new requirements are now in effect in all states.

RE: Implementation of At-Risk Youth Medicaid Protections for Inmates of Public Institutions (Section 1001 of the SUPPORT Act)

January 19, 2021

Dear State Medicaid Director:

The purpose of this letter is to provide guidance to states on the implementation of new Medicaid requirements for at-risk youth who are inmates of public institutions. Section 1001 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (the SUPPORT for Patients and Communities Act, herein referred to as "the SUPPORT Act," Pub. L. 115-271), signed into law October 24, 2018, amended section 1902(a) of the Social Security Act (the Act), to prohibit states from terminating Medicaid eligibility for "eligible juveniles" (defined as individuals under age 21 and individuals enrolled in the mandatory eligibility group for former foster care children) who become inmates of public institutions on or after October 24, 2019 due to their incarceration.[1] Section 1001 of

Operational Considerations for Implementing Section 1001 of the SUPPORT Act

Suspension Strategies

States may suspend Medicaid in one of two ways.
Under both suspension strategies, the individual maintains Medicaid eligibility.

Pathway 1

- **Eligibility Suspension**:
  - The eligible juvenile's eligibility is not terminated, but it is effectively paused. The individual cannot receive Medicaid coverage for services and no FFP is available.
  - When hospitalized, the State Medicaid agency needs to take action to lift the eligibility suspension and enable reimbursement.

Pathway 2

- **Benefit Suspension**:
  - The eligible juvenile continues to be enrolled in Medicaid, but Medicaid coverage is limited to inpatient services furnished to the individual while admitted to a medical institution for at least a 24-hour inpatient stay.
  - When hospitalized, the hospital can immediately claim for reimbursement.

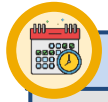
Pathway 1: Eligibility Suspension

Suspension

- ❑ Eligibility is not terminated but the individual is no longer eligible to receive Medicaid benefits.
- ❑ The individual's case is marked as:
  - "No pay" in a state's MMIS, or another status that indicates that no benefits are available.
  - "Suspended" in a state's eligibility system so that redeterminations are not triggered.
- ❑ Household composition generally is not affected by an individual's incarceration (*see slide 13 for additional detail*).

Individual is Hospitalized

- ❑ Inpatient hospitalization:
  - If the most recent renewal was completed >12 months ago: The State must conduct a redetermination and reactivate coverage prior to claiming federal financial participation (FFP) for allowable inpatient expenses.
  - If the most recent renewal was completed < 12 months ago: The State may reactivate inpatient coverage prior to claiming FFP for allowable inpatient expenses, without an additional redetermination.



Annual Renewal

- ❑ Annual renewals are not required while the individual remains incarcerated.

Pre-Release Redetermination

- ❑ For individuals with Medicaid at the time of incarceration, the State must conduct a redetermination prior to release.

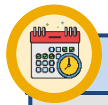
Pathway 2: Benefits Suspension

Suspension

- ❑ Eligibility is not terminated but the individual is only eligible to receive inpatient services delivered to inmates hospitalized in a medical institution.
- ❑ State limits payable benefits in MMIS to inpatient services.
- ❑ Household composition generally is not affected by an individual's incarceration (*see slide 13 for additional detail*).

Individual is Hospitalized

- ❑ For inpatient hospitalizations, the State may claim FFP for allowable services.



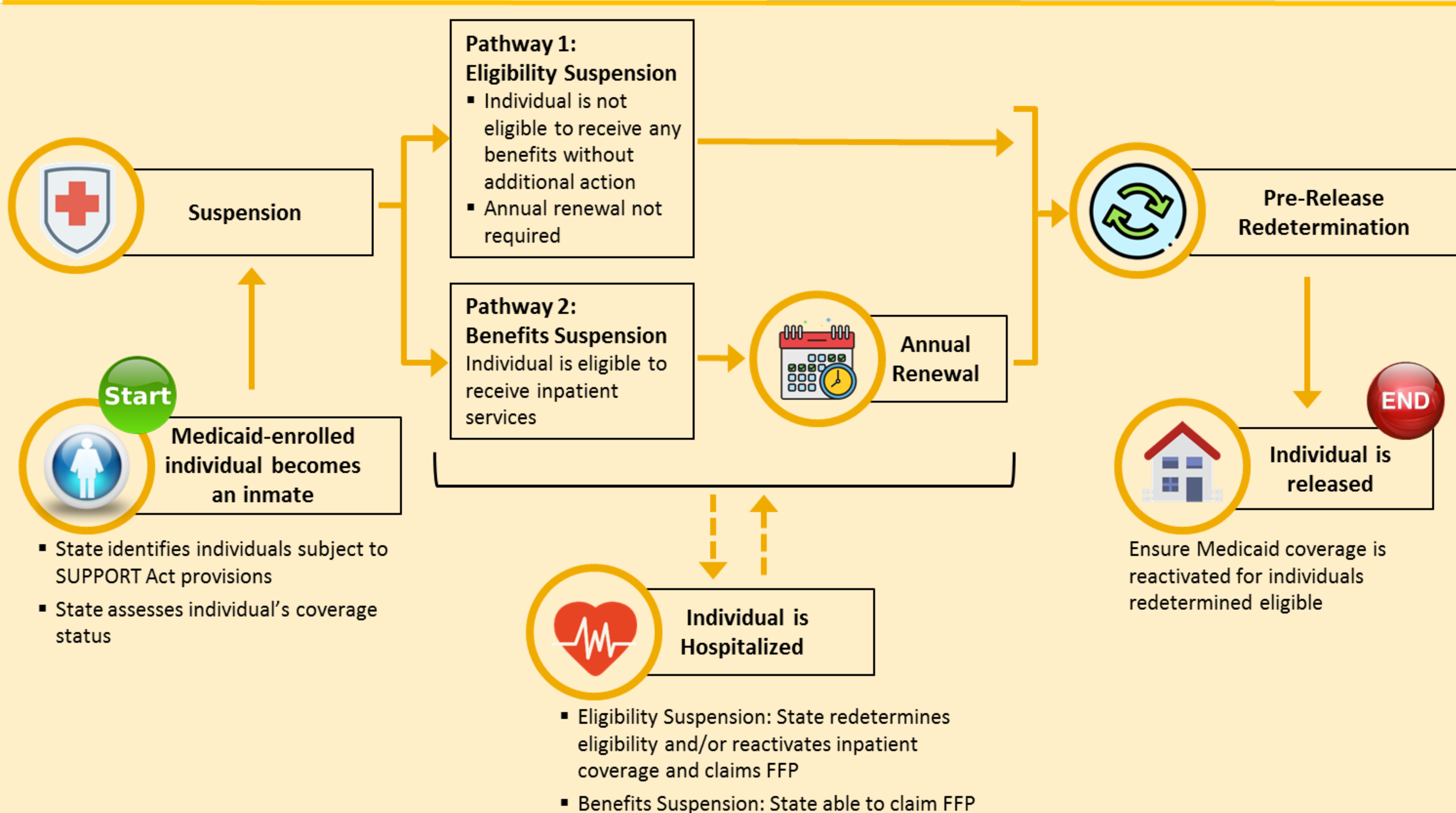
Annual Renewal

- ❑ Annual renewals are required while the individual remains incarcerated and must be conducted on the individual's annual cycle (i.e., not based on date of incarceration).

Pre-Release Redetermination

- ❑ For individuals with Medicaid at the time of incarceration, the State must conduct a redetermination prior to release.

Eligibility Lifecycle for Juvenile Justice-Involved Populations Enrolled in Medicaid



Key Components of the Medicaid Eligibility Lifecycle

Taking a Closer Look at Additional Key Components of the Medicaid Eligibility Lifecycle

Impact of incarceration on household composition

Processing Applications

Annual Renewal

Pre-release Redetermination

Issuing Notices

Impact of Incarceration on Household Composition

Non-MAGI Eligibility: incarceration may impact who is included in the individual's household. Generally, in non-MAGI eligibility determinations, only individuals who are actually living with the Medicaid applicant or beneficiary will be included in the household.

MAGI-based Eligibility: household composition for inmates generally remains unchanged for the length of incarceration in light of the IRS's temporary absence policy. Standard household composition rules apply (42 CFR 435.603(f)).

- The IRS defines a stay in a juvenile facility as a "temporary absence" that does not impact household composition for tax filing purposes. *(IRS Publication 501)*
  - It must be reasonable to assume the juvenile will return to the home after their incarceration the home is maintained during the absence.
- The IRS permits married couples to continue to file taxes jointly during incarceration. *(IRS Publication 501)*
- States should apply these temporary absence rules to both tax-filing and non-tax-filing households.
- The rest of the household is obligated to report any other change of circumstances while enrolled in Medicaid.

Source: Publication 501, "Dependents, Standard Deduction, and Filing Information," available at https://www.irs.gov/pub/irs-pdf/p501.pdf

Processing New Applications

Per regulations, states must process new applications upon receipt, promptly and without delay. This applies equally to applications submitted by or for juveniles and former foster care youth who were not enrolled in Medicaid when they became incarcerated *(42 CFR 435.906; 435.912)*.

Medicaid and justice agencies can collaborate to facilitate application processing at any time during the period of incarceration.

Medicaid Agency	Justice Agency
▪ Assign eligibility workers to correctional facilities ▪ Expedite application processing to ensure eligible individuals have access to full Medicaid benefits upon release ▪ Process telephonic applications ▪ Provide training and serve as a general point of contact for justice agencies ▪ Elevate systemic issues for leadership review	▪ Make Medicaid enrollment a routine part of the intake and/or discharge process ▪ Enable security clearance for eligibility workers, if needed ▪ Establish routine schedule for enrollment activities (e.g., every other Monday at 4:00 pm) ▪ Develop application approach for each facility: laptop/tablet where internet available or paper

Source: Urban Institute and Manatt Health Solutions, "Strategies for Linking Justice Involved Populations to Health Coverage," (March 23, 2017) available at http://www.urban.org/policy-centers/justice-policy-center/projects/connecting-criminal-justice-health-care

Annual Renewal for Inmates

States with Benefits Suspension must renew Medicaid coverage annually during the length of incarceration. States with Eligibility Suspension are not required to conduct annual renewals.

- In States with Benefits Suspension, eligibility for individuals must be renewed annually during incarceration. States should observe their normal processes for conducting annual renewals.
- State Medicaid Agencies must attempt to renew eligibility based on available information in the account, if reliable, and data sources.
  - If the available information indicates no change or a change that still results in Medicaid eligibility, the agency must renew without requiring further beneficiary action.
  - If the state Medicaid agency cannot renew based on available information, a pre-populated renewal form must be provided to the beneficiary.
  - *Reminder:* There is no income test for the former foster care youth Medicaid eligibility group.

States are likely to have access to all the information that is necessary to complete a renewal for inmates who are in a single-member household.

Sources: 42 CFR 435.916(a); 42 CFR 457.343.

Pre-Release Redetermination for Inmates

- The SUPPORT Act requires states to conduct a redetermination of eligibility prior to an individual's release from incarceration.
  - States should use available information to conduct a redetermination for individuals leaving incarceration, including information available in the individual's account and through electronic data sources.
  - States may request only necessary information to make a redetermination.
- The Medicaid agency will need to establish processes to ensure it is notified by the state justice agency - in advance of a release - so that it can begin a redetermination.
- If the individual remains eligible upon redetermination, the State must restore full benefits upon release from incarceration.
- If a redetermination cannot be completed prior to release due to administrative circumstances beyond the agency's control, the State must restore benefits and complete redetermination as expeditiously as possible. Additional guidance will be provided on this scenario.

Source: 42 CFR 435.916(d).

Issuing Notices to Incarcerated Juveniles/Former Foster Care Youth

- Benefits/Eligibility Suspension is an adverse action and advance notice must be sent. Notice must inform individuals of their fair hearing rights.
- For individuals who are in a multiple-member household, states continue to send notices to the last known household mailing address. Families of incarcerated juveniles are required to notify the state Medicaid agency of any change in circumstance.
- For individuals who are in a single-member household (e.g., household of one) states must update information in the individual's case file to reflect the new justice setting address so that consumer notices can be sent to the prison or jail rather than the last known address.
- Medicaid and justice agencies should collaborate to ensure that notices mailed to inmates in correctional facilities are routed appropriately and without delay and that notices sent via electronic communication are accessible.

Sources: 42 CFR 435.917; 42 CFR 435.918; 42 CFR 431.206; 42 CFR 431.210.

Questions

2018 T-MSIS SUBSTANCE USE DISORDER DATA BOOK

As required by the
Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (P.L. 115-271)

Background: Substance Use Disorder

- Substance use disorders (SUDs) are characterized by a problematic pattern of alcohol and/or drug use leading to clinically significant impairment or distress as manifested 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 (American Psychiatric Association, 2013).
- In 2018, an estimated 20.3 million Americans ages 12 and older had a SUD (Substance Abuse and Mental Health Services Administration, 2019).

Background: The SUPPORT Act

- In October 2018, Congress passed the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (P.L. 115-271).
- 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 (T-MSIS) SUD Data Book.

Background: The SUD Data Book

- Contains comprehensive data on Medicaid beneficiaries treated for a SUD and the services they received.
- Uses T-MSIS enrollment, claims, and encounter data to identify Medicaid beneficiaries with a SUD ages 12 and older with full or comprehensive benefits for at least one day in the calendar year.
- Includes the following SUDs: alcohol, cannabis, opioid, stimulant, tobacco, polysubstance, and other use disorders.

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Background: T-MSIS Data

- T-MSIS data represent the national data system for Medicaid and Children's Health Insurance Program (CHIP).
  - States continue to improve the completeness and quality of their T-MSIS submissions.
- This 2018 Data Book is based on T-MSIS Analytic Files (TAF) release 1.
  - 2018 TAF release 1 data are nearly identical to the first publicly available 2018 TAF Research Identifiable Files (RIFs), which became available in 2020.

Key Findings: Medicaid Beneficiaries Treated for a SUD

- Of the 55.9 million Medicaid beneficiaries with full or comprehensive benefits ages 12 and older, 4.6 million (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 (4.7%) were treated for a tobacco use disorder.
  - Approximately 1.4 million beneficiaries were treated for an opioid use disorder, representing 2.5% of beneficiaries and 30.5% of beneficiaries with a SUD.

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Key Findings: Medicaid Beneficiaries Treated for a SUD *(continued)*

- The highest proportion (40%) of beneficiaries treated for a 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 (ABD) categories made up the highest proportion of beneficiaries treated for a SUD.
- Across the major enrollment categories, beneficiaries in the ABD categories had the highest treated prevalence of SUD (11%).
- Almost 15% of Medicaid beneficiaries treated for a SUD were dually eligible for Medicare and Medicaid.

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Key Findings: SUD Services Provided by State Medicaid Programs

- There are many types of SUD services covered by Medicaid:
  - 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, physician services, screening and assessment, and treatment programs
- Most states have at least one Medicaid beneficiary who received each type of service.
  - The exceptions are peer support and partial hospitalization, which fewer states covered (37 and 35 states, respectively).

Key Findings: SUD Services by Service Type

- Acute care services were the most common SUD treatment service delivered to Medicaid beneficiaries.
  - Nearly half of beneficiaries (46%) treated for a SUD received emergency services (the most common SUD treatment service), and slightly fewer (42%) received inpatient care.
- About one-fourth (24%) of the Medicaid beneficiaries treated for a SUD received MAT.
- The distribution of treatment services varied substantially across states.
  - This variation most likely reflects variation in state policies, service and provider availability, population characteristics, and possibly data quality.

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Key Findings: SUD Services by Setting

- 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.
- Very few beneficiaries received SUD services in a residential (6%) or home- or community-based setting (2%).

Key Findings: Number of SUD Services Provided

- Average number of days of service among beneficiaries receiving that service across all states:
  - MAT: 130 days worth of medication (more than four months)
  - Treatment program: 31 days
  - Partial hospitalization: 16 days
  - Inpatient care: 10 days
  - Observation care: 4 days
- Average number of visits among beneficiaries receiving that service across all states:
  - Counseling services: 10 visits
  - Physician services: 4 visits
  - Emergency care: 2 visits

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Key Findings: Delivery System for SUD Services

- About 72% of Medicaid beneficiaries treated for a SUD received at least one service through a managed care organization.
  - In 12 states (Arizona, Delaware, Hawaii, Iowa, Kansas, Kentucky, Louisiana, Michigan, Nebraska, New Mexico, Pennsylvania, Washington) and Puerto Rico, 90% or more of the beneficiaries treated for a SUD received at least one service through a managed care organization.
- About 45% of Medicaid beneficiaries treated for a SUD received at least one service through a state’s fee-for-service system.

Key Findings: Progression of Care

- Among the Medicaid beneficiaries treated for a SUD who received SUD services in an inpatient or residential setting:
  - 26% received at least one service in an outpatient or home- or community-based setting within 30 days of discharge.
    - This varied across states, from a low of 13% in Arkansas, Colorado, and the Virgin Islands to a high of 44% in Massachusetts.
  - 18% received two or more services in an outpatient or home- or community-based setting within 30 days of discharge.

Interactive Data Tool

SUD data book Interactive Tool

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References

- American Psychiatric Association. “Diagnostic and Statistical Manual of Mental Disorders.” 5th edition. Arlington, VA: APA, 2013.
- Substance Abuse and Mental Health Services Administration. “Key Substance Use and Mental Health Indicators in the United States: Results from the 2018 National Survey on Drug Use and Health.” HHS Publication No. PEP19-5068, NSDUH Series H-54. Rockville, MD: SAMHSA, Center for Behavioral Health Statistics and Quality, 2019. Available at https://www.samhsa.gov/data/report/2017-nsduh-annual-national-report. Accessed June 29, 2020.

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Questions