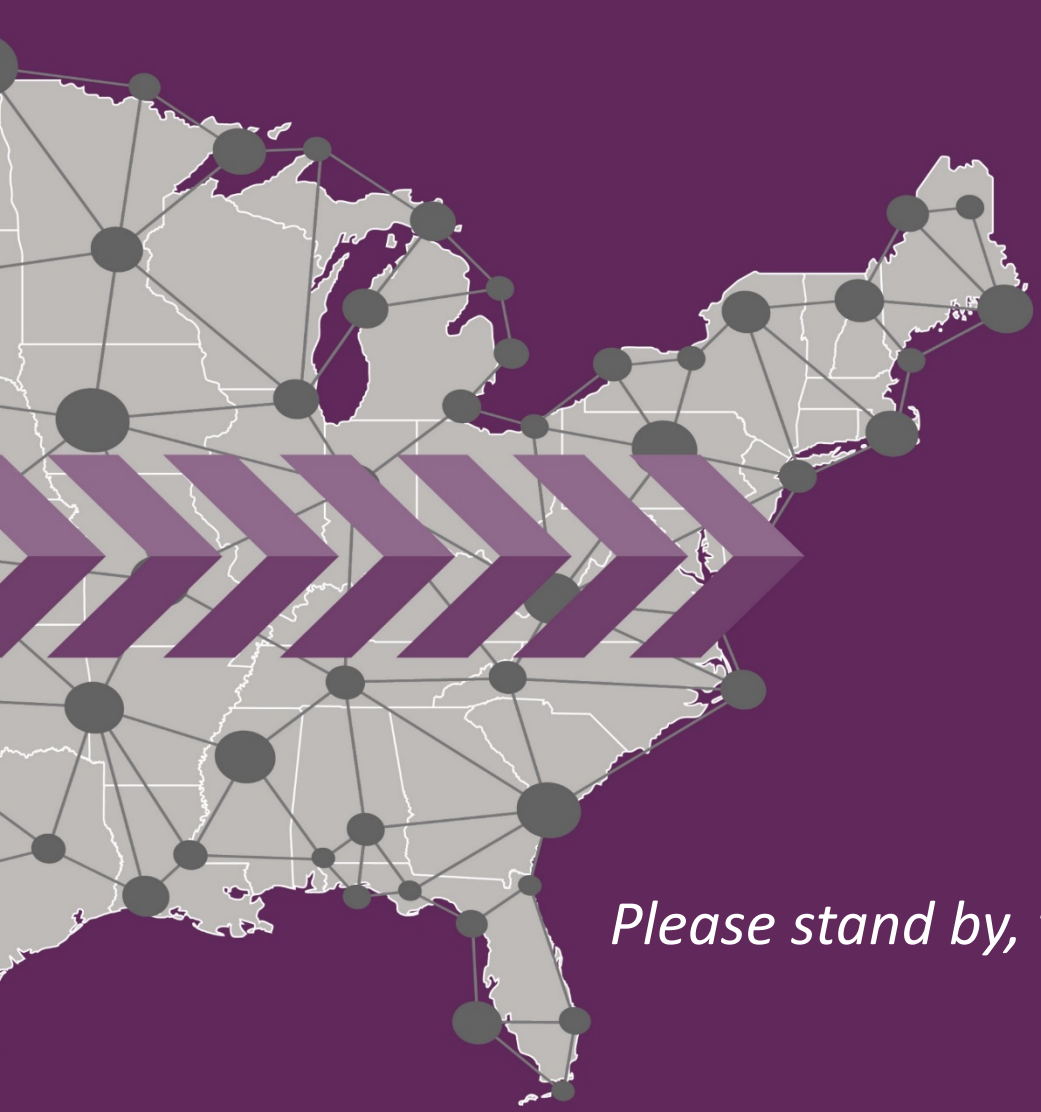


New CMS Guidance: CAA Requirements for the Provision of Medicaid and CHIP Services to Incarcerated Youth

August 19, 2024

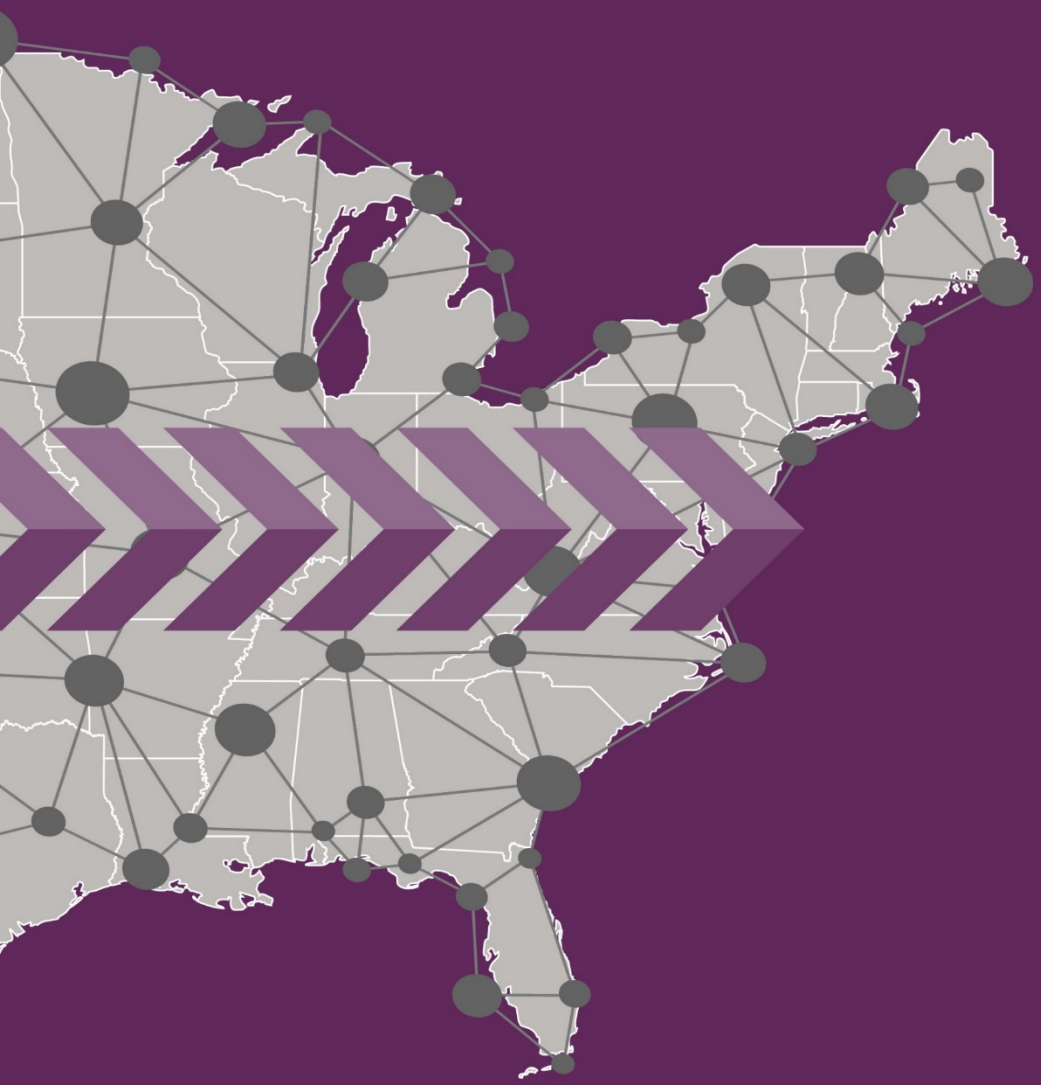
3:00 – 4:00 p.m. ET

Please stand by, this webinar will begin shortly

STATE Health & Value STRATEGIES

Driving Innovation Across States

A grantee of the Robert Wood Johnson Foundation



New CMS Guidance: CAA Requirements for the Provision of Medicaid and CHIP Services to Incarcerated Youth

August 19, 2024

3:00 – 4:00 p.m. ET

STATE Health & Value STRATEGIES

Driving Innovation Across States

A grantee of the Robert Wood Johnson Foundation

About State Health and Value Strategies

State Health and Value Strategies (SHVS) assists states in their efforts to transform health and healthcare by providing targeted technical assistance to state officials and agencies. The program is a grantee of the Robert Wood Johnson Foundation, led by staff at Princeton University's School of Public and International Affairs. The program connects states with experts and peers to undertake healthcare transformation initiatives. By engaging state officials, the program provides lessons learned, highlights successful strategies, and brings together states with experts in the field. Learn more at www.shvs.org.

Questions? Email Heather Howard at heatherh@Princeton.edu.

Support for this webinar was provided by the Robert Wood Johnson Foundation.
The views expressed here do not necessarily reflect the views of the Foundation.

About Manatt Health

Manatt Health, a division of Manatt, Phelps & Phillips, LLP, is an integrated legal and consulting practice with over 160 professionals in nine locations across the country. Manatt Health supports states, providers, and insurers with understanding and navigating the complex and rapidly evolving healthcare policy and regulatory landscape. Manatt Health brings deep subject matter expertise to its clients, helping them expand coverage, increase access, and create new ways of organizing, paying for, and delivering care. For more information, visit www.manatt.com/ManattHealth.aspx

Housekeeping Details

- Use the 'Q&A' function in Zoom to submit questions and comments to the meeting facilitators. **Note that you must select to submit a question anonymously.**
- All participant lines are muted.
- After the webinar, the slide deck and a recording will be available at **www.shvs.org.**

Agenda

- **Level-Setting**

- **Takeaways From CMS Guidance**
  - Section 5121: Mandatory Requirement to Provide Targeted Case Management and Screening and Diagnostic Services
  - Section 5122: State Option to Provide Full Scope Medicaid and Children's Health Insurance Program Services
  - Clarifications to Children's Health Insurance Program Eligibility Policy

- **Discussion**

Level-Setting

Background

On average, 36,000 youth and children are confined in juvenile justice settings and over 3,000 in adult carceral facilities, including prisons and jails, every day.

Incarcerated children and youth are more likely than the general population to:

- Have an untreated health and behavioral health need.
- Be at higher risk for having experienced sexual and physical abuse.
- Experience suicidal ideation.
- Be involved with the foster care system and adult justice system.

- **Youth of color account for a significantly higher proportion of those in all types of carceral facilities**: The rate of incarceration is six times higher for Black than White children and youth.
- **LGBTQ+ children and youth in detention facilities experience increased rates of emotional abuse, physical abuse, and time in isolation and represent almost 15% of the incarcerated population**.

Historically, states have been limited in their ability to deliver Medicaid services to incarcerated populations.

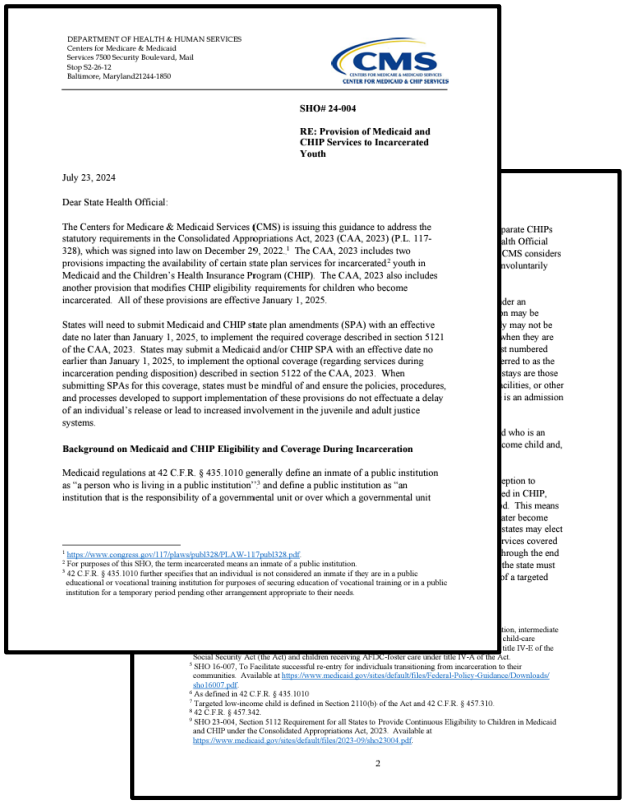
- A provision of federal Medicaid law known as the "inmate exclusion" limited Medicaid payments to inpatient hospital care.
- In April 2023, the Centers for Medicare & Medicaid Services (CMS) released guidance on how to pursue federal section 1115 waiver authority from the inmate exclusion to provide a targeted set of reentry services. To date, 24 states (including Washington D.C.) have a pending or approved reentry section 1115 demonstration application.

Source: CMS, Provision of Medicaid and CHIP Services to Incarcerated Youth.

New CMS Guidance on the 2023 Consolidated Appropriations Act, 2023 (CAA)

On July 23, 2024, CMS released a State Health Official (SHO) letter, "Provisions of Medicaid and CHIP Services to Incarcerated Youth."

- The SHO letter provides important **clarifications and implementation guidance for states on CAA requirements** related to the provision of services for incarcerated children and youth.
- Key areas of focus for today include:
  - **CAA section 5121**: Mandatory requirement to provide targeted case management (TCM) and screening and diagnostic services for incarcerated children and youth post-adjudication.
  - **CAA section 5122**: State option to provide full scope Medicaid and Children's Health Insurance Program (CHIP) services for incarcerated children and youth pending disposition.
  - **Clarifications to CHIP eligibility policy** for incarcerated children and youth.



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid
Services 7500 Security Boulevard, Mail
Stop S2-26-12
Baltimore, Maryland21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

SHO# 24-004

RE: Provision of Medicaid and CHIP Services to Incarcerated Youth

July 23, 2024

Dear State Health Official:

The Centers for Medicare & Medicaid Services (CMS) is issuing this guidance to address the statutory requirements in the Consolidated Appropriations Act, 2023 (CAA, 2023) (P.L. 117-328), which was signed into law on December 29, 2022.[1] The CAA, 2023 includes two provisions impacting the availability of certain state plan services for incarcerated[2] youth in Medicaid and the Children's Health Insurance Program (CHIP). The CAA, 2023 also includes another provision that modifies CHIP eligibility requirements for children who become incarcerated. All of these provisions are effective January 1, 2025.

States will need to submit Medicaid and CHIP state plan amendments (SPA) with an effective date no later than January 1, 2025, to implement the required coverage described in section 5121 of the CAA, 2023. States may submit a Medicaid and/or CHIP SPA with an effective date no earlier than January 1, 2025, to implement the optional coverage (regarding services during incarceration pending disposition) described in section 5122 of the CAA, 2023. When submitting SPAs for this coverage, states must be mindful of and ensure the policies, procedures, and processes developed to support implementation of these provisions do not effectuate a delay of an individual's release or lead to increased involvement in the juvenile and adult justice systems.

Background on Medicaid and CHIP Eligibility and Coverage During Incarceration

Medicaid regulations at 42 C.F.R. § 435.1010 generally define an inmate of a public institution as "a person who is living in a public institution"[3] and define a public institution as "an institution that is the responsibility of a governmental unit or over which a governmental unit

[1] https://www.congress.gov/117/plaws/publ328/PLAW-117publ328.pdf
[2] For purposes of this SHO, the term incarcerated means an inmate of a public institution.
[3] 42 C.F.R. § 435.1010 further specifies that an individual is not considered an inmate if they are in a public educational or vocational training institution for purposes of securing education of vocational training or in a public institution for a temporary period pending other arrangement appropriate to their needs.

Social Security Act (the Act) and children receiving AFDC-foster care under title IV-A of the Act.
[5] SHO 16-007, To Facilitate successful re-entry for individuals transitioning from incarceration to their communities. Available at https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/sho16007.pdf
[6] As defined in 42 C.F.R. § 435.1010
[7] Targeted low-income child is defined in Section 2110(b) of the Act and 42 C.F.R. § 457.310.
[8] 42 C.F.R. § 457.342.
[9] SHO 23-004, Section 5112 Requirement for all States to Provide Continuous Eligibility to Children in Medicaid and CHIP under the Consolidated Appropriations Act, 2023. Available at https://www.medicaid.gov/sites/default/files/2023-09/sho23004.pdf.

2

Source: CMS, Provisions of Medicaid and CHIP Services to Incarcerated Youth.

Takeaways from CMS Guidance

Eligible Children and Youth

Under section 5121, states are required to provide mandatory TCM and screening and diagnostic services to eligible children and youth who are being held post-adjudication.

CMS Implementation Requirements
▪ **Eligible population** includes children and youth who are: ☑ Enrolled in Medicaid or a separate CHIP; ☑ Under 21 years of age or between the ages of 18 and 26 under the mandatory former foster care eligibility group; and ☑ Being held in a carceral facility post-adjudication (e.g., children and youth who are incarcerated after conviction).

Facility Types

Correctional facilities that are subject to section 5121 are defined as all types of facilities where eligible children and youth are incarcerated, including:

Juvenile detention and youth correctional facilities, which exclusively house eligible children and youth both pre- and post-adjudication.

Local jails that may house eligible children and youth both pre- and post-adjudication.

Tribal jails and prisons that may house eligible children and youth both pre- and post-adjudication.

State prisons that may house former foster care children and youth who are post-adjudication.

***Federal prisons were not included in the guidance**, though CMS noted that it intends to provide further guidance on whether and how federal prisons may be subject to the mandatory requirements.*

Eligibility and Enrollment

State Operational Considerations

- **Size the Population:** As an initial step, states should identify facilities that hold post-disposition children and youth to size the eligible population.
  - States can stage implementation, first targeting facilities where most of the post-disposition children and youth are being held, and second targeting facilities holding both pre- and post-adjudication children and youth.
- **Understand the Current State:** States may wish to interview and survey facilities to outline the CAA requirements, establish partnerships/relationships, and begin to get an understanding of each facility's current capacity with respect to Medicaid/CHIP enrollment processes, data exchange systems, and service provision.
- **Ensure Threshold Eligibility and Enrollment Processes:**
  - States must work with correctional facilities to ensure that Medicaid and CHIP eligibility, enrollment and suspension processes are in place, including bi-directional information sharing on incarceration status and release dates.
  - Correctional facilities may need technical assistance on best practices for setting up enrollment processes for children and youth who are incarcerated and not yet enrolled.
  - States may want to consider setting up specialized short-term eligibility and enrollment processes as longer-term solutions are being built.

Scope of Screening and Diagnostic Services (1/2)

States must provide screening and diagnostic services to children and youth enrolled in Medicaid or CHIP in the 30 days prior to release (or no later than one-week post-release).

CMS Implementation Requirements

- **Medicaid:** States have flexibility in defining the scope of services, but at minimum must adhere to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) standards for those under the age of 21, including medically necessary:
  - Screening services that include:
    - Comprehensive health, developmental history, and unclothed physical examinations.
    - Appropriate vision, hearing, and lab testing.
    - Dental screening services.
  - Diagnostic services that include diagnosis of defects in vision and hearing, dental, and immunizations.
- **CHIP:** States with separate CHIP programs must provide screening and diagnostic services available under the CHIP state plan or waiver.
  - States that elect to provide EPSDT services for CHIP enrollees must provide all medically necessary EPSDT required screening and diagnostic services.

Scope of Screening and Diagnostic Services (2/2)

State Operational Considerations

- **Define Screening and Diagnostic Services for Post-Disposition Youth:** States can leverage their existing definitions for screening and diagnostic services for Medicaid-enrolled children and youth and may consider aligning for CHIP-enrolled children and youth and former foster care youth.
    - *Note:* CMS clarified during a National Association of Medicaid Directors (NAMD) call on August 9, 2024, that if an eligible child or youth has received screening and diagnostic services outside of the 30-day pre-release period, such provision of services will satisfy the requirement (but Medicaid financing is not available).
- **Understand the Current State:** Work with facilities to understand the scope of current screening and diagnostic services and identify gaps (e.g., dental screenings).
- **Develop Billing Guidance:** Outline billing codes for screening and diagnostic services, define eligible providers (e.g., correctional healthcare and community-based in-reach), and issue billing guidance to providers.
- **Provide Technical Assistance to Facilities:** To help facilities adapt existing screening processes to meet CAA requirements, as needed.
- **Confirm Legal Authorities**: Medicaid state plans will remain unchanged, but states should evaluate whether any changes are needed for CHIP state plans if the state elects to align Medicaid and CHIP screening and diagnostic service definitions.

Targeted Case Management Services (1/2)

States must provide TCM services to eligible children and youth in the 30 days prior to release, and for at least 30 days post-release.

CMS Implementation Requirements
▪ **Medicaid:** TCM is defined as: ○ Comprehensive needs assessments (health, behavioral health, health-related social needs). ○ Development of a person-centered care plan—including social, educational, and other underlying needs. ○ Referrals and related activities (e.g., appointment scheduling) to link individuals to needed services in the community. ○ Monitoring and follow-up activities (e.g., follow-up with service providers) to ensure the care plan is implemented. ▪ **CHIP:** CHIP regulations do not define TCM services, but CMS encouraged states to align CHIP requirements with Medicaid.

Targeted Case Management Services (2/2)

State Operational Considerations

- **Assess Current State:** Understand the extent to which pre- and post-release case management is currently being provided to post-disposition youth to assess whether the state can build upon existing processes.

- **Define Eligible Pre- and Post-Release Case Managers:**
  - Determine which providers will deliver pre- and post-release case management (e.g., embedded correctional healthcare providers, in-reach providers, and/or a centralized provider that will work across facilities).
  - If pre-and post release case managers are different, identify a mechanism for ensuring warm hand-offs [e.g., establishing information sharing between pre-release correctional facility healthcare provider and post-release managed care organization (MCO) to share care plan and ensure continuity of coverage].

- **Develop Operational Processes and Information Technology Systems for Assigning Pre- and/or Post-Release Case Management:** Ensure facilities know which plans are assigned post-release case management and post-release case managers (e.g., MCOs) know with which facility to coordinate.

- **Review and Update Legal Authorities and MCO Contracts:**
  - If MCOs or other contracted community-based providers will provide pre- and/or post-release case management, amend existing contracts, as needed.
  - Assess whether a new or amended TCM state plan amendment (SPA) is needed for Medicaid enrollees. (States with approved demonstrations already have pre-release case management authority.)
  - Amend the CHIP state plan to include case management as a covered service.

Participating Providers (1/2)

States may determine their own provider networks, as long as they comply with Medicaid and CHIP provider enrollment, billing, and related rules.

CMS Implementation Requirements
▪ Medicaid and CHIP services may be provided by carceral providers or community-based providers, though CMS noted a preference for leveraging community-based providers.   ○ If facilities leverage carceral providers, they must complete a warm handoff to community-based providers prior to release. ▪ All participating providers must comply with Medicaid and CHIP provider participation and enrollment requirements and follow applicable data sharing requirements.

Participating Providers (2/2)

State Operational Considerations
▪ **Consider Leveraging Community-Based Providers**: ○ Community-based providers likely have more experience with Medicaid/CHIP and may already be enrolled as billing providers, can more easily scale based on the volume of clients in a facility, and provide continuity of care between the pre- and post-release settings. ○ States that leverage community-based providers will need to work with facilities to address operational issues (e.g., security clearances, space for visits, telehealth capabilities). ▪ **Require Correctional Healthcare Providers to Enroll in Medicaid** (if those providers are delivering services): ○ Consider ways to ease the provider enrollment process by expediting provider enrollment processes and establishing the same enrollment process a state would afford other clinics (e.g., where not all providers within a facility/clinic need to enroll separately, except those ordering and prescribing). ▪ **Consider a Glidepath Implementation Approach:** Where initial focus is on ensuring correctional healthcare providers are enrolled as Medicaid providers and then building billing and claiming processes (offering technical assistance support, as needed).

Delivery Systems

States have flexibility to use either fee-for-service (FFS) or managed care delivery systems for providing eligible services under section 5121.

State Operational Considerations
▪ **A pre-release FFS approach may be more operationally simple but can overlook the existing role of MCOs:** For the 30 days post-release case management, states will need to identify whether such services will also be provided FFS or whether an MCO can be assigned in a timely fashion. ▪ **States that opt to use a managed care delivery system pre-release will need to solve for several operational issues**, including: ○ Developing capitation rates for applicable pre-release services. ○ Amending MCO contracts, as necessary. ○ Ensuring that correctional healthcare service providers are credentialed with participating MCOs. ○ Ensuring services are provided through an alternative mechanism for managed care exempt/excluded populations (e.g., American Indian/Alaska Native and foster care youth).

Other Operational Requirements (1/2)

State Operational Plan

- **States are required to have an internal operational plan in place no later than January 1, 2025**, but are not required to submit plans to CMS except upon request. (See the Appendix for Operational Plan elements.)

- **Operational plans must detail system changes, policies and procedures, training programs, and other actions** the state will take to implement CAA requirements.

- **CMS clarified that states with section 1115 implementation plans that intend to subsume CAA requirements into the demonstration do not need to submit a separate CAA 5121 operational plan.**

Other Operational Requirements (2/2)

Process for SPA Submissions

- **CMS will release section 5121 SPA templates for states** to attest that they have an operational plan in place and will provide mandatory services as required under section 5121. Per CMS guidance during a NAMD call on August 9, 2024, states must attest to one of the following options:
  - *Fully Ready:* All 5121 requirements are in place (i.e., systems, facilities, all youth populations are ready for January 1, 2025).
  - *Partially Ready*: State Medicaid is prepared to operationalize 5121; however, only some facilities are ready to participate, *or* services are being delivered but not claimed, *or* carceral providers are not ready/services are not being provided.
  - *Not Ready:* State Medicaid is not prepared, and services are not being provided.
- **CMS intends to meet with all states in the fall to discuss readiness** (starting with states that have a section 1115 demonstration).
- **States must submit their SPAs by no later than March 31, 2025 (with a retroactive effective date of January 1, 2025).**

State Option to Provide Full Medicaid/CHIP Benefits

Under section 5122, states have the option to provide full scope Medicaid and CHIP benefits to incarcerated children and youth who are otherwise eligible, pending disposition.

CMS Implementation Requirements

- Option applies to children and youth who are pending disposition (i.e., incarcerated children and youth who do not yet have a conviction, but otherwise meet Medicaid or CHIP eligibility requirements).
- States that take up this option must provide *all* mandatory and optional Medicaid and CHIP benefits authorized under the state plan and/or section 1115 demonstrations, which includes EPSDT services for Medicaid enrollees under age 21.
- States have flexibility in determining implementation timing.

State Operational Considerations

- States that are interested in this option will need to **assess whether correctional facilities will be able to support full scope Medicaid and CHIP services** for all eligible pre-disposition children and youth.
  - In particular, states should engage facilities to understand the feasibility of implementing full scope services, including services that will require in-reach service provision such as dental services, physical therapy, and occupational therapy.
- States may wish to consider a glidepath approach where they first implement section 5121, then they implement a reentry section 1115 demonstration, and then based on level of correctional facility engagement and the building of infrastructure and capacity, consider implementing section 5122.

Clarifications to CHIP Eligibility Policy

Context

- Unlike in Medicaid, **an individual's incarceration status is an eligibility factor for CHIP**, meaning they can be denied eligibility on the basis of their incarceration.
- CMS clarified in prior guidance that **the CAA requires states to provide CHIP children and youth under age 19 with 12-months continuous eligibility (CE).**
- However, **under prior guidance, states were required to terminate CHIP eligibility** for incarcerated children and youth once the CE period ends.

New CMS Clarifications in SHO Letter

- **States may not terminate CHIP eligibility for incarcerated children and youth** if they would otherwise be eligible if not for their incarceration status, even if their CE period ends while incarcerated (effective January 1, 2025).
- **States have the option to either suspend CHIP coverage or continue to provide state plan services to incarcerated children and youth**.
  - States that opt to suspend coverage may choose to effectuate a benefits suspension (i.e., limit coverage to state plan services not provided by the correctional facility) or an eligibility suspension (i.e., pause the individual's CHIP coverage until they are released).
- **States must conduct CHIP eligibility redeterminations prior to release if a redetermination has not been conducted for 12 months or longer.**
  - States must also reinstate benefits without a redetermination for individuals who are released before their CE period ends (effective January 1, 2024).
- **Incarcerated children and youth who are within 30 days of release may be found eligible to receive pre-release services.**
  - States must also process any applications for full CHIP benefits upon the individual's release from a carceral facility.

Discussion

The slides and a recording of the webinar are available at www.shvs.org.

Thank You

Patti Boozang
Senior Managing Director
Manatt Health
pboozang@manatt.com

Kinda Serafi
Partner
Manatt Health
kserafi@manatt.com

Chris Cantrell
Director
Manatt Health
ccantrell@manatt.com

Heather Howard
Director
State Health and Value Strategies Program
heatherh@princeton.edu

Sally Mabon
Director of Programs
State Health and Value Strategies Program
smabon@princeton.edu

Appendix

Section 5121 Operational Plan Elements

- **Actions for establishing an operational system** and updating the system as needed on an ongoing basis, to perform functions such as exchanging data with the carceral system.
- **Procedures for Medicaid and CHIP eligibility**, enrollment, applicable notifications, and claims processing.
- **Processes to ensure the timeliest possible provision of screening and diagnostic services** if they are not able to be covered beginning 30 days prior to release.
- **Policies, procedures, and processes to ensure pre-release services do not effectuate delay** of an individual's release or lead to increased involvement in the juvenile and adult justice systems.
- New or updated written **staff-level operational policies and procedures** where workflows and processes are impacted by the new requirements.
- New or updated **provider and enrollee-level processes, procedures, policies, and systems** related to accessing services such as case management, prior authorization, linkages with MCOs, payment, claims processing, and data analysis, where these are impacted by the new requirements.
- **Training, education, and outreach actions.**
- **Integration with current Medicaid and CHIP operations**, such as disaster planning and continuity of operations, hearings and appeals, enrollee notices, record retention, and other operational activities associated with program administration.

States are required to have a plan in place no later than **January 1, 2025**, but are not required to submit this internal operational plan to CMS, except upon request. CMS is available to provide TA to states.