4/28/2026 CMCS All-State Webinar-

April 28, 2026,

Ryan, Jacquelyn (CMS/CTR) 0:40
Thank you everyone for joining. We will be starting at 302.
Good afternoon, everyone, and thank you for joining today's CMCS call and webinar. Today's meeting is being recorded. If you have any objections to being recorded, you may disconnect at this time. And now I would like to turn it over to Nick Wallace to get us started. Nick.

Wallace, Nick (CMS/CMCS) 2:13
Jacqueline, thanks so much and thanks everybody. Good afternoon. My name is Nick Wallace. I'm an advisor in the office for the Center Director here at CMCS and welcome to the April Allstate Call. Before we get started, I just wanted to note that Dan Brillman, our Center Director, is unfortunately unable to join today, but should be back with us for next month's call.
In the meantime, I'm going to go ahead and get us started. I wanted to acknowledge that we've been hearing a lot from states in the last few weeks and months. Over the past several weeks, we've gotten a steady stream of questions about community engagement, about renewal requirements, about immigrant eligibility, but more broadly, how all of those pieces fit together from an operational standpoint.
And that's not surprising. These are significant policy, operational, and systems changes, and they're happening with overlapping timelines. So the common thread we've been hearing from states is less about one specific provision, but more about how all of these things fit together and how to sequence the work and plan across multiple requirements at the same time.
So that's really the goal and the theme of today's call, to keep making progress in answering some of those questions that you all have, and to walk through a few tools and updates that can help with the implementation planning. And so we have a lot to get through. And so I'm going to walk through the agenda and then we can dive right in.
So first, we're going to walk through a new tool for states called the Medicaid and CHIP Policy Implementation Roadmap. This is a new tool developed by CMCS to support state planning across all major statutory and regulatory changes. It lays out

key policy and systems related provisions over time and across 2026, 27, beyond. and to help with sequencing and prioritization. We know states are managing a lot in parallel, and this tool is meant to give a clearer picture of what's coming so you can plan and sequence all of this work.

Next, we'll turn to section 71109 titled Alien Medicaid Eligibility. As noted in the recent state health official letter, this provision includes changes to how federal financial participation applies for certain populations beginning October 1st, 2026. Candace Anderson and Rachel Nichols from our Children and Adults Health program group will provide a high level overview of the guidance and key implementation considerations for this provision. I'll note that we had a preliminary discussion about this provision last month, and so we'll dive a little bit deeper this month. After that, we are going to shift to state directed payments. I'll note that this discussion is going to be focused on existing regulatory requirements.

not changes related to the working families tax cut legislation. There are requirements that are already in place with upcoming applicability dates over the next several years. And Alex Loisius from our managed care group will walk through key requirements and timing with a focus on helping states plan ahead and stay on track. And finally, we're going to move to the EPSDT

Children's Behavioral Health Toolkit. We shared a brief preview of this resource on a previous call, and today we're going to go into a little bit more detail. The toolkit includes a range of practical strategies states can use to strengthen behavioral health services for children and youth across delivery systems, early intervention, service integration, and workforce capacity.

And Betsy Conklin from our Medicaid Benefits and Health Programs group is going to walk through the toolkit for us. After our final update, we'll open your lines for additional questions. Just before we get started, a quick logistical note that we'll be using the webinar platform today to share slides. So if you're not already logged in, we encourage you to do so, so you can follow along.

And we do have a packed agenda today, so we're encouraging you all to submit questions as the presentations go along, and hopefully we can get to as many as we can at the end.

And with that, I am actually going to take our first agenda item, which is a new tool for states called the Medicaid and CHIP Policy Implementation Roadmap. I am actually going to see if our technology works here, and I'm going to toggle one screen off.

and see if I can share my screen.
Okay, I am hoping folks can see what I am seeing. This is the Medicaid.gov Working Families Tax Cut Legislation subpage. I wanted to remind states about this resource. This page is being updated on an ongoing basis with new guidance documents, tools, and other materials from CMCS.
related to the Working Families Tax Cut implementation. This is really our one-stop shop for all things WFTC. And you'll notice that there is a new resource on this page. So if you scroll down, you'll see these high level and detailed timeline views. And I am going to move ourselves over to the high level.
We're really excited about these tools. These are intended to support state implementation planning, and they reflect key policy and technology milestones across selected final rules and statutes that may require changes to state Medicaid enterprise systems. And just to underscore here,
These reflect timelines associated with final rules and enacted statutes, not proposed rules, and they are not meant to capture all of the existing requirements, but they're focused on provisions that are most likely to have systems or operational level impacts.
And I want to just take a quick step back here. We know there's a lot here and we're going to acknowledge up front that this can be hard to read, but don't worry, these are already public. We will include the link into the chat and folks can dive deeper and zoom in as needed. And so we have these timelines in two formats. The first is this high level roadmap.
And we also have a more detailed roadmap that I will also give an overview of. In this high level version, you'll see a simplified timeline across years, and it differentiates between statutes and regulations. The regulations are in orange, the statutes are in blue, and you'll note that we have provisions from 2025
Through 2030.
And I am now going to scroll over.
Apologies for one second here.
I am sorry for the technical difficulties, folks. Here is our high-level timeline view, and additionally, we have a more detailed view. There it is. Sorry about that. The more detailed view includes A color-coded legend at the top that is going to denote the different
types of provisions. You will note that we have from 2025 through 2030 and beyond. And more specifically here, you can filter not just by the year itself, but we have the

working families tax cut legislation, we have the access rule, we have the managed care rule, we have the E&E rule.
We have the MSP rule, the interoperability rule, and we have the legislative requirements from the CAA 2024 and the CAA 2026. I am going to stop sharing my screen and try to get us back on track with the rest of the presentation. But we wanted to just give folks...
a quick overview of these new tools. We will include them in the chat. We are hoping that you can use them in follow up and wanted to note that we're hoping to iterate on these tools moving forward. Right now, you can't really print these. We know that there is a lot there. You need a very large piece of paper to get all of this, but we're hoping to have a more dynamic.
filterable version in the future and we hope that our first iteration in version serves as a very helpful tool for states. And I want to now try to get us back to my original screen.
Sorry about that, folks. We're almost there.
There we are.
Thanks everybody for bearing with me.
Okay, and then just one final note here on the roadmaps, which is that I think the scope of this work here is very clear. There is a lot that fits on one page and it reflects not just all the work that CMS is doing, but all the works that you states have to do. And so we hope that these tools serve as a very useful timeline.
And I am going to actually turn things over to Candace and Rachel to move us into our next agenda item, which is related to section 71109. Candace and Rachel, I will turn it to you.

Anderson, Candace (CMS/CMCS) 12:12
All right, thank you and good afternoon. Today, my colleague and I will walk through key aspects of the policy and operational guidance addressed in the Section 71109 show letter. We encourage you to review the letter fully for more information.
All right, diving in. Beginning October 1st, 2026, Section 71109 restricts, with limited exceptions, federal financial participation, or FFP, for full Medicaid and CHIP benefits to specific groups of individuals who are residents of the United States. This includes U.S. citizens and U.S. nationals, and three groups of non-citizens, which are one, lawful permanent residents, or LPRs, commonly known as green card holders, two, Cuban Haitian entrants, and three, Compact of Free Association Migrants, or COFA

migrants. We use the term FFP-eligible non-citizens throughout this guidance to refer to those non-citizens listed

Wallace, Nick (CMS/CMCS) 12:47
Yeah. The. Three.

Anderson, Candace (CMS/CMCS) 13:12
under Section 71109 for whom FFP continues to be available for full Medicaid and CHIP coverage. Again, those three groups of non-citizens are LPRs, Cuban Haitian entrants, and COFA migrants. Next slide.
There are three exceptions to these new FFP limitations listed in the statute. First, payment for the treatment of an emergency medical condition in Medicaid, often referred to as emergency Medicaid. Second, full Medicaid and CHIP coverage for lawfully residing children and or pregnant women in states that have elected the option in their state plan, commonly referred to as the CHIPRA 214 option.
And third, a narrow program under CHIP, which is a state-designed health services initiative, or HSI, to improve health of low-income children. The FFP limitations under Section 71109 do not apply to these exceptions, and so FFP will remain available for the
expenditures on and after October 1st. Next slide.
Section 71109 is applicable on and after October 1st, 2026, and it does not provide for a grace period to implement these changes. States should implement any necessary systems and operational changes before October 1st to ensure that those, only those non-citizens eligible for coverage are provided full Medicaid and CHIP. coverage on and after October 1st. Next slide.
All right, so for some level setting.
Today, federal law sets out non-citizen eligibility for Medicaid and CHIP under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, or PRWRA. Section 71109 did not amend the key non-citizen eligibility framework under PRWRA, including the definition of qualified alien or the five-year waiting period. Therefore, states must continue to apply the five-year waiting period, including any exceptions to the five-year waiting period, as specified in statute, to individuals who are FFP-eligible non-citizens. This means that on and after October 1st, the five-year waiting period will continue to apply for most LPRs.
And Cuban Haitian entrants and COFA migrants will be accepted from the five-year

waiting period as they are today.
Next slide.
For those non-citizens who are not LPRs, Cuban, Haitian entrants, or COFO migrants, and are not eligible for full Medicaid or CHIP benefits under the CHIPRA 214 option, beginning October 1st, CMS will not require states to provide state-only funded health coverage to such individuals.
Should a state opt to provide state-only funded coverage to non-citizens for whom FFP is not available for full Medicaid or CHIP benefits on and after October 1st, the state must have financial controls in place to ensure appropriate claims accounting.
Next slide, and I will turn it over to Rachel.

Nichols, Rachel (CMS/CMCS) 16:22
Thank you, Candace. Now we'll walk through the implementation requirements. So states will need to implement these changes by October 1st, 2026. This applies to individuals who apply for coverage on and after October 1, 2026, and for beneficiaries
who are enrolled in Medicaid or CHIP on October 1, 2026. These new requirements apply when verifying citizenship or satisfactory immigration status to new and current beneficiaries. Next slide.
Okay, this slide outlines the steps states should take to redetermine eligibility of current Medicaid and CHIP beneficiaries by October 1, 2026. First, the state needs to identify all potentially affected beneficiaries.
Those potentially affected include all those receiving full Medicaid or CHIP benefits whose immigration status is not LPR, Cuban Haitian entrant, or COFA migrant, or are not lawfully residing children or pregnant women in states that have elected the CHIP or 214 option. Then states must attempt to
re-verify if the beneficiary continues to have a satisfactory immigration status through electronic data sources before attempting to contact the beneficiary.
If the state is unable to verify satisfactory immigration status electronically, the state must request information from the beneficiary. If the beneficiary responds with a new declaration of satisfactory immigration status and the state is unable to verify such status, the state should provide a 90-day reasonable opportunity.
Opportunity period.
If the state verifies that the beneficiary continues to have a satisfactory immigration status, the beneficiary retains coverage, and the state should provide notice to

inform the individual that they continue to be eligible for the coverage in which they are enrolled.
If information or documentation provided demonstrates the individual no longer has an FFP eligible non-citizen status, or if they do not respond within the time specified, the state must consider all bases of eligibility and terminate if not eligible on another basis.
If an individual is no longer eligible for full Medicaid or CHIP benefits, or they do not respond, states must provide advance notice of adverse action, including the right to a Medicaid fair hearing or CHIP review before terminating coverage or reducing benefits. Next slide.
This slide just describes the notice requirements, which I just briefly touched on. Next slide.
So over the next few slides, we will talk about some operational and cleaning considerations. Next slide.
So updates to applications. Generally, we anticipate that the application modifications needed to effectuate these changes may vary among states. This slide outlines a couple areas in which changes may be needed, noting that in states that have elected the CHIPR 214 option, application changes may be more limited.
as the application must continue to collect the necessary information to determine eligibility. We want to emphasize that states are not required to submit a SPA to CMS to make these changes to their single streamlined or alternative applications.
Next slide.
Some other materials where states may need to make modifications could be renewal forms, policy and procedure manuals, eligibility worker training materials, call center scripts, and website language. States should review and make changes where appropriate. And I will now pass it back to Candace.

AC **Anderson, Candace (CMS/CMCS)** 20:25
Thank you. All right, so over these next few slides, I'll briefly go over verification of immigration status. Listed on this slide are the three different pathways that states can use when verifying immigration status with DHS's SAVE program. These pathways are the Hub VLP service,
a direct connection between the state and Save, or Save's manual web-based GUI. States can also use a combination of these three pathways. I want to stress that Save offers point-in-time data and does not update past Save verification responses. This

means that states need to submit a new verification request in order to receive the most up-to-date information.
on a beneficiary or applicant's immigration status, including if the individual's immigration status has changed. Next slide.
Taking a closer look at the hub, the Federal Data Services hub receives data from states, sends the verification request to save, and then applies hub eligibility logic to the responses from save before returning eligibility indicators and the save responses to the state. CMS has updated the hub to help states implement the WFTC legislation. This is the Hub VLP version 37.1v2. On this slide, you will see a list of the indicators that the Hub will return to states under this new version. Specifically, the Hub will continue to return all current indicators as it does today, including the verified lawful presence indicator used for the CHPRA 214 option.
In addition to the current indicators, the hub will return a new eligible non-citizen indicator. This new eligible non-citizen indicator will confirm whether an individual is an FFP eligible non-citizen. Again, that's an LPR, accumulation entrant, or a COFA migrant.
The hub version 37.1v2 is available for states to start testing and implementing now. Next slide.
For states that don't use the hub and instead verify satisfactory immigration status by using a direct connection with SAVE and or the SAVE GUI, they would need to update their logic to ensure that they read and interpret the codes from SAVE to determine FFP eligible non-citizen status accurately.
As save returns the same codes to the hub as it does via the GUI or a direct connection, we want to point states to a resource available at Appendix B of the show letter, which provides a summary of hub changes.
and they could help inform their state eligibility verification logic changes. All right, next slide.
Now turning to FMAP and proper claiming. We want to note that Section 71109 did not change FMAP provisions, only for whom FFP is available for full Medicaid and CHIP coverage. Also, as previously discussed, the new Section 71109 limitations to FFP
do not apply to expenditures for emergency Medicaid or to the coverage under a state selection of the CHIPRA 214 option.
Now, regarding emergency Medicaid, we want to note that a separate WFTC provision, section 71110, which also goes into effect on October 1st, 2026, limits

FMAP for emergency Medicaid services to no greater than a state's regular FMAP. This applies to emergency Medicaid expenditures for the adult group, and other applicable eligibility groups. CMS is working to modify MACFIN to reflect these changes. Next slide.

We want to stress the importance for states to continue to ensure proper claiming and expenditure reporting. Specifically, states may need to update their MMIS or other accounting systems to ensure accurate claiming of expenditures. And for any state that elects to provide state-only funded health coverage, states must be able to identify and isolate administrative costs directly related to the administration of their Medicaid or CHIP.

program, separate from the state only health program costs to ensure accurate reporting and claiming. Next slide.

Lastly, I want to flag that we expect all states and territories in D.C. to submit a Medicaid SPA no later than December 31st for an effective date of October 1st, 2026. For separate CHIPS, we expect a submission of a CHIP SPA with the following deadlines. The submission deadline for CHIP SPA in a state that has not elected the CHIPRA 214 option for all covered populations is no later

than November 30th. The submission deadline for a CHIP SPA in a state that has elected the CHIPRA 214 option for all covered populations is by the end of their state fiscal year. We are working on revisions to the Medicaid and CHIP SPA templates to reflect Section 71109 provision. The revised templates are currently posted in the Federal Register for comment until May 6th.

At a high level, the templates implement Section 71109 and closely track the language in the show letter. We will spread the word widely when these spot templates are available. So that concludes our Section 1109 content, and I will pass it to Alex.

Loizias, Alex (CMS/CMCS) 25:54

Thanks so much, Candace. So my name is Alex Lojas. I'm a technical director within the Division of Managed Care Policy within the Managed Care Group. And my presentation today will focus on state-directed payments and ensuring compliance with upcoming regulatory requirements. Next slide, please.

So just a quick agenda. We'll start off with some level setting on state directed payments, and then we'll spend the majority of this presentation really talking about those upcoming SDP regulatory requirements, including preprint submission timing

requirements, contract documentation requirements, and then a handful of other key SDP regulatory requirements.
And at the very end of this all staff or all state call will have Q&A. Next slide, please.
So as Nick mentioned at the very beginning, all of the regulatory requirements that I'll talk about today and that are outlined in this presentation are existing SDP regulatory requirements that can be found in 42 CFR 438.6. This presentation is not going to cover regulations or rules that are under development.
nor will we be able to answer any questions specific to the working families tax cut legislation.
Also want to note that this presentation is not intended as a comprehensive summary of all SDP regulatory requirements or applicability dates. It's really just honing in on those that are forthcoming and will hit pretty soon. And then finally, we always encourage states to reach out to state-directed payment at cms.hhs.
at any time to receive technical assistance, whether it's on these topics or any other SDP requirements. Next slide, please.
So to get into the meat of our presentation, we'll first talk about pre-print submission timing requirements. So the current kind of state of things with state-directed payments is that for SDPs that require written prior approval by CMS, states are required to submit pre-prints for new or renewal SDPs before the end of the applicable Medicaid managed care rating period.
Meaning, we do not accept new or renewal preprint submissions after a rating period has concluded.
And so what is changing in terms of regulatory requirements? Moving forward, a state must complete and submit all required documentation for each SDP for which written prior approval is required, and for each amendment to an approved SDP before the start date of that state directed payment or the start date of that amendment.
And that requirement is 42 CFR, 438.6 C2 romanette 8.
And this provision is applicable with the first rating period beginning on or after July 9th, 2026. And in terms of the actual impact, it means that state directed payment preprints and any preprint amendments must be submitted in advance. They must be submitted prospectively.
of the start date of the actual SDP arrangement. Next slide, please.
So let's talk about what this actually looks like on the ground and in practice, right? So let's say we have a state that has an annual rating period that's tied to a calendar

year. So that state wants to implement a uniform dollar increase state directed payment for inpatient and outpatient hospital services for their calendar year 2027 rating period. And they want that SDP to take effect with the start of the rating period, which is January 1st, 2027.

Again, 438.6C2 romanette 8 is applicable for rating periods beginning on or after July 9th, 2026. So this means that for this state, the first rating period that is impacted by these regulatory requirements will be the calendar year 2027 rating period. In terms of ensuring compliance with this regulatory requirement, the state

If they wish to implement an SDP by that January 1st, 2027 start date, then the state must submit the preprint to CMS no later than December 31st, 2026, right? At least one day ahead of the start date of that SDP. Now, if for some reason

the state misses that submission date, they can still submit a preprint at a later date, but the start date of that SDP that's reflected in the actual preprint itself must be perspective. So for example, if a state submits the preprint on February 15th, 2027, then the SDP start date that is documented in the preprint must be February 16th, 2027 or later. Again, has to be perspective. The same is true for SDP amendments. Those timing requirements also apply.

So if a state wishes to amend an SDP, they must do so prospectively. Again, you can't retroactively amend your pre-print, but you could come in, for example, mid-rating period with a pre-print amendment, and you could choose to amend from that point forth.

Next slide, please.

So now we'll get into the contract documentation requirements. Current status is that states must document all state directed payments as a contractual obligation within the applicable managed care contracts. And that makes sense, right? Ultimately, state directed payments are the state obligating and requiring that the plan pay providers in a certain manner.

Moving forward under 438.6C5, states must be much more granular and specific in how they document SDPs. And there are certain minimum components that are required under the regulation. And it does vary by the type of SDP. But that does need to be documented within the managed care contract itself.

And then if there are any changes to the SDP, for example, as the result of a pre-print amendment, that would also require that the contract be updated accordingly. And then in terms of applicability dates, this one also hits with the first rating period beginning on or after July 9th, 2026. Next slide, please.

So in terms of the actual impact and what states need to do, states must include detailed information about each and every one of their state directed payments and their applicable managed care contracts and contract amendments if there are any SDP changes. For all state directed payments, states need to document the following minimum
elements, the SDP start date, the end date, a description of the provider class or classes that are eligible for the SDP and any eligibility requirements. Also needs to include any encounter data reporting or separate reporting requirements necessary for the state to be able to audit the SDP.
The contract also must include a description of the SDP and the regulations are very specific about what needs to be included in the contract depending on the type of SDP. And that's outlined in 438.65 romanette 3, A through E. So A through E each correspond with a different type of SDP, whether it's a uniform increase, a minimum fee schedule, a maximum fee schedule, a pay for performance type SDP, or a population and condition based SDP. All of those have different documentation requirements for the contract. Next slide, please.
So again, let's talk kind of talk about this in practice. What does this actually look like on the ground? So let's say we have a state that has an annual rating period that's tied to the state's fiscal year. Their fiscal year is a July to June period, and they want to implement a minimum fee schedule SDP for primary care services for the state fiscal year 2028 rating period, which means the rating period starts July
2027 through June 30th, 2028. Again, because 438.6C5 is applicable for rating periods that start on or after July 9th, 2026. That means that the first rating period that is implicated under this regulatory requirement for the state will be that state fiscal year 2028 rating period. Next slide, please.
So how does the state make sure that they're ensuring compliance with the regulatory requirements? In addition to the minimum documentation that we described on the previous slide, the state also has to include all of that minimum documentation in the contract that's required for a minimum fee schedule type SDP. So they've got to include the required fee schedule,
the procedure and diagnosis codes to which the fee schedule applies, the applicable dates of service within the rating period for which the fee schedule applies. And then if it's a minimum fee schedule that ties to a certain percentage of state plan approved rates or a minimum fee schedule that ties to a certain percentage of Medicare rates,

then the contract would need to include additional information that's specific to those types of fee schedules. Next slide, please.
And so in the next few slides, we'll talk about some other key SDP regulatory requirements. They're coming up quickly, coming up in the next few years, and I'll just touch on these very broadly. So in the same rating period that we're talking about, all of the other requirements, beginning on or after July 9th, 2026, states that have SDPs that are either
population or condition based SDPs must ensure that that SDP is fully replacing the negotiated payment rate between the provider and the plan.
Next slide, please.
This next set of SDP regulatory requirements all kick in effective with the first reading period on or after July 9th, 2027. We do have a number of new evaluation requirements for SDPs, including kind of a risk-based approach where moving forward, states will only need to
provide us with an evaluation report if the SDP is above 1.5% of total capitation payments. And then all states will need to post evaluation reports and results publicly on their own state website. That is also the same time period that the prohibition on the use of separate payment terms will take effect.
Moving forward, states will be required to include SDPs and actuarially sound capitation rates. And I will just note here that we have had several MC TAG presentations on this topic over the past month. And so if you are interested in receiving those slides, we're happy to reach out to us and we're happy to send them to you.
And then finally, state, oh, go back one more slide. Thanks. And then finally, states will be required to condition payment on actual utilization during the rating period, meaning that post-payment reconciliation processes are prohibited. States will no longer be able to
ask their plans to make payment, interim payments based on historical utilization, and then reconcile that to actual utilization after the rating period has ended. Next slide, please. And then finally, effective with the first rating period on or after July 10th, 2028, that is when all of the submission timeframes for
rate certifications and managed care contracts that include SDPs kick in. And that will require that states submit rate certs, managed care contracts that include SDPs no later than 120 days after the start date of the SDP.

And that concludes my presentation. I believe I'm passing it over to the next speaker. Thank you.

Conklin, Elizabeth [Betsy] (CMS/CMCS) 38:26
Yeah, thanks, Alex. Hi, my name is Betsy Conklin, and I'm the acting deputy director in the Division of Benefits and Coverage, and I'm going to provide an overview of the state Medicaid and CHIP behavioral health toolkit they released this past February. But before we get started, I wanted to note that given the amount of information in the toolkit for this presentation, I'm only going to be able to highlight a small portion of the many strategies in the toolkit.
If you're interested in learning more about these strategies or any of our other strategies, you can access the toolkit online at medicaid.gov. I also want to mention that we're hosting a series of EPSDT technical assistance webinars exclusively for state personnel. And the next one, which is scheduled for Thursday, May 21st, will be a detailed overview of the first portion of this toolkit.
So to register for that webinar or just to ask general follow-up questions on the toolkit or request related technical assistance, you can email the EPSTT mailbox at EPSTT at cms.hhs.gov. Next slide, please.
So improving access to high quality behavioral health treatment is among CMS's highest priorities. In 2021, approximately 30% of children with public health coverage reported having a mental, emotional, developmental, or behavioral problem. Medicaid and CHIP are the largest single source of funding for behavioral health treatment and support services in the United States.
and as such, provide critical coverage for behavioral health conditions for the 38 million children enrolled in these programs. CMS developed this behavioral health toolkit to support state Medicaid and CHIP agencies in ensuring that children and youth experiencing behavioral health conditions get the care they need. Next slide, please.
The main body of the toolkit is divided into 4 main sections that are listed here. The first section is on developing and supporting a behavioral health care delivery system that can meet a range of children's needs. The second is on promoting early intervention for children's behavioral health conditions. The 3rd is on improving children's access to behavioral health care through service coordination and integration.
And finally, section 4 is on increasing the workforce capacity for children's behavioral

health services. Within each of these sections, we identify actionable state strategies and sub-strategies and state examples when possible to demonstrate implementation options. Additionally, the toolkit includes 3 appendices that provide states with supplemental information
as they expand behavioral health coverage for children. And I'll go over these appendices a bit more at the end of the presentation. Next slide, please.
Before going over some of these strategies and sub-strategies, it's important to understand the intersection of EPSDT requirements and behavioral health coverage for EPSDT eligible children. Under EPSDT requirements, children enrolled in Medicaid and eligible for EPSDT are entitled to services, including behavioral health services. that can be covered under EPSDT rules. Specifically, under the EPSDT requirements and the Social Security Act or the Act, certain children and youth who are enrolled in Medicaid and under the age of 21 are entitled to coverage of health care, diagnostic services, treatment, and other measures described at Section 1905A of the Act.
that are medically necessary to correct or ameliorate defects in physical and mental illnesses and conditions. While there's no nationally available standard for assessing children's mental health needs and describing the related continuum of care using a common language, the extent of possible Medicaid coverage allows states to cover a broad array of behavioral health services
necessary to achieve good outcomes for children. EPSDT can play a vital role in ensuring that children and their families are connected to behavioral health care that supports stability, minimizes the need for higher levels of care, and prevents involvement with the child welfare and juvenile justice systems. Next slide, please.
As I mentioned previously, the first section in the toolkit describes how states can develop and support behavioral health care delivery that meet a range of children's needs. The strategies in this section include, for example, covering a continuum of behavioral health care for children and developing a behavioral health care system that accounts for children with specialized needs.
Next slide, please.
The first strategy in Section 1 provides information on how states can cover a continuum of behavioral health care for children that accounts for a range of needs, as well as the different stages of childhood development. Delivering mental health and STDs treatment to children poses challenges unlike those in other areas of care. Behavioral health treatments that are effective for adults may not be effective for children,

And similarly, the type of treatments and their effectiveness may vary across the stages of childhood.
By covering behavioral health services that account for these challenges, range in intensity, and vary in service delivery location, states can help ensure children get the right care and the right setting at the right time without having to rely on high-cost inpatient services except when clinically indicated. Next slide, please.
A service array of behavioral health care that is consistent with EPSDT requirements includes, but is not limited to, the five components mentioned here, from screening and assessment through inpatient care when medically necessary. To develop such a service array, in addition to covering these services that can be authorized under Section 1905A to meet EPSDT obligations,
States can also consider using other Medicaid authorities to supplement, not supplant coverage for EPSDT eligible children. This includes, for example, 1915C Home and Community-Based Service or HCBS waivers. Next slide, please.
Our second strategy in Section 1 discusses implementing a CHIP Health Services Initiative, or HSI, that is focused on improving the behavioral health of low-income children. States can develop a state-designed HSI under CHIP that must directly improve the health, including behavioral health, of certain children who are eligible for CHIP
and or Medicaid. A number of states have used HSIs for behavioral health initiatives, including, for example, providing opioid overdose reversal kits. As noted here, states must assure that claims for HSIs and administrative expenses don't exceed 10% of the total amount of Title 21 funds
claimed by the state each quarter. States must also assure in the CHIP state plan that they won't supplant or match CHIP federal funds with other federal funds, nor allow other federal funds to supplant or match CHIP federal funds. Next slide, please.
In Section 2, we described 6 strategies for promoting early intervention for children's behavioral health conditions, such as allowing behavioral health services to be provided without a formal behavioral health diagnosis and establishing a quality improvement plan to identify early intervention opportunities for children's behavioral health conditions. Next slide, please.
Under our second strategy in Section 2, we provide information on implementing A standardized behavioral health assessment tool to assist providers in identifying appropriate diagnostic and treatment services for children. Implementing such a tool can help children get access to appropriate services, establish a consistent process

for assessment among providers,
and ensure transparency and accountability for children and their families. When selecting a standardized assessment tool, state Medicaid and CHIP agencies should be sure to work with other child-serving state agencies and stakeholders.
Additionally, local behavioral health agencies can help support provider training, capacity building,
and licensure and certification requirements related to the tool. Next slide, please.
Next in Section 3, we describe the five strategies listed here to improve children's access to behavioral health care through service coordination and integration. This includes utilizing care coordination and case management to ensure children receive medically necessary behavioral health services and facilitating the integration of primary and behavioral health care to improve children's access to care.
Next slide, please.
Under our fourth strategy in Section 3, we describe how designing and implementing a single pathway for children to access behavioral health care can help facilitate timely access to care and reduce unnecessary utilization of emergency departments.
We include two sub-strategies under this strategy, the first of which is on coordinating with
local 988 suicide and crisis lifelines to facilitate children's access to behavioral health care. These lifelines provide access to crisis counselors for individuals who are struggling with mental health conditions, suicide, and or substance use related conditions. States can use the 988 lifelines as a no wrong door pathway for individuals, including children and their families,
to access behavioral health care by connecting them to local crisis services, as well as the broader array of Medicaid cover services and supports. Next slide, please.
Finally, in section 4, we described 6 strategies to increase the workforce capacity for children's behavioral health services, such as continually monitoring the roster of behavioral health providers available to serve children. Next slide, please.
In this last section of the toolkit, our second strategy describes how states can reduce the administrative burden and regulatory barriers faced by providers that could impact their participation in delivering behavioral health care for children. Within that strategy, we identify 2 sub-strategies, the second of which is to allow interstate licensure portability models
for behavioral health providers and streamlining their credentialing to expand the pool of available providers. Generally, each state licenses or certifies providers to

practice in the state, which can be burdensome for providers. States can facilitate behavioral health providers' participation in the Medicaid workforce and enhance availability of services by participating in interstate licensure portability models and streamlining the credentialing process. A state that's interested in this option should assess its current licensing and credentialing requirements and potentially collaborate with the state legislature to amend related laws or regulations. Next slide, please.

As I mentioned previously, the toolkit includes 3 appendices that provide states with supplemental information on expanding behavioral health coverage for children. Appendix A includes a table of information for every behavioral health service and model of care described in the toolkit. Among other information, each table includes a description of the service or model of care,

the potential delivery settings, possible Medicaid coverage authorities, and related resources. For Appendix B, we developed a matrix of impact categories that could apply to each of the strategies and sub-strategies described in the toolkit. States can use these impact categories, such as coverage policy and operational efficiency,

to determine which strategies to implement based on the actions they would need to take and or the desired outcome. And finally, Appendix C identifies resources related to the delivery of behavioral health services for children and youth. Next slide.

I will turn this back to Nick.

Wallace, Nick (CMS/CMCS) 50:07

Betsy, thank you so much and thank you to all of our panelists for their very informative and helpful presentations. We are now ready to transition to the Q&A portion of the call. We covered a lot of ground today and we already have a few questions teed up. And as a reminder, while our team is going to try to answer the questions to the best of their ability, it's possible that we don't have the right staff member on the call.

And the CMCS team is hard at work to issue more guidance self-flag that there are a couple of questions coming in asking when the question is, when are you going to answer our question? And the answer is, we're trying as soon as possible. So just get, we're doing the best we can and we really appreciate your patience. And we have a few questions teed up.

that we're going to get started. And so I'll invite some of our panelists back on screen here and we'll start with the three that we have related to the immigrant eligibility

show.
And...
The first one is related to FMAP restrictions applying to hospital-based presumptive eligibility. Kirsten, I think you're going to take that one.

Speaker 1 51:18
Sure, thanks, Nick. The question that we have is, do the FMAP restrictions apply to hospital-based PE? I'll caveat this answer a little bit. We are still working to release some more information on this very question as it relates to both HPE and presumptive eligibility broadly.
However, we expect that the answer to this question is no. The changes to FFP under section 71109 described today do not apply to HPE.

Wallace, Nick (CMS/CMCS) 51:52
Thank you so much. And Kirsten, while we still have you, there's another question here. Can CMS confirm that when states attempt to verify status for the potentially impacted population and the VLP returns this code, then the state must send the individual a request for information. Essentially, VLP is saying that the member is not eligible, but the state.
Can't directly act on this information without first asking the member for information.

Speaker 1 52:22
Thanks, Nick. The answer to this question is yes. When states are unable to verify that a beneficiary is an eligible non-citizen electronically, then the state has to request additional information from the BENI and provide a reasonable period of time for the person to respond prior to terminating eligibility.

Wallace, Nick (CMS/CMCS) 52:45
Thank you.
And Sarah, I'm going to turn this one over to you. So a question about information on a prior call related to citizenship changes. CMS stated they would have further guidance related to 1634 states and SSI. Do you have any more that you can offer this person in the meantime?

Spector, Sarah (CMS/CMCS) 53:06

Yeah, just a touch, just a little bit. We are really actively working with the Social Security Administration on the situation about the impact of this provision of law on SSI beneficiaries. We are acutely aware of the situation of 1634 states as well as obviously the impact.
based on 209B and SSI criteria states as well. So there is more information coming to a theater near you soon. We are really day in and day out working with them and hope to be able to come back to you soon with some more specifics. But we are engaged with them and really hoping to
working with them to try to address this issue.

Wallace, Nick (CMS/CMCS) 53:53
Thank you, Sarah.
We're going to pivot actually to our second presentation related to SDPs. Alex, looks like there's a question here. Can the SDP requirements be incorporated by reference? For instance, if the state already posts on their public website the requirements of the SDP, can the contract reference a specific page on the public website rather than listing
all provider types and procedure codes covered by the SDP within the contract itself.

Loizias, Alex (CMS/CMCS) 54:23
Yeah, that's a great question. So generally, the contract needs to clearly define the contractual responsibilities between the state and the plan. And that can't be done by like a minor incorporation by reference. The regulations are very clear that the minimum documentation for SDPs does need to be in the contract itself. And we did opine on this in the 2024 final report.

Wallace, Nick (CMS/CMCS) 54:37
Yeah.
Alex, thank you very much. While I have you, I might actually publish this other question related to SDPs. If the initial rate certification includes a trigger to update the UPI during the rate year and a risk pool to get back to the initial funding, would an amended rate certification be needed if the final funding is scaled based on actual utilization?
This is really wonky and technical. Anything that we can opine on for Jill, or is this something we'd have to take back?

Loizias, Alex (CMS/CMCS) 55:19
No, I would encourage you to send your question to the state directed payment mailbox. That seems a little weedy and I think we'd want to better understand your arrangement before we provide guidance.

Wallace, Nick (CMS/CMCS) 55:30
Alex, thank you very much.

Loizias, Alex (CMS/CMCS) 55:30
But I appreciate the question.

Wallace, Nick (CMS/CMCS) 55:33
Thank you. And I think we have time just for one more. And Betsy, this one was for you. This was specifically about your presentation on the toolkit. It says on slide 38, is there more specific information regarding strategy 1.5? Will this be outlined in the toolkit?
For our viewers who are interested in learning more about the EPSDT toolkit, where can they go to get more information generally?

Conklin, Elizabeth [Betsy] (CMS/CMCS) 56:02
Yeah, that's a great question. So I had to scroll really quick to see strategy 1.5. Oh, it's about implementation of utilization controls. So yeah, we didn't talk about that much in this presentation, but there is a wealth of information in the toolkit itself, including a state example. To find the toolkit,
It's a little bit varied, but it's in two different locations. If you go to medicaid.gov and then select Medicaid, there's a benefits category and you can find it under either behavioral health or the early and periodic screening diagnostic and treatment. Both of those have a side screen that talk about
either EPSDT guidance on the EPSDT one where it's located, or in the behavioral health, there's a child and youth side that you can find it there. And if you can't find it, please feel free to email that EPSDT at cms.hhs.gov mailbox and we will get you the link.
Thank you for your question.

Wallace, Nick (CMS/CMCS) 57:02
Thanks, Betsy, and thanks to all of our panelists and presenters. I think we're going to wrap up for today. Thank you, the team, for the great discussion. As a reminder, the slides from today's call will be posted in the next week or so to Medicaid.gov. The date for the next all-state call will be Tuesday, May 26th.
And of course, if any questions come up between now and then, feel free to reach out to us, your state leads, or bring your questions to the next call. Thank you all for joining, and Jacqueline, you can adjourn the call. Thank you.

Ryan, Jacquelyn (CMS/CTR) 57:34
Thank you for attending, everyone, and you may now disconnect.