Centers for Medicare & Medicaid Services
COVID-19 Medicaid and CHIP All State Call
July 27, 2021
3:00 pm ET

Coordinator: Good afternoon and thank you all for standing by. At this time all participants are in a listen-only mode. After today's presentation you will have the opportunity to ask questions and you may do so over the phone by pressing Star 1 at that time or in the Q&A chat panel in the WebEx. Today's call is being recorded. If you have any objections to a disconnect at this time. It is my pleasure to turn the call over to your host for today 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 and Webinar. Our Center Director, Dan Tsai, will provide opening remarks and then turn to Anne Marie Costello, our Deputy Center Director, who will provide highlights for today's discussion. Dan?

Dan Tsai: Thanks Jackie. Hi folks. I just want to hit on a few topics that you'll hear from the team today. So the first one will be on the HCBS spending plans which I think states probably are eagerly awaiting some news on. And so having just come from a state it's a life changing amount of funding to think about for the HCBS system.

And we've had a lot of incoming questions around how states can use the funding. And I think you'll see some very positive things. I'm sorry I've got apparently a lawnmower in my back yard. Hopefully some very favorable guidance coming back in some of the approval letters that really encourage states to think about not only immediate rate enhancements but also structural and systematic investments to really build capacity of the HCBS system.

And the team will always be very clear about the distinction between what will generate FFP versus what's eligible for enhanced funding or use of the enhanced funding. But we're very excited to see states exploring things of that sort.

There are certain boundaries that still do exist that the team will talk about but I'm hopeful that folks can embrace that and we can together think about how to use some of the very large amounts of funding to not only provide some immediate relief but also to think about longer term ways to build capacity in the system as well. So that that's an exciting piece.

And then one other topic I just wanted to highlight you'll hear a little bit more about the - some grant opportunities for states to help develop Mobile Crisis Intervention capacity and that's a very exciting thing. Behavioral health and a lot of the challenges of how to deal with crisis and folks ending up boarding in the emergency department things of that sort I know are in many states' minds. And we're quite excited about the ability to partner with states and think about that sort of piece so.

So, I think we have a rich agenda today. I just wanted to highlight those two pieces. They are very - they are two things I'm very excited about, themes we're excited about. And Jackie I think I will turn it to Anne Marie now.

Anne Marie Costello: Great, thanks Dan and hi, everyone. As Dan mentioned we have a number of topics to cover on today's call. First up, Jen Bowdoin, from the Disabled and Elderly Health Programs Group will join us. Jen will address, as Dan mentioned, some frequently asked questions that we recently received related to Section 9817 of the American Rescue Plan Act which is the provision that provides states with a temporary ten percentage point increase in the federal

medical assistance percentage to certain Medicaid home community-based services.

After Jen's presentation, Jean Close also from our Disabled and Elderly Health Programs Group, will present a walkthrough of the recently released Notice of Funding Opportunities for state Planning Grants for qualifying community based Mobile Crisis Intervention services also authorized by the American Rescue Plan under Section 9813.

And then finally, and it really is a Disabled and Elderly Health Programs Group day on the call, we'll be joined by Kirsten Jensen. Kirsten, will provide an overview of guidance we recently released on a provision related to the medical coverage of transportation that was included in the Consolidated Appropriations Act of 2021. Kirsten will also provide some reminders about Medicaid coverage requirements under certain benefits for the provision of PREP or pre-exposure prophylaxis for HIV prevention.

So after Kirsten's updates we'll open up the lines to your questions. We'll use as we have in the last several All State calls our Webinar for open mic question and answer session at the end of the call. If you're not logged into the Webinar platform I suggest you do so now.

But before we jump into Jen's update I wanted to make sure you were all aware of the two-part Webinar series that (Sam Sass) is launching this Thursday on ensuring continuity of coverage and preventing inappropriate terminations of eligible Medicaid CHIP beneficiaries. Promoting continuity of coverage could help ensure that individuals have access to critical health care services, Medicaid churn, reduce the application volume for states and minimize the number of appeals that state agencies must process.

In the Webinar series CMS will share operational strategies that states can employ to mitigate inappropriate coverage loss. The strategies described may be used during the, during and immediately after the COVID-19 public health emergency but also has broad applicability beyond the PHE period.

The first Webinar will take place this Thursday July 29 from 3:00 to 4:30 Eastern and the second Webinar will take place next Thursday August 3 from 3:00 to 4:00 pm, also Eastern. To register for the Weather series, you can visit the link included in the slide deck from today's call. It will be posted on the COVID-19 page on medicaid.gov by the end of the day.

If you're not able to access the links to the slides you can send an email to our email box at medicaidcovid19@cms.hhs.gov, again you can email medicaidcovid19@cms.hhs.gov and we can help you access the registration page. We hope you'll join us for the Webinar series as we think it will be useful tool for states as they continue planning to the eventual end of the PHE and the FFCRA's continuous enrollment requirements.

With that I'll turn things over to Jen to start her presentation. Thanks. Jen, it's all yours.

Jen Bowdoin: Thanks Anne Marie and hello everyone. This is Jen Bowdoin. I am the Director of the Division of Community Systems Transformation in the Disabled and Elderly Health Programs Group. So as Anne Marie mentioned I'm going to address some frequently asked questions that we've received related to Section 9817 of the American Rescue Plan which provides states with a temporary ten percentage point increase to the federal medical assistance percentage for certain Medicaid home and community-based services from April 1, 2021 through March 31, 2022.

Before I get to those however I wanted to provide updates related to the implementation of Section 9817. So first of all, thank you to the states that have submitted their spending plans and narrative. Since our last All State call we now have 51 spending plans, initial spending plans and narrative's in hand. And we really appreciate states timely submission of the plans and the time, attention and thoughtfulness that have been provided in developing the plans.

The spending plans we've reviewed so far include a broad range of activity to expand, enhance and strengthen HCBS. And they include a number of innovative ideas to address the challenges that states are experiencing in their HCBS systems.

In particular we wanted to note that we strongly encourage and we want to work with states you to use the ARP funding to make investments in their HCBS systems that will lead to structural or systematic changes and improvement. And that includes capital investments and strategies to build HCBS systems capacity which I'll talk about in more detail in a few minutes.

Second, CMS is reviewing the spending plans as quickly as possible. And we are pleased to report that last week we sent either partial or conditional approvals or requests for additional information for the first ten plans that were submitted. And we expect to follow-up with several more states this week and the remaining states over the next several weeks.

Third, we wanted to specifically note that approval of any activity in your state spending plan does not provide approval to claim federal financial participation for any expenditures that are not eligible for federal financial participation. And lastly, we wanted to clarify that unless CMS requests an updated initial spending plan and narrative the next quarterly spending plan and narrative is due 75 days before the quarter beginning January 1, 2022.

However, at the states option you can choose to submit an updated spending plan for the quarter beginning October 1, 2021. So, for example if a state wanted to receive approval for a new activity or to address questions or issues that CMS noted through the initial spending plan review you do have the option to send it prior to the due date for the January 1, 2022 quarter.

And with that I'm going to now turn to some frequently asked questions and provide some additional points of clarification on how states may implement Section 9817. So, the first question I'm going to address has to do with claiming the FMAP increase for only a portion of eligible expenditures.

So, the question is, "Can states choose to claim the FMAP increase for only a portion of the expenditures for which they could receive them? For example, can a state claim the increased FMAP for only some services listed in Appendix B? Can a state claim the increased FMAP for eligible expenditures up to a certain amount and not claim the increase FMAP eligible expenditures above that amount?"

So, the answer to that question is yes. A state may choose to claim the increased FMAP for only certain services listed in Appendix B or only up to a certain amount. However, the state must meet the requirements to maintain covered benefits, eligibility and payment rates at April 1, 2021 levels for all of the services listed in Appendix B of the SMDL or it must forgo the increased FMAP for all services.

The second question has to do with the services eligible for the FMAP increase. So the question is, "Are services that are similar to those in Appendix B but claim this other Medicaid services on the CMS 64 eligible for the increased FMAP?" So the answer to that question is no, services of the

same type as those lists in Appendix B but claimed by the state under another category on the CMS 64 are not eligible for the increased FMAP.

However, to the extent that such services could be claimed under category specified in Appendix B CMS is available to provide technical assistance to optimize utilization of categories eligible for the increased FMAP. For example, states may utilize the Rehabilitative Services Benefit category to authorize behavioral health services currently claimed under the other licensed practitioner benefit category as long as all the requirements of the Rehabilitative Services Benefit category and requirements of the SMDL are met.

In addition, we did want to note that given the importance of expanding access to behavioral health services in the HCBS system particularly in light of the devastating impact that the pandemic has had on people with mental illness and people of substance use disorders we strongly encourage states to implement behavioral health focused activities as part of their activities to expand, enhance or strengthen HCBS. And we are providing states with flexibility to do that as we review their spending plans.

So for instance we are allowing states to implement activities that are focused on services that could be listed in Appendix B even if the state is claiming them under another Medicaid authority. As an example, a state could include in its spending plan a rate increase or a recruitment activity for providers that deliver behavioral health services that are covered under another Medicaid benefit but could be covered under the Rehabilitative Services Benefit.

However just to reiterate to the extent that a state wants to take advantage of the flexibility in their spending plan to please keep in mind what I noted previously that services of the same type as those in the Appendix B but

claimed by the state under another category on the CMS 64 are not eligible for the increased FMAP. So you have some additional flexibility related to the activities that you implement under Section 9817 but the increase FMAP is limited to the services in Appendix B.

CMS is available to provide technical assistance to support states with implementing behavioral health focused activities under Section 9817 as well as with optimizing utilization of categories eligible for the increased FMAP. So please reach out if you need assistance related to either of these areas.

And then the last three questions I'm going to answer all have to do with the use of funds for certain activities to expand, enhance and strengthen HCBS. So the first question is, "Can states use the funds to pay for room and board such as rent or rental subsidies?"

So the answer to that question is no. States cannot use the funds to pay for room and board for several reasons. So first Home and Community Services Statute clearly prohibits funding room and board. As early as 1981 when Section 1915(c) was added to the Social Security Act statutory language explicitly excluded room and board from the definition of HCBS. As a result CMS cannot approve activities that include room and board.

Second, room and board is primarily of general utility and as a result it will be difficult for states to sufficiently demonstrate that the intent of the activity is predominantly to expand, enhance or strengthen HCBS. And third, CMS is concerned that states may be unable to identify a sustainable funding source for room and board in the absence of being able to claim federal financial participation or ensure that all beneficiaries would be targeted, that we'd be targeted with room and board would qualify for and receive housing assistance through another source.

The absence of ongoing housing assistance for Medicaid beneficiaries could have a catastrophic impact on these individuals when the ARP Section 9817 funds are no longer available. So while funds cannot be used to pay for room board we do strongly encourage states to consider using the funds to build Medicaid housing partnerships, provide housing related services and support or implement other activities that can help to address the housing needs of people receiving HCBS.

So the next question at (unintelligible) has to do with using the funds for capital investment. "So can the funds attributable to the increased FMAP be used for capital investment?" The answer to that question is yes, expenditures that support long term investment in HCBS infrastructure are permissible as part of a state's activities to expand, enhance or strengthen HCBS.

Providing grants or loans to explore, encourage or build affordable senior housing, capital or financing for affordable housing developments, physical upgrades such as remodeling or renovation to residential care settings and funding for converting or renovating intermediate care facility settings to smaller residential settings is permissible if the funding is to support the expansion or establishment of settings that comport with HCBS regulations. Such expenditures are not room and board cost but our capital investments increase the capacity of settings that further community living and integration.

As states are determining the HCBS reforms to be facilitated through utilization of the funds made available under the ARP we strongly encourage the development of strategies that will enhance compliance with the Medicaid Home and Community Based setting regulation. Of particular importance when considering capital investments is furthering the availability of non-disability specific settings as part of a states HCBS options.

In addition, we remind states of two critical provisions. First, all new settings must be in compliance with the settings criteria in order to receive federal reimbursement of HCBS as the transition period does not apply. And second, any new construction of settings that meet the regulations definition of a presumptively institutional setting must adhere to the guidance CMS published on August 2, 2019. That guidance is available on Medicaid, on the medicaid.gov Web site.

And CMS reiterates that states must demonstrate how capital investments would expand, enhance or strengthen HCBS. And we note that approval of capital investments in ARP Section 9817 spending plans narrative does not authorize such activities for federal financial participation.

And finally, the last question I'm going to respond today has to do with ongoing Internet connectivity cost. So the question is, "Can states use the funds to pay for ongoing Internet connectivity cost?" The answer to that question is yes. Internet connectivity provides important access to HCBS providers with telehealth delivery modalities which are so critical during public health emergencies.

CMS reminds states that they must demonstrate how paying for ongoing Internet connectivity cost expands, enhances or strengthen state CBS. In addition, we note that approval of ongoing Internet connectivity cost in ARP Section 9817 spending plans narrative does not authorize such activities for federal financial participation.

Before I close out this portion of the agenda and turn to the next topic we also wanted to note that we will follow-up as needed this week with states that have already received partial or conditional approval for requests for

additional information based on the new information presented on today's call. And with that I'm going to turn the call back to Jackie Glaze who will transition to our next speaker. Jackie?

Jackie Glaze: Thank you so much Jen for your presentation. We'll now transition to Jean Close and she will provide an overview of the mobile crisis Notice of Funding Opportunity. Jean?

Jean Close: Thank you Jackie. It's a pleasure to be with you today to talk about Section 9813 Planning Grants. We received a lot of interest in this funding opportunity and we're so looking forward to receiving your applications. But first, a little background. The American Rescue Plan of 2021 amended Title 19 of the Social Security Act by adding a new Section 1947 an option to provide qualifying community based Mobile Crisis Intervention services.

The Mobile Crisis Intervention option is expected beginning April 1, 2022 through March 31, 2027. This funding opportunity reflected in Section1947(e) authorizes CMS to make funding available for Planning Grants to states to prepare for implementing qualifying community based Mobile Crisis Intervention services.

So when issued a Notice of Funding Opportunity, or NOFO, on July 13 which makes available Planning Grants to state Medicaid agencies to support the development of a new Medicaid option, qualifying community based Mobile Crisis Intervention services for Medicaid beneficiaries in the community who are experiencing mental health or substance use disorders crisis.

So the definition at Section 1947 of the act says that qualifying community based Mobile Crisis Intervention services means with respect to a state items and services for which medical assistance is available under the state plan

under this title, that are furnished to an individual otherwise eligible for medical assistance who is outside of a hospital or other facility setting and experiencing a mental health or substance use disorders crisis.

A separate State Health Official Letter, or SHO, aligning with this NOFO will provide guidance on that state option. And states should refer to that SHO for it's specific details on the requirements for the state option. Today we are talking about only the plan grant opportunity.

So this is a new funding opportunity. The Center for Medicaid and CHIP Services will award 12-month Planning Grants to states to support efforts to develop this Medicaid option that meets the requirements contained under Section 1947(b) for the act. We are pleased at this point to have received an expression of interest from 33 states and territories which is very exciting.

We'll be awarding a maximum of $15 million total. These discretionary grants will be awarded using the competitive process. And the application materials are available on grants.gov.

So what can you use the Planning Grant funds for? Planning grant funds support state efforts to develop the new option. The Planning Grant prepares states to submit and receive approval of a State Plan Amendments, or SPA, Section 1115 demonstration application or a Section 19A5(c) or a 1915(b)-waiver request or amendment. Beyond submitting the amendments states need to be able to support this new Medicaid option that's described in Section 1947(b) of the act.

Now states vary in provider and systems capacity to implement the option so this Planning Grant may support states in strengthening this capacity. Since states are unique states may choose a number of approaches. These

approaches would be described in the Applications Work Plan. Examples of activity for which Planning Grant funds may be requested are included in the NOFO.

But please note the grant funds are not intended for the actual provision for the mobile crisis services. So grant funds may be used by state Medicaid agencies to obtain technical assistance in developing SPAs demonstration applications, waiver program requests and other amendments including the writing and submission of documents for implementing community based Mobile Crisis Intervention services under the Medicaid program.

Grant funds may also be used for, but are not limited to, technical assistance on planning mobile crisis services that are integrated with longer term post-crisis care coordination programs or resources. Funds could be used for conducting a state-wide needs assessment for Mobile Crisis Intervention services including such factors as provider capacity, provider qualifications, set up of services furnished, equity strategies and privacy protections.

Grant funds could be used for enrolling prospective Medicaid providers and making technical assistance available for meeting Medicaid claiming requirements for furnishing Mobile Crisis Intervention services. Also funds could be used for training Medicaid providers on trauma informed care and treatment modalities listed in Section 1913 and the national standards for culturally and linguistically appropriate services or class in health and health care and supporting the safety of individuals experiencing violence.

Training Medicaid providers on sex and gender responsive approaches, response across the life course for example tailored crisis intervention for teens and older adults and connections or referrals to long term ongoing post-crisis services to address mental health and substance use disorder.

Plans could be used for an assessment of state information systems to identify options for improving inter-agency communication and data sharing for facilitating individuals access to ongoing treatment and to prevent recurring crises. And funds could be used for technical assistance to identify the need for and to implement state information systems edits and changes, support data driven decisions related to quality, sustainability and expansion of this Medicaid option.

And important dates to be aware of the electronic application is due Friday August 13, 2021 3:00 pm Eastern Standard Time. And the one-year project period begins September 30, 2021, just around the corner. The period of performance is one year from September 30, 2021 through September 29, 2022. If you have questions these may be sent to the Planning Grant dedicated mailbox, just planninggrantsmcis@cms.hhs.gov, I'll say that again, planning grants capital M, capital C, capital I, capital S at cms dot hhs dot gov. So thank you for your interest today and now I'll turn you over to Jackie Glaze.

Jackie Glaze: Thank you Jean very much for sharing this information. We'll now transition to Kirsten Jensen. And she will provide an overview on the NEMT informational bulletin and share some updates on the PREP coverage. Kirsten, turn to you now.

Kirsten Jensen: Thank you Jackie. I'm going to spend a few minutes providing an overview of the guidance CMS recently released on a provision that was included in the Consolidated Appropriations Act of 2021 related to Medicaid coverage of transportation.

As I know you're aware CMS has long recognized the need for states to assure necessary transportation to and from covered services helping to ensure access

to care for beneficiaries who have no other means for transportation. Historically the transportation insurance included both non-emergency medical transportation and emergency medical transportation and was based on the principle identified in Section 1902A4 of the act which requires that state plans provide such methods of administration as are found by the secretary to be necessary for the proper and efficient operation of the plan.

This provision was the basis for CMS to promulgate the assurance of transportation requirement at 42 CFR 43153. Section 209 of the Consolidated Appropriations Act formally incorporates the assurance of transportation requirement previously only found in regulation as I just described.

As a result the statute now provides that subject new provisions in Section 1903(i). The Medicaid state plan must include a specification that the single state agency will ensure necessary transportation for beneficiaries under the state plan to and from providers and a description of the method that such agency will use to insure such transportation.

Congress also made corresponding amendments to Section 1933A1 of the act adding a new paragraph applying substantially the same assurance of transportation requirements for a benchmark and benchmark equivalent coverage which is also known as Alternative Benefit Plans. Prior to this amendment the assurance of transportation in ABPs was also required by regulation at 42 CFR 44390.

Section 1903(i) of the Act was amended to include a new paragraph specifying that no payment may be made for NEMTs unless the state plan provides for the methods and procedures required under Section 1902A30A. Section 1902A30A is an existing statutory requirement that generally requires the state plan to provide methods and procedures as may be necessary to

assure that payments are consistent with the efficiency, economy and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan to the extent, or at least to the extent that such care and services are available to the general population in the geographic area.

This provision in Section 209 also established minimum provider and driver requirements for non-emergency medical transportation providers. Specifically, Section 209 added Section 1902A87 of the act requiring the Medicaid state plan to provide for a mechanism which may include attestation that ensures any provider including transportation network companies or individual drivers of non-emergency transportation receiving payments meet the following minimum requirements, A, they are not excluded from participation in any federal health care program and are not listed on the exclusion list of the Inspector General of the Department of Health and Human Services.

They must have a valid driver's license. They must have a place, in place a process to address any violation of the state drug laws and have in place a process to disclose to the state Medicaid program the driving history including any traffic violations of each such individual driver employed by the provider.

Notably these requirements apply to the transportation network companies and individual drivers. And this is an important point as we recognize that these have been maybe some areas of tension over the last few years. This provision does exclude providers that are part of public transit authorities however.

The provider and driver requirements are generally effective upon enactment and apply to services furnished on or after the date that is one year after the

date of enactment which is December 27 of 2021. So this means that states must submit a SPA in the 3.1 D section of the state plan with an effective date of no later than December 27, 2021 to specify the mechanism that the state will use to ensure the statutory minimum requirements for NEMT providers and individual drivers are satisfied. This may include an attestation to this effect.

The legislation does not include an exception to the effective date to accommodate states that the secretary, I'm sorry let I'm - the legislation does include an exception to the effective date to accommodate states that the Secretary of HHS determines requires state legislation to meet any of the newly added requirements. There is a section in the letter about this particular provision and if you're interested in pursuing this exception you should contact your state lead as soon as possible.

And then finally the Section 209 specifies that states exercising the option under Section 192A70 of the act then have established NEMT brokerage, brokerages, brokerage programs may consult with relevant stakeholders including stakeholders representing disability advocacy organizations, medical providers, Medicaid managed care organizations, brokers for NEMT and transportation providers including public transportation providers. So those were the provisions that were included in the guidance that was released.

Looking forward section 209 also requires a series of stakeholder meetings. And these meetings are intended to obtain input and shared learning about leading practices for improving the Medicaid program integrity for NEMT. These efforts will be formally announced at a future date.

Additionally CMS will need to conduct a comprehensive review of guidance regarding NEMT. And as part of Section 209 we may update such guidance as necessary. There is a third provision that does require a report to Congress and we are working on that as well. So that is the NEMT provisions.

Now I will switch over to talking about Pre-Exposure Prophylaxis for HIV. And first we'll provide some background on what PREP is and then discuss its coverage under Medicaid. So HHS, HRSA, CMCS, HRSA and CDC issued a joint informational bulletin called Opportunities to Improve HIV Prevention and Care Delivery to Medicaid and CHIP Beneficiaries on December 1, of 2016.

The Joint Informational Bulletin stated that evidence from several large randomized controlled trials indicates that daily oral Pre-Exposure Prophylaxis, or PREP, was an FDA approved HIV prescription medicine can reduce HIV acquisition risk by more than 90% when taken as prescribed.

Recent PREP demonstration studies and programs have also shown that maintaining the requisite high levels of adherence is possible and results in high levels of effectiveness under real world conditions. As a consequence, the US Public Health Service recommends PREP as one prevention options for people who are HIV negative and at substantial risk for HIV.

United States Preventive Services Task Force recommends that clinicians offer PREP with effective antiretroviral therapy to persons who are at high risk of HIV acquisition. The USPSTF gave this recommendation a grade of A and released it on June 11, 2019.

So in terms of Medicaid coverage, coverage for PREP and any associated counseling by a qualified medical, Medicaid provider can be covered under

the Medicaid State Plan Preventive Services Benefit. The preventive services benefit at 1905A13 of the Social Security Act authorizes services, is further described as 42 CFR 440.130C. And the regulation indicates that services recommended by a physician or other licensed practitioner of the healing arts acting within the scope of authorized practice under state law to prevent disease, disability and other health conditions or their progression prolong life and promote physical and mental health and efficiency.

States availing themselves of the 1 percentage point increase in FMAP authorized under Section 4106 of the Affordable Care Act and codified in the Social Security Act of Sections 1905A13A and B must provide without cost sharing any clinical preventive services that are assigned a grade of A or B by the United States Preventive Services Task Force and all approved vaccines recommended by the Advisory Committee on Immunization Practices and their administration. Therefore PREP must be offered under the preventive benefit in the states that currently have 4106 approved and any other states that would like to apply for the increased FMAP.

An alternative, the Alternative Benefit Plan must include services that fall under the ten essential health benefit categories including preventive services. States and territories must comply with the requirements of 45 CFR 147130 when providing preventive services. This means the state or territories is provided a minimum a broad range of preventive services including A and B services recommended by the United States Preventive Services Task Force, the Advisory Committee for Immunization Practices recommended vaccines, preventive care and screenings for infants, children and adults recommended by HRSA's Bright Futures Program and additional preventive services for women recommended by the Institute of Medicine.

States may not impose cost sharing on these preventive services. And these services are a requirement under Alternative Benefit Plans.

As mentioned above on June 11, 2019 the USPSTF releases a recommendation with A rating for PREP services and accordingly states and territories must cover consistent with that recommendation without cost sharing within the Alternative Benefit Plan. CMS is available for technical assistance to ensure that states are providing necessary coverage of PREP. With that I will turn it over to Jackie Glaze.

Jackie Glaze: Thank you Kirsten for your update. We're now ready to take your questions. So we'll begin by asking that you use the chat function if you'd like to submit your questions that way. And then we will follow by taking questions over the phone line. So I'll now transition to (Ashley).

Ashley Setala: Thanks Jackie. So we have a few questions that have come in so far. First, we've gotten a number of questions about whether a recording from the call will be provided or whether the HCBS FAQs will be provided in writing. And we will post the audio recording from today's call as well as the written transcripts that will include the HCBS FAQs to medicaid.gov as soon as they are available. So to access those you can click on our COVID-19 page from the medicaid.gov home page and scroll all the way down to the bottom and you'll find all of our written transcripts and recordings from these calls.

Then we have a question that came in for Kirsten on her NEMT updates. And it says, "Is CMS going to share a SPA pre-print for the non-emergency transportation assurances or should state Medicaid agencies just adjust their existing Attachment 3.1D pages?"

Kirsten Jensen: Sure. We will not be issuing a separate 3.1D page for this given that it's just an attestation to the provider driver requirements. And we recommend that states update their 3.1D pages.

Ashley Setala: Okay. Then we have a question that says, "For ARP changes that would require approval under an existing waiver due for renewal effective January 1, 2022 can the changes be added to the renewal application with tribal and public notice started for the changes yet not complete at the time of filing by September 1, 2021?"

Ralph Lollar Can you repeat that please? This is (Ralph).

Ashley Setala: Sure. It says, "For ARP changes that would require approval under an existing waiver that is due for renewal effective January 1, 2022 can the changes be added to the renewal application with tribal and public notice started for the changes yet not complete at the time of filing by September 1, 2021?"

Ralph Lollar: The state needs to complete the public notice process prior to submitting the waiver. The state can submit the waiver in draft on September 1 while it is out for public comment and we will begin looking at it. This state should simply notify us that there will be a delay in the submission of the renewal while public notices being completed as a result of the issues with addressing the spending plan inside of that document.

Ashley Setala: Okay.

Ralph Lollar: Thank you.

Ashley Setala: Then we have a question around the HCBS enhanced FMAP. And it says, "Would TEFRA services qualify for HCBS, or the HCBS FMAP bump?"

Jen Bowdoin: I'm sorry, can you repeat the question?

Ashley Setala: Sure. It says, "Would TEFRA services qualify for the HCBS FMAP bump?"

Ralph Lollar: Jen, do you want me to take that?

Jen Bowdoin: Yes, I was going to say do you want to you want to respond to that (Ralph)?

Ralph Lollar: Sure. Remember that the money is to be reinvested to enhance, expand or strengthen HCBS. TEFRA, or the Katie Beckett Group, is considered an HCBS eligibility group. And certainly, we would consider that as part of any state spending plan if you were adding that group or those services to your existing authorities.

Ashley Setala: Okay.

((Crosstalk))

Ashley Setala: I'm sorry, oh go ahead.

Jen Bowdoin: Sorry just one note on that though just, you know, just sort of sort word of I guess just caveat is that the state needs to make sure that it's expanding, enhancing or strengthening HCBS it can't use it - it can't, you know, implement something that's going to supplant what the state already have in place.

Ralph Lollar: Exactly. Thank you, Jen, for the clarification.

Jen Bowdoin: Thanks (Ralph).

Ashley Setala: Okay. Then we have a question that says, "Is there an ETA for the SHO letter mentioned in the NOFO for ARP Section 9813?"

Kirsten Jensen: Sure. This is Kirsten Jensen. We are working on that as quickly as possible and will be issuing it as soon as we can. I know that's not definitive but do know that we are working on it. Yes.

Ashley Setala: Okay. Then we have a question for the latest update from the HCBS enhanced funding. And it says, "Before the FAQs on the spending plans a few introductory points were made about the plans and updates. Can you please restate those?"

Jen Bowdoin: Sure. So I can repeat all of them. And so there were I think four. So the first update was just it was really just thanking states for submitting the funding plans and narrative and was just noting I noted that, you know, they did include a number of innovative ideas and activities.

And we are strongly encouraging states and we do want to work with states to use the ARP money to make investments in their HCBS systems that will lead to structural or systematic changes and improvements. And that includes capital investments and strategies to build HCBS systems capacity which I talked about during the Q&A.

The second note was that CMS is reviewing the spending plans as quickly as possible and will provide the update that we did send partial or conditional approvals or a request for additional information in response to the first ten plans that were submitted and that we do expect to follow-up with the remaining states over the next several weeks.

The third update was that, and this was repeated several times I think in my remarks, is that approval of any activity in a state spending plan does not provide approval to claim federal financial participation for any expenditures that are not eligible for federal financial participation. So we can improve, we can approve them in the spending plan but that does not just because we have approved it in the spending plan does not mean that that activity is automatically eligible for federal financial participation. So the regular claiming rules in terms of what is allowable still apply.

And then the last clarification or last update was to note that unless we request an updated spending plan and narrative the next spending plan and narrative for states is due 75 days before the quarter beginning January, 2022. However, at a states option it could choose to submit an updated spending plan for the quarter beginning October 1, 2021 if for instance the state wanted to get approval for a new activity or if it wanted to address questions or issues that were raised through our initial spending plan review.

Ashley Setala: Okay, thanks Jen. Then we have a couple of questions that have come in around the mobile crisis NOFO. And the first says, "Do we have to have a TA subcontractor selected for the application at the time of the submission?" Jean, do you want to address that question?

Jean Close: I'm sorry could you repeat the question again?

Ashley Setala: Sure. It says, "Do states have to have a TA subcontractor selected for the application at the time of submission?"

Jean Close: No, that can be added later on.

Ashley Setala: Okay. Then the second question says, "If planning a mobile crisis has already begun could a state still apply to go back and ensure that all available options and technology has been considered and integrated?"

Jean Close: Is that - it sounds that that questions related to actually implementing the service. So let me say it this way then, as far as the Planning Grants go this is - these are grant funds. And they can be used in relationship to a particular state's work plan.

Some states are going to be farther along than others in actually implementing this service. So I'd suggest that explaining in the application where the state currently is as far as the status of the preparations and then also clearly stating what their plans are for use of the funds depending on their unique situations.

Jackie Glaze: (Ashley), I'd like to switch over to see if we have callers wanting to submit questions. So I'm asking the operator if she could give the instructions and then we'll see if we have any calls coming through the phone lines.

Coordinator: Thank you. If you would like to ask a question over the phone please unmute your phone, press Star 1 and record your first and last name only when prompted so I may introduce you. Again that is Star 1 to ask a question. And it may take a few moments for questions to come in. Please stand by. And please stand by for our first question. I did not get the party's name however your line is open. You may ask your question.

Kian Messkoub: Hi. This is Kian Messkoub from Oregon Health Authority in Oregon. And my question was just whether or not there would be slides, written materials relevant to the NEMT portion of today's presentation? Thank you.

Kirsten Jensen: This is Kirsten. We were not planning on presenting slides. I think the call will be recorded though. And if you have any particular questions please contact your state leads who will make sure that the transportation SMEs in my division can be available to answer any questions that you might have.

Coordinator: And I have no more questions over the phone at this time. But again if you would like to ask a question please press Star 1.

Ashley Setala: Okay. We have a couple of other questions in the chat. The first one says, "Among the ten states that have submitted funding plans for the HCBS enhanced FMAP and have some elements approved when will CMS share the approved elements or initiative?"

Jen Bowdoin: So I'm assuming -- this is Jen Bowdoin -- I'm assuming that question is more when we will publicly share that information as opposed to when we will respond to those states. So we are responding directly back to those states, you know, as those approvals or requests for information are available. As far as publicly releasing that information we don't have a clear timeline on that yet but we will provide updates on this call as that information becomes available.

Ashley Setala: Okay.

Coordinator: And we do have question over the phone...

Ashley Setala: Okay, thank you.

Coordinator: ...if you want to take that now?

Ashley Setala: Sure.

Coordinator: And our next question is from Beth Jackson. You may go ahead.

Beth Jackson: Hi. Thank you. Yes, my name is Beth Jackson. I'm from the state of Oregon, Oregon, Department of Human Services Aging and People with Disabilities. I am the one in the chat who asked the question about renewal application that's due, the application due by September 1.

And so I just want to make sure that I'm clear that when we're submitting it on September 1 we can indicate that it's in draft format because of changes that we are including as part of the ARP and noting that we have the tribal and public notice open. And then we would just notify CMS when they are closed, is that correct? I just want to make sure that we do not put our waiver at jeopardy for being renewed on January 1.

Ralph Lollar: Sure. You will notify CMS when you've finished your public notice and if you are making any changes to the waiver document based on that public notice and tribal review.

Beth Jackson: Okay, thank you.

Ralph Lollar: Okay, thank you very much.

Jackie Glaze: (Ashley), I think we have time for one more question.

Ashley Setala: Okay. So the final question says, "When completing reconciliation for spending under 9817 will states be required to spend the additional 10% FMAP on a net state share basis or will the reconciliation be on a gross funding basis?"

Jen Bowdoin: Hi. This is Jen Bowdoin. If the person who submitted that could send the question to the mailbox that would be great. And we will respond as quickly as possible or we can schedule call. I just want to make sure that we fully understand all the implications of your question. So the mailboxes hcbsincreasedfmap@cms.hhs.gov.

Ralph Lollar: And it would be helpful if in the question you included an example of what would be considered gross and what would be considered net by the individual who was asking the question.

Jackie Glaze: So in closing I'd like to thank Jen, Jean and Kirsten for their presentations and updates today. Looking forward we will look forward to talking with you again on August the 10th and we will send the topics and the invitation shortly. If you do have questions between calls feel free to reach out to us, reach out to your state lead or you can bring your questions to next, to the next call.

If you'd like to resubmit a question for the open Q&A portion of the next call you can email it to medicaidcovid-19, all one word, at cms dot hhs dot gov by 1:00 pm Eastern Time on the day of the call. We thank you again for joining and appreciate your participation and hope everyone has a good afternoon. Thank you.

Coordinator: And this concludes today's conference. Thank you for participating. You may disconnect at this time. Speakers please stand by.

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