HHS-CMS-CMCS
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Coordinator: Welcome and thank you for standing by. At this time, I'd like to inform all participants that today's call is being recorded. If you have any objections, you may disconnect at this time. All lines have been placed in a listen-only mode for the duration of today's conference. I would now like to turn the call over to Miss Jackie Glaze. Thank you, ma'am. You may begin.

Jackie Glaze: Thank you and good afternoon and welcome everyone to today's All State Call In Webinar. I'll now turn to Anne Marie Costello, our Deputy Center Director for opening remarks. Anne Marie?

Anne Marie Costello: Thanks, Jackie and hi everyone. And welcome to today's All State Call. On today's call we'll be discussing two important topics. First, Charlene Wong, from the Centers for Disease Control and Prevention, will provide an update on fall and winter respiratory illnesses, including the availability of new data dashboards and vaccine recommendation.

Our second presentation will feature Michael Tankersley from the Medicaid Benefits and Health Programs Group, who will provide an overview of the state health official letter released last - in July that addresses the statutory requirements of the Consolidated Appropriations Act of 2023 related to provisions, impact, and availability of certain health plan services for incarcerated youth in Medicaid and the Children's Health Insurance Program. These provisions provide new opportunities to improve in healthcare

transitions for justice involved youth as they reenter the community.

But before we get started I wanted to remind participants that this will - that we will be using the Webinar platform to share slides today. If you're not already logged in I suggest that you do so now, so you can see the slides for today's presentation. You can also submit any questions that you have into the chat at any time during our presentation. With that I'm pleased to introduce and turn things over to Charlene Wong. Charlene?

Charlene Wong: Thank you so much. We're so pleased to be back on this call from the Centers for Disease Control and Prevention. Next slide, please. So wanted to provide some updates from what we presented on one of the past All State Medicaid calls.

So this is an updated visual of ED visits for viral respiratory illness through just a couple of weeks ago. You can see that yellow mustard-colored line is COVID. And so we had our summer bump as we have seen the last several years, and we'll continue to monitor for this.

We anticipate, based on past years and our modeling data, that flu and RSV will also start picking up as they usually do in the fall-winter season. And we expect there to be about the same to lower total volume or activity of these viruses this season compared to last season.

Next slide. Since I last presented I did want to share that we have updated our respiratory virus dashboard. We have this respiratory illnesses data channel. You can see a QR code on the right side so that you can easily find the location of the Web site for these dashboards.

What you'll notice when you look at these dashboards this year compared to

last is, you know, very easy visual indicators of what overall respiratory virus activity is in the US. You'll see that wastewater activity listed as well.

And then, of course, people are very interested in knowing what is happening in their own community. So you can certainly look by state as well as down to the county level to see what the different activity levels are for viruses, including emergency department visits for the three different viruses, or all of them together.

Next slide, please. I am showing this slide again. This is our at a glance reminder for the updated recommendations for this year's COVID, flu, and RSV immunization. This slide is a little bit more detailed so great slide to be using with, for example, clinical audiences, again, to remind folks that for COVID and flu, we've got the updated vaccines this year that include the strains that are currently circulating or that are expected to circulate in the community recommended for everyone 6 months and older.

And then, again, RSV, we have several different options to protect babies. We've got the nirsevimab infant RSV for infants less than 8 months old, as well as young children 8 to 19 months old with risk factors or the maternal RSV vaccine for those 32 to 36 weeks of gestational age. We also have, again, reminder the updated recommendation for RSV vaccine for older adults. This is different than last season.

We now have a universal recommendation for all adults 75 and older. And then a risk-based recommendation, so adults 60 to 74 years old with risk factors, and that includes very common risk factors, chronic heart disease, chronic lung disease, severe obesity, severe diabetes, and many others on that list.

On the next slide, this figure we have updated on our Web site. This is a more layperson public-facing figure that is an at a glance who should be getting these recommended immunizations this year. So again this is available for download on the CDC Web site. There is a QR code on the left to help people understand, remember which vaccines they should be thinking about for this season.

Next slide. This is, again, a reminder. I showed you all this slide last time. This timeline is also now available on our Web site for when are the ideal times to be immunized against COVID, flu, and RSV. In short, the answer is right now. COVID and flu these are - this is the ideal time.

We do have COVID and flu vaccines available in the market right now. So if you yourself have not gotten vaccinated, we encourage you to make a plan to go do so. And certainly working with all of your partners to make sure that folks are having access to COVID and flu vaccines.

For RSV, also for older adults, now is the ideal time as well as for maternal RSV vaccine. And then for the infant RSV immunization, or nirsevimab, that is just getting ready to start next month, so in October. So a couple days away. And even in some parts of the continental US the time is actually already now, and we're starting to see nirsevimab also be more broadly available in clinics now.

Next slide, please. This is similar to the slide that I presented in the last call which is that the number one request and call to action we have for healthcare providers is to order and offer immunizations in their clinic. And we are asking for you all's help as Medicaid leaders in your state. We have plenty of vaccine supply that clinicians, pharmacies, other healthcare vaccine providers can order.

We are concerned that some of our early data are showing that we would love to see more clinics ordering these vaccines and offering them in their clinics because we know that if it's not available in as many places it's just yet another barrier to vaccination for patients who want to get these vaccines. So this is a link again here to - we've tried to make it easier for health care providers to order vaccine because now there are many different products available. So we've got all that summarized.

And one thing I want to emphasize because we get this question a lot, perhaps you do as well, well, we're concerned that we're going to order a vaccine, maybe we're going to have a bunch left over at the end of the season. You know, I don't want to be on the hook for all that money. And so just a reminder that there are really generous return policies for unused products.

Next slide. Now I want to provide some updates on nirsevimab. Again, nirsevimab, this is the monoclonal antibody immunization for babies and young children to protect them against RSV, which is the number one reason that babies are hospitalized in the US.

So the update on the left side of this screen is that nirsevimab we have updated the clinical consideration because we want really in the ideal setting that infants born between October and March should be getting nirsevimab in the first week of life, ideally during the birth hospitalization. The smaller the baby the more at risk or more likely they are to get very sick with RSV. So looking to really reduce those missed opportunities for vaccination when they're in the birth hospital.

Now, that would mean that we would want more birthing hospitals also than to be enrolled in VFC. Obviously, this is very important for our Medicaid

insured babies and young children, wanted to make sure that you all have this information that there are VFC benefits specifically for birthing hospitals.

There is a pathway called the Specialty Provider Pathway in the VFC program that allows birthing hospitals to only offer nirsevimab and the birthing dose of hepatitis B vaccine. So they are not required to offer all of the ACIP recommended vaccines for children.

There are some additional flexibilities that have been put into place because we have heard from birthing hospitals. For example, they are not required to maintain separate public and private stock. And also for this respiratory season they are not currently required to meet the private inventory requirement for COVID-19 or nirsevimab.

There is a link in the slides that you all have received about the VFC program benefits for hospitals. We have heard from some of you all that you all are really helping to champion and spread the word amongst your healthcare hospital partners about this benefit. And again, particularly with this clinical consideration that babies ideally get nirsevimab during the birth hospitalization, we continue to appreciate your partnership in making that possible.

On the right side of the slide I also wanted to remind folks about nirsevimab administration timing. I mentioned that in most of the Continental US October through March is the recommended time frame for getting nirsevimab. That being said, there are many parts of the country based on the local epidemiology, or when we start to see RSV, start circulating that may start sooner or may run a little bit later.

So those of you, for example, who are in southern states you may have

providers who are wanting to administer nirsevimab even starting now or even last week or the week before when nirsevimab became available because clinicians know that RSV starts circulating perhaps earlier in your community. And some of your state epidemiologists may have been putting out statements or data to help you all understand what that circulation pattern looks like.

And certainly, one of the things that we have heard from clinicians is saying, well, we just want to make sure that we're able to provide nirsevimab because we know that there is a clinical indication to do so and that they will be reimbursed for that nirsevimab administration.

Next slide. And then I also wanted to provide an update. This year the bridge access program that was in place through late this summer is no longer running. And we have additional information on where people can find a free adult COVID-19 vaccine. So, obviously, those beneficiaries, patients with Medicaid are able to get it through their Medicaid insurance, but for folks who are uninsured or underinsured, there are these two options currently to access free COVID-19 vaccines.

The first is through state and local health departments. CDC identified an additional $62 million to support state and local public health immunization programs to purchase the updated '24 to '25 COVID-19 vaccine. And so if you all are getting questions about where can people go get a free COVID-19 vaccine, you can be directing them to their state or local health department where additional resources have been provided this year, this season, to those health departments for COVID-19 vaccines.

In addition, HRSA, and their HRSA-supported community health centers, also have resources for those no-cost, no-out-of-pocket-cost COVID-19 vaccines. There are 15,000 sites across the country. Most of them have that COVID-19

vaccine available and adjust their fees based on income and family size. And you can find contact information at the link listed on the slide.

Next slide. We also wanted to share that we are focused also on vaccines for healthcare workers, as this is a very important way for people - healthcare workers, to protect themselves and also protect patients. And so we've listed here some strategies that healthcare organizations can use to support their own healthcare workers getting vaccinated, including vaccinations on-site, low or no-cost vaccines, and then also thinking about the non-clinical staff.

We will be having some data - more data coming out on this as well as additional tips, but we know you all intersect very closely with healthcare partners. And we want to make sure that our healthcare workers are protected in addition to the patients that they serve.

Next slide. As my last slide before the call to action, just wanted to again relift our communications campaign for this season. The tagline is,
Risk Less, Do More to get the season's vaccines. These ads are directing folks to vaccines.gov as a place they can get started if they're not sure where to get a vaccine.

There are many resources, social media ads, posters, conversation guides. And more are being added every day to this Web site. And so we do encourage you all to take a look and use any of these materials that you feel would be appropriate in your program.

And finally, on my call to action slide, I just wanted to – on the next slide thank you, just wanted to, again, make the ask that for all of you, all who are running state Medicaid programs, we continue to hear from clinicians that they're just not sure if they're going to be paid for the vaccine, if their patients

are going to get a big bill for the vaccines that they're getting. So just, again, asking you all to continue to be clear about what your coverage and reimbursement policies are, so providers feel confident that they will be paid so they'll be then ordering and offering vaccines in their clinics.

Again, we appreciate you all every year assistance and partnership in increasing awareness and confidence in vaccines. And we've linked to some resources there. And then thinking about the different coverage and reimbursement levers you all have that some of us have talked about in smaller group settings to increase access to and confidence in vaccines as well as treatment for these viruses.

And then finally one more quick slide. I know this is a Medicaid call, but because we know you all also intersect with many other partners in your communities, I did want to flag long-term care facilities continue to be an area that we are very concerned about because we know that some of our most vulnerable patients are in long-term care facilities. And so I just wanted to remind folks about the conditions of participation requirements.

And some of the materials that CMS has made available, and we at CDC have made available, related to billing. And a toolkit for making sure folks both staff and residents in long-term care facilities have access to this protection. Thank you so much.

Jackie Glaze: Thank you, Charlene, for your presentation. So we do have a few minutes now to take questions for Charlene. So if you do have a question about her presentation, please submit that through the chat function at this time. I'll turn to you, (Krista). I do see one question.

(Krista): I do see one question in the chat. It is related to DACA. "Does CMS have an

update for states on what the requirement is to transfer DACA individuals to the marketplace? The latest update that I have is from the July E-tag call in which CMS stated they are still reviewing."

Sarah Lichtman Spector: Hi (Krista). This is Sarah Lichtman Spector in the Division of Medicaid Eligibility Policy. I can take that one. We are really, really actively working to sort that out. We don't have an answer today, but promise to be back in touch as quickly as possible. We understand the absolute urgency to getting an answer to states. And we'll be back with you as soon as we can.

Jackie Glaze: Thank you, Sarah. So I'll just ask again if there are any questions for Charlene, and if not, we'll move on to the next presentation. So we'll give it another minute or so. Okay, I think we'll move on. We do have another presentation.

And if you do have questions please submit them through the chat. So next up is Michael Tankersley. And he's going to provide an overview of the July SHO letter on juvenile justice. So Michael, I'll turn to you at this time.

Michael Tankersley: Thank you, Jackie, and hi, everyone. My name is Michael Tankersley. And Jackie - as Jackie just said, I'm going to be providing an overview of Sections 5121 and 5122 of the Consolidated Appropriations Act of 2023. Next slide, please.

First, I'm going to start with a little bit of background. Numerous studies have shown that incarcerated youth experience high rates of physical and behavioral health conditions. One study showed that as many as 90% of such youth have experienced trauma. Another study showed that roughly 2/3 of youth in the correctional system reported at least one substance-related problem.

Many of these youth either are already enrolled in Medicaid and CHIP or would otherwise be eligible. And obviously improving care transitions for these - for this population is critically important as providing access to services may provide these youths with more stability.

Next slide, please. As I'm sure you're aware Congress has shown increased interest in improving healthcare transitions for justice involved individuals. Notably, Section 5032 of the SUPPORT Act directed the Secretary of HHS to convene a stakeholder group and develop best practices to support reentry.

This ultimately led to CMS' Section 1115 demonstration opportunity related to reentry. And then another SUPPORT Act provision prohibited states from terminating Medicaid eligibility for eligible juveniles.

Next slide. So Medicaid and the inmates of a public institution the important regs are outlined at 4351010. And an inmate of a public institution - defines an inmate of a public institution as a person living in a public institution. And defines a public institution as an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control.

A correctional institution is considered a public institution, and includes all types of carceral facilities. CMS considers an individual of any age to be an inmate if the individual is in the custody, and held involuntarily through operation of law enforcement authorities in a public institution. And these same definitions also apply to separate CHIPs.

Next slide, please. So Medicaid has what we refer to often as the inmate of a public institution payment exclusion. That's how it's implemented in Medicaid. And so individuals who are held involuntarily in a public

institution, they may be eligible for and enrolled in Medicaid, but federal Medicaid funds may not be used to pay for services for such individuals while they are incarcerated.

There is one exception and that applies to institutional care. FSP is available for those types of services. And CHIP, it's a little bit different, it's actually an eligibility exclusion. And so a child who is an inmate of a public institution is excluded from the definition of a targeted low-income child and therefore generally is ineligible for a separate CHIP.

Next slide, please. All right, turning to Section 5121, this provision addresses Medicaid and CHIP requirements for certain Medicaid and CHIP eligible juvenile beneficiaries who are incarcerated post adjudication of charges. That's really important to remember and helps distinguish 5121, which is a mandatory requirement from Section 5122, which is optional. Fifteen twenty-one, like I said, it's mandatory and takes effect on January 1, 2025.

We noted this multiple times in our guidance because we - it's - we think it's critically important as we're all working to implement these provisions that we are mindful of. And ensure that it does not effectuate a delay of an individual's release or lead to increased involvement in the juvenile and adult justice systems.

Particularly 5121 it's really aimed at supporting the reentry. It's a fairly targeted provision. It's the last 30 days prior to release. And so we just want to make sure that it's really important as we start to engage with our crossroad providers that we work to avoid any of these unintended consequences.

Next slide, please. All right. So, eligible juveniles is defined in Section 1902(nn). And for Medicaid that is Medicaid-eligible individual who's under

the age of 21. It also includes an individual between 18 and 26 who is eligible for Medicaid under the mandatory form of foster care group.

CHIP does not use that same terminology, but for purposes of Section 5121 children within 30 days of their release - 30 days of release from incarceration are not considered to be subject to the eligibility exclusion that I just discussed.

Next slide. So what do we - so for Medicaid there are really three services that are required to be provided. So Medicaid programs must have a plan in place. In accordance with such plan provide the following services for an eligible juvenile who is within 30 days of their scheduled date of release from a public institution following adjudication.

In the 30 days prior to release, or as soon as practicable after release, any screenings and diagnostic services which meet reasonable standards of medical and dental practice as determined by the state or as otherwise indicated as medically necessary in accordance with EPSDT requirements. Importantly, this includes a behavioral health screening or diagnostic services.

Also, so that's two. The third service in the 30 days prior to release, and for at least 30 days following release, targeted case management services. And this includes referrals to appropriate care and services available in the geographic region of the home or resident for the eligible juvenile where feasible.

Next slide, please. So under the statute, the requirement to cover any screening and diagnostic services which meet reasonable standards of medical and dental practice as determined by the state. This is actually independent to the reference to Medicaid EPSDT requirements.

However, because we know that states have similar standards in place now for the under 21 population that receives EPSDT services outside when they're incarcerated, so states can utilize those standards to dictate the screening and diagnostic services, pre-release and post-release, or you have the flexibility to establish additional standards for that population.

For the over 21 population this is the folks that are going to be enrolled in the former foster care group. That population typically does not have access to EPSDT services, so those standards are not in place currently. So states will need to implement policies based on reasonable standards of medical and dental practice.

Next slide, please. In addition to those types of screening and diagnostic services, Section 5121 requires provision of medically necessary EPSDT screening and diagnostic services. For the under 21 population the folks that currently have access to EPSDT services when they're in the community, states should cover screening and diagnostic services for that population in the same manner as for youth who are not incarcerated. So you should apply those standards effectively.

What this means is EPSDT screening and diagnostic services are really the floor for coverage for the under 21 population. And you have the flexibility to establish additional standards, as I spoke about on the previous slide. For the over 21 population what this means is you must cover screening and diagnostic services when they are otherwise medically necessary.

Next slide, please. We know that in certain situations eligible juveniles may be screened either prior to involvement in the justice system, during the court process, upon entry to a carceral facility, or during other points of

incarceration prior to what is effectively a 30-day window for Medicaid coverage.

In these instances states should establish policies and procedures to determine if those services align with the Medicaid program and CHIP program standards. And if they do the CAA requirement can be satisfied. There is no need to screen that individual again if they've already received those services.

For targeted case management, this includes the activities covered under the targeted case management services benefit. This service is crucial to build a bridge to post-release physical health, behavioral health, health-related social needs.

We noted here, and in the letter, the case manager it can be different between pre and post-release. However, when this happens it's crucial that there's a warm hand-off between those different case managers to ensure continuity of services.

Next slide. Next slide, please. Oh, sorry. Sorry, go back. It's a little delay. I'm not there. This slide it just summarizes the requirements that I just went over. So it only applies to eligible juveniles who are within 30 days of the date on which they are scheduled to be released following adjudication, so it's that 30-day window prior to release.

Screening and diagnostic can be provided 30 days prior to release or as soon as practicable after release from a public institution. TCM is different. It must be provided in the 30 days prior to release and for at least 30 days post-release.

In certain situations, we recognize that release dates they change a lot of times

due to factors, frankly, that are outside the control of Medicaid program. If that happens, and such a change results in the eligible juvenile no longer being within that 30-day window, state Medicaid programs should suspend coverage of the screening diagnostic in TCM services until such time that the individual is within that 30-day window for coverage.

Next slide, please. Turning to CHIP, so there are three provisions that impact CHIP. First, Section 5121 applies generally to similar pre-release case management, screening, diagnostic services, and the time frames under Medicaid and CHIP. The one caveat is EPSDT is not required in separate CHIPs, so there will be differences across states.

Second, it aligns CHIP rules with existing Medicaid rules regarding suspension rather than termination of coverage and requirements regarding redeterminations of coverage. Third, finally, children within 30 days of their release from incarceration are no longer considered to be subject to the eligibility exclusion that we talked about earlier.

Next slide. This Section 5121 it includes a fairly unique requirement that we don't see in many of Medicaid benefits or CHIP. And it requires states to have a plan in place in accordance with such a plan to provide the necessary coverage.

We term this as an internal operational plan in our guidance. And in the guidance as you can see here we outlined a number of items that we thought should be included in an internal operations plan.

Next slide, please. And then one more. So I'm not going to go over every one, but those are some suggestions from CMS on what we think that should be included in the plan. But every state has flexibility to include additional or

different items within that plan that you think are necessary to implement the required coverage.

This plan should be in place no later than January 1, 2025, which is the effective date. States are not required to submit this plan to CMS except upon request. We're obviously available to provide any necessary technical assistance along the way though.

Next slide, please. So states can choose to rely on carceral and/or community-based health care providers to furnish any of the required services, the screening, the diagnostic, and TCM services. Regardless, states must ensure that all providers comply with Medicaid and CHIP provider participation and enrollment requirements.

The statute also does not limit the types of carceral facilities, so this applies broadly. This can include state prisons, local jails, tribal jails, juvenile detention, and youth correctional facilities. The one caveat is federal prisons, as we noted here and in the guidance, DMS is still reviewing how this impacts federal prisons. And we're hoping to provide guidance soon on that.

Next slide. I think infrastructure is really important to implementing these provisions, both 5121 and 5122, particularly on the carceral side. So we wanted to note that certain IT systems calls may be eligible for enhanced FFP. This includes IT systems and support data.

That support data is shared between the Medicaid agency and the correctional agency facilities, Medicaid providers, and other systems. If you have particular questions about this we encourage you to reach out to your Medicaid Enterprise Systems state officer.

Next slide, please. All right, turning our attention to the SPA process that CMS is going to be utilized. First, all states must submit a SPA with an effective date of no later than January 1, 2025. For Medicaid, that means you must submit a SPA no later than March 31, 2025 to have that effective date.

In CHIP it works a little bit differently. In order to have that effective date the state must – should submit a SPA no later than the end of the state fiscal year in which January 1, 2025 falls. We are developing SPA templates for states and are hopeful we'll be able to share those soon.

Next slide, please. As noted here we, you know, we're certainly committed to supporting the successful implementation of this provision. We do however recognize the complexities associated with this. And we've heard from a number of states that are concerned about the time frames and the potential need to need additional time to successfully implement these provisions.

And so what we've tried to do is develop a SPA review framework that recognizes these challenges and balances that with our regulatory requirements for reviewing SPAs, our general oversight responsibilities, and as well as the statutory effective date of January 1, 2025. This framework will be based on states' readiness. And so, depending on the level of readiness, states will either be fully ready, partially ready, or not ready to implement Section 5121.

Next slide, please. So full readiness, these are states - the state Medicaid CHIP programs are all ready to implement. All of the carceral providers in the state are also ready to implement the provisions. For these states CMS will - we will follow our normal SPA processing procedures. This could include a request for additional information, if necessary, or approval,

disapproval. Obviously, if you're ready I would imagine it would be an approval.

Next slide, please. Partially ready states, so this, for example, would be a state where the state Medicaid and the CHIP programs are prepared to operationalize these requirements. But perhaps only a limited number of your carceral facilities within your state are ready for any number of reasons.

In these instances, we will approve the SPA with the sunset language - sunset date in the SPA. And we will issue a companion letter that documents areas of non-readiness and establishes a deadline for full readiness.

Once the state achieves full readiness the state would submit a SPA to remove that sunset date from the state plan. Importantly, this approach allows states to claim for services in carceral facilities that are ready to participate in Medicaid and CHIP while giving states additional time to achieve full readiness.

Next slide, please. Finally, the - just states that are not ready. This would be, for example, the state Medicaid and CHIP program is not quite ready to operationalize the requirements on January 1, 2025, and therefore, neither are the carceral facilities within that state. In these instances what we plan to do is issue an REI documenting areas of non-readiness with Section 5121.

Importantly, this still allows us to retain the January 1, 2025, effective date while giving states additional time to fully implement the provision. But these states, as you make progress, you can move from a not-ready state to a partially ready state, which would allow us to approve the SPA and follow the same process I just outlined for partially ready states.

Next slide, please. So next steps here, I think I received my first couple of

appointments today. So you should be hearing from us either today or soon, because we are planning to meet with each state starting in October. If we haven't contacted you yet, don't worry, it's going to happen soon.

And so - and these calls are really intended just to be an open conversation on how things look today in your state. We are going to ask questions about your internal operational plan. Do you have the necessary coverage and reimbursement already in your state plan for the TCM screening and diagnostic services?

How is your engagement with the carceral facility going? What are you learning, health provider enrollment issues, infrastructure needs, all of these types of questions. And again, it's just meant to be an open conversation because these conversations will help dictate how we approach the SPA from your state.

Next slide, please. Interaction with the Section 1115 demonstration opportunity, there's a number of states that are currently participating in that demonstration opportunity or they are planning to in the near future. So what we've said is states may either partially or fully implement the mandatory coverage under 5121 as part of your reentry Section 1115 demonstration.

However regardless, whether you implement via the state plan or via the demonstration, all states must submit a SPA attesting to meeting the requirements in Section 5121. So once we have those SPA templates available even if you haven't approved 1115, you still must submit those SPA templates to CMS for approval. States that do this, that implement via the 1115 demonstration opportunity, may satisfy the internal operational plan requirement with the demonstration implementation plan that is associated with your Section 1115 demonstration.

If you have specific questions you can reach out to your project officer. I will say we do plan, including my colleagues from the State Demonstrations Group, on these calls that I mentioned that we're going to have in October. So there'll be a lot of coordination between the CMS teams here, between the state plan and the demonstration experts here at CMS.

Next slide, please. All right, turning to 5122, this addresses Medicaid and CHIP requirements for certain Medicaid and CHIP-eligible juvenile beneficiaries who are incarcerated pending disposition of charges. So that's the big - it's the same population, but these are folks that are incarcerated pending disposition of charges.

This one is optional. And it also takes effect on January 1, 2025. Again, it's really important that we're all mindful of and ensure that implementing these provisions do not effectuate a delay of an individual's release or lead to increased involvement in the juvenile and adult justice systems.

Next slide, please. Again, it's the same population, eligible juveniles that 1902(nn), it's a Medicaid-eligible individual who is under age of 21, or a Medicaid-eligible individual ages 18 to 26 who is eligible for them under Medicaid under the mandatory former foster care group. And CHIP, again, doesn't use that terminology, but a state may choose to lift the eligibility exclusion for children who are incarcerated pending disposition of charges.

Next slide, please. So under 5122 this is an option that provides full Medicaid coverage. So everything that they are entitled to in the community would be available while they're an inmate of a public institution pending disposition of charges, and receive FFP for those services.

Additionally, in CHIP instead of applying the eligibility exclusion, that we talked about, states will have the option to consider children who are inmates pending disposition of charges as eligible for CHIP during that period, their pending disposition of charges. In short, it's full Medicaid and CHIP coverage during this period.

Next slide, please. Again, everything I told you earlier about providers and settings applies to 5122. States can use carceral and/or community-based healthcare providers. Regardless they need to comply with Medicaid and CHIP provider participation enrollment requirements. Fifty-one twenty-two also does not limit the types of facilities. So it applies broadly with the one exception to federal prisons that we're hoping to address shortly.

Next slide, please. As far as state plan amendments, states may submit a Medicaid and/or CHIP SPA anytime with an effective date no earlier than January 1, 2025 to implement the optional coverage. And we are also developing a SPA template to assist states with this provision as well.

Next slide. Next slide, please. One more. Next slide, nope, forward. There we go. All right, finally we just wanted to note here, the CDC has some recommendations for correctional and detention facilities. They address HIV or viral hepatitis, STDs, and TB screening, treatment and vaccination, recommendations for people who are incarcerated or detained.

And given the states you're going to be developing new standards - potentially new standards for both the under 21 population and then for the adult population, the 21 to 26 population, we wanted to share these standards, these recommendations with you in case they are helpful. And I think that is it. So I will turn it back to Jackie and (Krista).

Jackie Glaze: Thank you, Michael, appreciate your presentation today. So now we're ready to take state's questions. And so we'll begin by taking questions through the chat function. So we do have a couple of questions, but please continue submitting them. And then we'll transition to the phone lines. So we'll take questions there as well. So I'll turn now to you, (Krista).

(Krista): Thanks so much, Jackie. The first question here is from (Henry Lippman). The question is, "Is a 30-day supply of needed medications included in the Section 5121 given the EPSDT requirements and the 30-day period post-release?"

Michael Tankersley: So, no it is not. So for the state plan Section 5121 requirements the pre-release service package is just the EPSDT screening and diagnostic services. It's not the full breadth of EPSDT services under 5121, just screening, diagnostic, and TCM. And then once they're released, post-release, obviously they would be entitled to all otherwise available Medicaid and CHIP coverage.

(Krista): Great. Thank you, Michael. The next question is from (Joanna Ruth). "If states are interested in pursuing a cost allocation plan for the case management work required by both, or either, 5121 or the 1115 entry waiver, does CMS anticipate approving this as an option? "

Michael Tankersley: We may need to take that one back unless there's somebody from, I don't know, if FMG would answer that, but we're probably going to have to take that one back.

(Jeremy): Yes, Michael, this is (Jeremy) from FMG. I think we should talk through that one.

(Krista): Okay, thank you guys. The next question is from (Lynette Rhodes). "Our Department of Juvenile Justice places some of the juveniles in group homes and community residential settings. Can you confirm that these settings are not considered as being in custody and incarcerated?" Second, "Does CMS consider remote monitoring, for example, ankle monitors, as being in custody?"

Michael Tankersley: So this is Michael. (Lynette), I think I would recommend reaching out to your state league so we can have a conversation on that one. It gets - I would need more details to confirm whether or not those group homes and community residential settings would qualify as a public institution, and therefore we would consider them inmates. Generally I would say no, but the specifics are going to matter. So I would think just reach out, and we'll set up some time to discuss that.

For the second question, generally speaking remote monitoring, that would not mean that the individual is considered an inmate of a public institution. I assume you're talking about someone who is on parole or released, but has to wear that ankle monitor. And if that's the case then they would not be an inmate of a public institution, but we can talk through those specifics when we meet.

(Krista): Thank you. Next question here is from (Nikki Blythe). "If the carceral facility is unwilling to make a change, or can't, how much falls on the state Medicaid agency to be in compliance? Is it enough that the state Medicaid agency has the framework in place, or is it enough for the state Medicaid agency to do the best that they can with what is given to them by the carceral facility?"

Michael Tankersley: Yes, (Nikki), that's a good question, and one that comes up all the time. I think (Nikki)'s getting at that a lot of these - this provision 5121 applies

broadly to all carceral facilities. And it can be difficult, particularly I think with the local facilities, to get them to participate.

I don't have a perfect answer here, frankly. I think my recommendation is reaching out early and often to those types of facilities. I think the reality is we have a federal Medicaid law that says we must be doing this in these types of facilities, so that needs to be part of the conversation.

I also think we can make a compelling argument that these services, in combination with the federal funding that is available for these services, can make a big impact in the lives of these eligible juvenile beneficiaries. So there's a number of - and I would recommend that, you know, you engage with the state leaders within your state as well.

But to your point, I think, you know, it may be difficult for us to convince everyone to participate. And I think if all else fails I would just encourage you to document, document, document when you're talking about particularly the local types of facilities that you're doing - that the Medicaid agency, the CHIP agency are doing everything that you can to get these types of facilities to participate and deliver the required coverage under Section 5121.

(Krista): Thanks, again. One other question here is from (Lynette Rhodes) again. "In the instance wherein the juvenile is in custody for less than 30 days, for example one to seven days or less, is the state Medicaid agency still expected to comply despite not having enough time to coordinate services?"

Michael Tankersley: The short answer is yes. So that would - that's the time frame for coverage that an individual would be within the 30 days of their scheduled release date. So that's the short answer. I think the reality is for those very, very short stays it can be very difficult. And we may not be perfect on all those

instances, and that's okay.

I would also note, (Lynette), that the statute does give us the flexibility to provide or requires us actually to provide the screening and diagnostic post-release when we can't do it pre-release, right? It also requires us to provide targeted case management post-release when we can't do it, you know, pre-release and post-release.

And so there may be instances where for a number of reasons we can't provide those services in the pre-release time frame because it's a very, very short stay. But that's when we really need to focus on providing those services after the individual is released.

And I think I would just highlight here, (Lynette), too my comment earlier that in no circumstances should the availability of Medicaid coverage effectuate a delay of the individual. So if you have someone that's been there for one day, we should not be keeping that individual a longer just to fulfill the requirements of the CAA. In those instances, let's try to provide those services post-release.

(Krista): Great. Thanks so much. Another question here from (Rene Mollo). "Given these requirements, what is envisioned to get the carceral settings to comply with these provisions that have been placed on state Medicaid and CHIP agencies?"

Michael Tankersley: Yes, (Rene), I think I would just point to my response earlier from (Nikki). I think you're raising the same question, and understandably so. And I think any one of those, or all of those arguments for lack of a better term, we can utilize to hopefully bring our carceral facilities along and get them to participate in Medicaid and CHIP.

Melissa Harris: And Michael, this is Melissa Harris. And the only thing that I would also add, in response to these concerns, is that we are having pretty frequent conversations with the Department of Justice. And they are doing a lot of outreach to the carceral settings that we at CMS don't have a direct link to.

And so they are pushing out a lot of information about 5121, encouraging their folks to reach out to states if they're not hearing from states proactively, and just generally encouraging a lot of cooperation and partnership. And so I wanted to let people know that we're having those conversations at the federal level, and they are pushing out a lot of information to their carceral stakeholders.

But again want to reiterate what Michael was saying about the states reaching out to their carceral partners early and often, because it might take a couple of outreaches for folks to realize this is an expectation on them. We've also had a couple of stakeholder calls with carceral stakeholders reiterating that this applies to all kinds of jails and prisons and youth detention facilities, et cetera.

And so there is that growing awareness of the parameters of 5121. And so hopefully the cases of unresponsive carceral providers will really be the exception rather than the norm. But do continue to reach out and let us know if you're having any particular difficulties. Thanks.

(Krista): Great. Another question here is from (Grace Johnson). "If states do not take advantage of the 5122 flexibility on 1-1-25, can they adopt this at a later date given they meet all requirements under 1521 for January 1 but aren't ready for 15, I'm sorry, for 5122?"

Michael Tankersley: The answer is yes. You can - states can elect 5122, the optional provision,

at any time on or after January 1, 2025, which is when it goes into effect. So the answer is yes. And you can elect it either in Medicaid or CHIP or both.

(Krista): Great. "There will be carceral settings that will not agree to participate. I can build it, but I have no authority to make them participate. Is that CMS' approach to that?" I think Melissa and Michael, you have answered that question. So unless anything else to add I will move on to the next one.

Michael Tankersley: Yes, I agree we've already addressed that one.

(Krista): Okay, great. From (Casey Ingress), "Has there been any discussion about how states that determine eligibility on a monthly basis can comply with the 30-day period if the 30-day period starts after the first of the month? For example, an individual doesn't begin the 30-day pre-release period until mid-month, but when the state determines eligibility, the eligibility is effective the first of the month."

Michael Tankersley: So this is Michael. There has been - I don't know if we have - if I have my eligibility colleagues on that I've been working on that issue with. So we may have to take that one back unless somebody from eligibility can address it.

Jackie Glaze: Thank you, Michael. So what I think we'll do now is we'll move to the phone lines to see if we have any questions there. So, (Missy), if you could provide instructions for registering the questions, and then if you could open the phone lines, please.

Coordinator: Yes, ma'am. If you would like to ask a question over the phone please press Star followed by 1. Please make sure that your phone is unmuted and record your name when prompted. If you wish to withdraw your question, you can press Star 2. Please allow a moment for questions to come in. Thank you.

Our first question comes from (Patrick). Your line is open.

(Patrick): Well, thank you. Quick question, it just occurred to me would we be allowed to pay the carceral setting for the staff time and activities related to 5121? It's not the TCM, it's not the case management, it's their - because they're going to have to escort kids to HIPAA compliance spaces, monitor them in ways that they don't normally, and that kind of stuff. So there's a lot of background activities that are going to go in, which is why carceral settings are going to resist this. Can we pay them?

(Jeremy): So this is (Jeremy) again from FMG. I think this is something that we'd want to engage with you one-on-one to talk about the specifics of the activities that would be performed here. You know, there are funds available for the proper and efficient administration of your C plan. So to the extent that, you know, it would be acting and doing activities on behalf of the Medicaid agency, there might be federal funds available, but we would really need to dig into the specifics here.

(Patrick): Okay, because yes we've actually been engaging with all of our carceral settings for a couple months now, talking to them about their operations, what they do. And there will be a lot of activity that they have to engage in for this TCM, and screenings, and that kind of stuff to get the providers into the setting and to monitor a kid, And yes, so that's where the resistance is going to come from, but yes.

(Jeremy): Okay.

Jackie Glaze: Thank you. So in closing I do want to thank our presenters for their discussion today. And I would like to remind you that we will be holding an ad hoc All State Call this Thursday, September the 26, from 3:30 to 4:00 pm Eastern

Standard Time. So that we hope that you can join us.

If you do have questions in the meantime please feel free to reach out to us, your state leads, or bring your questions to our next call. So we do thank you again for joining us and for your questions. And we hope that you all have a great afternoon. Thank you.

Coordinator: Thank you. That does conclude today's conference. You may disconnect at this time. And thank you all for joining.