

Centers for Medicare & Medicaid Services
COVID-19 Medicaid & CHIP All State Call

June 8, 2021

3:00 pm ET

Coordinator: Welcome and thank you for standing by. At this time all participants will be on listen only until the question-and-answer session of today's conference. At that time, you may press star 1 to ask a question. Today's conference is being recorded. If you have any objections please disconnect at this time. I'd now like to turn the meeting over to your host, Jackie Glaze. Ma'am, you may begin.

Jackie Glaze: Thank you and good afternoon and welcome everyone to today's All State call and webinar. I will now turn to Anne Marie Costello, our Acting Center Director. And she will share highlights for today's discussion. Anne Marie?

Anne Marie Costello: Thanks, Jackie and welcome to today's call everyone. And thanks for joining us. First up on today's call, Candace Anderson from the CMS Medicare and Medicaid Coordination Office, will join us to highlight a proposed rule published on April 27 that aims to improve state processing of Medicare cost sharing claims, the services provided to dually eligible individuals.

After Candace's update we'll take any questions you may have about the proposed rule. Then Kim Proctor from the CMCS Data and Systems Group, will present a new preliminary Medicaid and CHIP COVID-19 data snapshot which was released on May 14. The snapshot includes data from the beginning of the public health emergency through October 31 of 2020, and provides a variety of information of COVID-19 related service utilization by beneficiaries, including data on treatment and outcomes, service use among Medicaid and CHIP beneficiaries who are 18 years of age and under.

Services delivered via telehealth during the public health emergency, and

services for mental health and substance use disorders during the public health emergency.

After Kim's presentation, Jen Bowdoin and Ralph Lollar from our Disabled and Elderly Health Programs Group, will address some of the state submitted questions on Section 9817 of the American Rescue Plan Act that we did not have time to address on our last All State call. After that, we'll open up the lines for your questions. We'll use the webinar for today's data presentation.

So if you're not logged into the webinar platform I suggest you do so now. I'll note that we started using a new webinar platform for our All State calls starting on May 11. Instructions for joining the platform were sent again with the invitation for today's call, in case you weren't able to join one of our recent calls.

Before we jump into today's agenda, I wanted to highlight two recent releases. First, on June 3rd, CMCS released the Center Informational Bulletin providing general information on the Medicaid kit and basic health program related provisions of the American Rescue Plan Act of 2021. As always, this Center Informational Bulletin may be found on [Medicaid.gov](https://www.Medicaid.gov).

Second, also on June 3rd, CMCS released two new (CMCS) that contain annual managed care plans and provider research identifiable files for calendar years 2014 through 2016. Over the next few months, this data will be included in new releases of the research files for calendar years 2017 through 2020. The release of this data allows you to make additional plans of provider information to existing beneficiary and claims data to perform more complete analysis by plan and provider.

We plan to continue to release this data in all future T-MSIS data releases and are excited to continue to increase the availability and quality of additional T-MSIS data. With that, I'll turn things over to Candace to start her proposed rule update. Candace?

Candace Anderson: Thank you. Hi everyone. I'm Candace Anderson from CMS's Medicare Medicaid Coordination Office, also known as MMCO or the dual office. I'm joined here with my colleague, Nina Brown-Ashford, to amplify awareness to states of our specific proposal in the FY 2022 IPPS LTCH proposed rule.

So like previously said, on April 27, 2021 CMS issued the Medicare Hospital Inpatient Prospective Payment System and Long Term Acute Care Hospital Proposed Rule. A specific proposal in this NPRM relates to dually eligible individuals and state Medicaid agencies.

Under this proposed rule for purposes of processing Medicare cost sharing claims for services furnished to dually eligible individuals, CMS would require that state Medicaid provider enrollment systems allow valid enrollment from Medicare providers serving dually eligible individuals. Even if that provider or supplier is of a type not explicitly included in their state plan. If finalized, this proposal will improve compliance with current statute and reduce burden for providers related to crossover claim submissions and claiming of Medicare bad debt.

Additionally, we have requests for information from stakeholders on instances where states determine their cost sharing liability for a Medicare service by applying Medicaid payment and coverage rules for the service, as if the service rather than the cost sharing, were being paid by Medicaid. This proposal is found under Section 10 or Section X of the NPRM. It is officially entitled The Medicaid Enrollment of Medicare Providers and Suppliers for Purposes of Processing Claims for Cost Sharing for Services Furnished to Dually Eligible Beneficiaries.

The IPPS proposed rule is open for public comment now. So while I can't answer many questions on this proposal, I do encourage you to review and based on your understanding, submit any comments that you might have on this NPRM. The comment period closes on June 28th. If you have any additional questions on where to find NPRM or difficulty finding the exact link, please reach out to the Medicaid COVID-19 email address included in

this call, in this webinar. And thank you.

Jackie Glaze: Thank you, Candace. And so now we'd like to take a couple of questions. If you do have any regarding the proposed rule that Candace proposed the update on, if you would like to send your questions through the chat function, we will watch for those and then we'll continue. So we'll look to see if you have any questions at this point. I'm not seeing any questions, so we'll continue on with our agenda. And then we will have time at the end to take additional questions.

So at this point, I will now turn the call over to Kim Proctor. And she will share information regarding the CM - or the COVID-19 public health emergency and on the Medicaid and CHIP data. So Kim, I'll turn to you.

Kim Proctor: Great. Thank you. Hi everyone. My name's Kim Proctor, and I'm a technical director in the data and systems group at CMCS. And today we're going to talk about a data snapshot that we recently released, on the COVID-19 public health emergency and the Medicaid and CHIP programs. The snapshot is publicly available online and it is a long report with over 40 slides. So today I'm going to focus on the key highlights, such as the background context for interpreting the slides, the overall layout and content of the slides, and some of the key results.

Before I jump into the slides I want to mention that the release features services through the end of October 2020. So that is the reference period that we will be discussing today. And I also want to take a moment to highlight all the work across the CMS teams and with our state partners, that have made this presentation possible.

So states have done a great job of submitting timely high quality data to us, facilities presentations like these. And our partners throughout DSG, have supported our ability to process the data as quickly as possible, and also improve data quality through the ongoing data quality lifecycle.

So the first few slides provide an overview of the context for interpreting the results. And these slides are really important. So if you review these online I would definitely emphasize spending some time here. This slide summarizes the Medicaid and CHIP programs, our approach for measuring COVID-19 treatments and some key factors about data processing and state data quality.

And the takeaway here is that these are very large programs with lots of variation across states in terms of program design, data collection systems and data quality. So it's important to be aware of that information as you interpret the results.

Additionally, we encourage you to explore the link at the bottom of the slide that references the task in DQ Atlas, because that will provide additional information on how we develop the files that we use for this analysis, and the different ways that we assess data quality for research purposes. So the next three slides focus on claims lag or claims runout. You'll hear both terms used. And that's how many months it takes for CMS to receive claims from states.

So there will always be a delay or a lag between when a service occurs and when that service is reflected in our databases.

The length of that lag will depend on the submitting state, the claim type and the delivery system. So this slide will show you that - shows you that fee for service claims are normally submitted faster than managed care coms. Or - and OT claims or those other services claims are normally submitted faster than IP or inpatient claims, for example.

So there's variation in claims runout. And that can impact the results as more claims are submitted over time. So we really encourage you to keep that in mind as we review this publication with the knowledge that the results can change as CMS receives more claims. And that might impact certain services that you're interested in or certain states that you're interested in, differently. And the next two slides really just drill into a focus on inpatient

claims, and the one after that is outpatient claims.

And we just focused on these two because those are the claim sites we used in these analyses. So this one's IP and then this one will show you the OT. So this slide highlights that the results we discussed today will be grouped along four dimensions. The first one is COVID-19 treatments, acute care use and testing.

The second is services for children during the public health emergency. The third is services delivered via telehealth during the public health emergency. And the fourth is services for mental health and substance use disorders during the public health emergency.

And we will start with the slide - with the section on COVID-19 treatments. The key piece of context for this section and every section that follows for the whole deck, is that we only display results for services covered Medicaid and CHIP. So any services that were covered via a different insurance program - like if a treatment was covered by Medicare for a dually eligible beneficiary, that's not submitted through our database, so we do not have a record of that. That will not be included in the results.

In this instance, particularly for this section of the deck, we know that there's a relationship between COVID-19 treatments and age. So it might be particularly relevant for these results. But CMS does public information on the COVID-19 public health emergency and Medicare, which we reference in this slide. And that's also publicly available online and you can explore that as well. But I just want to highlight that this is only about services paid via Medicaid and CHIP.

So because there are so many slides in this deck and I think the slides in this section are fairly straightforward, I'm going to walk you through how the slides are laid out, to make it easier for you to review on your own if you're interested in exploring after the call is over.

For the first few slides the top right will show the total number of beneficiaries that received the treatment, it will show the treatment rate per 100,000 beneficiaries. The left portion of the slide will contain a map that shows some variation across states. And the bottom portion will show a time series that shows how the outcome changes over time.

So this slide is specifically for COVID-19 treatment. You can see that over 1.2 million beneficiaries were treated for COVID-19 through the end of October 2020. And then this slide is the same information but it's for - only for beneficiaries for under - under age 19. So it really just breaks out the results just for children. On here you can see that nearly 267,000 children were treated for COVID-19 through October 2020. This slide demonstrates acute care use for COVID-19 has the same layout as before. The only difference is that the treatments in that time series chart, are broken apart by some different options.

So here we have ED visits, inpatient stays, ICU stays and ICU stays with a ventilator use. And this slide demonstrates that there were nearly 125,000 hospitalizations for COVID-19 through October 2020 with the majority of those services being ED visits. And then this slide shows the same thing but it's only for beneficiaries under age 19. And we see that there were nearly 4000 hospitalizations for COVID-19 for children, through October 2020.

And the majority of those were ED visits as well, although there does appear to be less variation for beneficiaries under 19, where the vast majority are ED visits. And then there's less among those other breakouts.

And then the last two slides show the number of COVID-19 tests paid by Medicaid and CHIP. The first one is for the total population, the second one focuses on children. So a key piece of context to highlight here, is kind of going back to that point I just made about, you know, these are only tests paid by Medicaid and CHIP. We know there were millions of tests provided for free or covered via other insurance programs. They are not going to be reflected here even if they were provided to the Medicaid or CHIP enrollee.

But these results also don't show the outcomes. So we don't know if someone is positive or negative; we don't receive lab results; we only know that the test was administered. But we can see that Medicaid and CHIP covered nearly 10 million tests through the end of October 2020. And then this slide shows the same thing focusing only on children, showing that there were more than 3.2 million tests for children through the end of October 2020.

And then this next section highlights primary preventive and mental health services for children during the public health emergency. So for context, what I want to highlight here is that we cover millions of children including the majority living in poverty and many with special healthcare needs, which means that Medicaid and CHIP cover millions of critical services that we want to continue to monitor.

And the key takeaways for this section are that primary preventive and mental health services all fell drastically at the onset of the pandemic. Also rates for many of the services have rebounded to pre-pandemic levels, millions of services still need to be delivered for those that were lost. And some services have either not recovered to pre-pandemic levels, like dental services which you'll see in a couple of seconds, or they don't really appear to be recovering much at all, like mental health services, which we'll also highlight.

The number of services delivered via telehealth, did dramatically increase but it was not enough to offset the declines that we see in other areas. And for some of the services that were - we discussed today and we released in this data snapshot, they can't really be delivered via telehealth, like a vaccination or a dental exam.

So the next few slides will show some of that key output. In terms of the layout, the headline at the top will sort of tell that key story about the data. The section right below that will show our rate per 1000 beneficiaries and how that's changed over time. The chart will show this trend over time compared to prior years, so you can see what the pandemic period looks like

to prior years. And then that text box will tell you the percentage and the numerical change.

And it's comparing the public health emergency period. So for this deck that's marked through October, to the same time period in the prior year, because we really wanted to compare the same month to the same month because we know there are some seasonalities to some of these services.

And for this slide for example, the results indicate that we had about 1.8 million fewer vaccinations for children under 2 during the public health emergency. Although it does appear that vaccination rates have rebounded to normal for this particular measure. And then this slide shows child screening services. Here if you look at that text box, you can see we're missing about 4.6 million services in 2020 compared to the same timeframe in 2019.

Another important thing to highlight for this slide is that we did not see the normal seasonal increase around the start of school that we normally see for this service.

So normally we would see a large bump in the number of child screens around the end of summer, early fall, around the time that school starts, and the number of child screens. And that does not appear to have happened during this - the 2020 year. So we do want to highlight that that's something they are continuing to monitor. And then this slide is for dental services. They declined dramatically at the onset of the public health emergency. I think that that drop between March and April was almost a 90% decline. It was an enormous decline.

And in total, we are over 11 million fewer dental services during that pandemic period, compared to the prior year. And I think this is a good example of a service that has recovered. We do see a V-shaped recovery, right? Like there is this decline and then a sharp rebound. But we have not rebounded back to the pre-pandemic level. So even though we have recovered which is encouraging, this gap between, you know, the 2020

services and prior years, just continues to persist into the fall.

And then this slide shows mental health services. So here you can see that mental health services have declined over 14 million treatments. I think the most important thing to highlight here is that we are not seeing a rebound in service utilization in this area. The recovery appears to be flat unlike the other measures. So I just mentioned that V-shaped trend that we see, I think dental services show it the most dramatically partially because they had the sharpest drop and then a pretty sharp rise.

But if you look through other measures you will see a drop and a return. You'll see that V-shaped trend. We just don't see that here. We see a sharp decline at the onset of the pandemic. And then the recovery is just kind of flat.

We really don't see services begin to bounce back up. They appear to drop and stay lower than normal. So this is I think of all the measures that we're monitoring, we don't see a lot of variation across states. In terms of like some states having a great recovery and some states not, it appears to be fairly consistent and it appears that it has not returned back to pre-pandemic levels.

And then this slide is showing services delivered via telehealth. And I think the main takeaway here is that we saw an explosion in the use of telehealth during the public health emergency. The sharpest increase was in April. It has declined since then but it continues to remain higher than pre-pandemic levels. And like the other results that I've mentioned, there really is considerable variation across states in terms of the affected services.

So this section highlights services delivered via telehealth on a broader level. And I'm just going to jump straight to the results on this one because I think it was fairly straightforward. So here you'll see this is very similar to what we see for children, which is that there was an explosion of services delivered via telehealth at the onset of the pandemic. It was nearly 70 million services delivered via telehealth since the start of the pandemic in March. It

peaked in April and it has declined since.

But it has remained substantially higher than prior year levels. And just like - the same exact thing that we just mentioned, there does appear to be considerable variation across states through this measure as well.

And then for the last section we're going to discuss mental health and substance use disorders during the public health emergency. You know, we briefly touched on this with children, but we want to also highlight the broader Medicaid and CHIP populations as well. So the concept to highlight here is that Medicaid is the largest payer for behavioral health services. It could be difficult for people suffering from these conditions, to access the care that they need.

And we know that a substantial portion of the adult Medicaid population is receiving treatment for these conditions.

So for example, in 2019 we saw that nearly a quarter of the adult Medicaid and CHIP beneficiaries were receiving mental health or substance use disorder services, with services for mental health conditions being more common than those for substance use disorders. And we also have preliminary evidence coming out that looks at what happened during the actual COVID-19 public health emergency itself. And it does appear that the COVID-19 public health emergency has increased the need for services with more adults reporting adverse mental or behavioral health conditions in 2020 compared to prior years.

You know, so taken together like we know that we service a lot of beneficiaries in this area; we know that this is a need for the beneficiaries enrolled in our program. We have evidence suggesting that there is a greater need than there was before. So I think this is a particularly important area to monitor.

And what we see is that so we see similar results that we thought for children,

which is basically that mental health services dropped at the onset of the pandemic and they continued to decline through October for nearly all states. So just like we talked about for kids, these services don't appear to be recovering.

And this slide here just redisplay the information from that section on children; it shows information on mental health services for children. We already reviewed this but I want to reemphasize that we saw approximately 14 million fewer mental health services for children during the pandemic period, compared to the same time period in the prior year. I really want to reemphasize that point. And then this slide is showing the results for adults age 19 to 64 and we see a similar trend for adults that we saw for children.

So there's a decline at the onset of the pandemic that has not started to recover that's translating to approximately 12 million fewer services during the pandemic period compared to the prior years. And if you think about this slide in connection to the one that we just reviewed, so together with children, if you look at both of these, that would represent over 26 million fewer services for mental health conditions at a time when need appears to be increasing.

And then finally, this last slide is showing the same results for substance use disorder. And here what we see is that we see the decline at the beginning of the pandemic. It does appear to have somewhat of a recovery. But even with the services returning somewhat to normal by the summer, we still have approximately 3.6 million fewer services when we compare the pandemic period to the prior year. So that concludes our presentation for the data snapshot. I want to thank you so much for your time, and encourage you to explore our resources online. And I look forward to your questions.

And with that, I will turn it back to Jackie Glaze.

Jackie Glaze: Thank you so much, Kim. I really appreciate your presentation today. So next up we have Jen Bowdoin and Ralph Lollar. And they will address some of the

questions that you asked last time we had our call, on the HCBS Enhanced FMAP. So we did receive a number of questions. And so Jen and Ralph will be able to share some of the information with you now. So Jen, I'll turn to you.

Jen Bowdoin: Okay. Thanks so much, Jackie. Hi everyone. This is Jen Bowdoin. I am the Director of the Division of Community Systems Transformation here at CMCS. And so before we jump into some of the questions that we got on the last call, I think what we'd like to do is address some broader themes and concerns that we've been hearing from states. And so first, I wanted to mention that we have indicated in the SMDL that the initial spending plan and narrative is due within 30 days of the release of the SMDL.

So what this means is that those first spending plans are due on June 12. But because this is a Saturday, states can plan to submit the initial spending plan and narrative by the following Monday, which is June 14th.

As we announced on the last call, states can request a 30 day extension to submit their initial spending plans and narratives within the first 60 days. If a state requests a 30 day extension the initial spending plan and narrative is then due on July 12th. And if a state would like to do this, would like to request an extension, all they need to do is send an email to the mailbox that is identified in the SMDL for Section 9817.

So that's HCBSIncreasedFMAP@CMS.HHS.gov. And they just have to indicate that they would like to request an extension and indicate specifically what date they plan to request the extension for. So they can request up to 30 days and they just need to tell us what day they plan to submit the initial spending plan and narrative.

The first quarterly spending plans and narratives are due within - due 75 days before the quarter, beginning October 1. So states submit their initial spending plans. Those are due depending upon whether a state requests an extension either by June 14 or possibly as late as July 12. In the

SMDL though, states also have to submit quarterly spending plans and narratives.

And what we had said in the SMDL is that the first quarterly spending plans and narratives, after the initial one is due 75 days before the quarter - with the quarter beginning October 1. And so for that first quarterly submission what that means is that's due July 18th.

You know, unfortunately that timing, you know, may create an issue for a state if they have requested an extension because essentially what that would mean is that that initial spending plan is due less than a week before the first quarterly submission. And so in that case, if a state has requested an extension to mid-July to submit the initial spending plan, that initial spending plan and narrative would then also serve as the state's first quarterly submission.

We understand that some states are concerned that delaying their spending plan submissions could delay their ability to access enhanced funds back to April 1, 2021. So we have heard from some states that if they request an extension it could put some of the funds essentially, at risk where they wouldn't be able to claim all the funds back to April 1. We do want to clarify that requesting an extension to the deadline, will not impact the amount of increased funds that the state is eligible to receive.

It could however, delay when the state begins receiving the additional funds through Medicaid grant awards through the form CMS 37. And it may impact at least initially, when a state could receive increased FFP for expenditures through the form CMS 64.

So states will be able to make prior period adjustments and eligible states can apply for supplemental grant awards. It's really - so essentially the kind of takeaway is you're not going to lose the money. You will still be able to get the additional federal funding. It just may impact the timing of when exactly a state could begin receiving it.

We also want to flag that the information contained in the SMDL that describes three benchmarks to ensure that enhanced funding received under the American Rescue Plan, will supplement and not supplant existing state programs. Generally speaking, those benchmarks involve maintaining payment rates, service availability and eligibility at April 1, 2021 levels. Some states may have submitted SPA or waiver actions prior to the publication of the SMDL to implement planned service eligibility or payment reductions.

We will flag the implications of approval of those actions during our review, but we also ask states to analyze submissions that you've already sent to CMS, to determine if any of them need revisions. The last thing, you know, that we really want to happen is for an approval of a SPA or a waiver action to jeopardize the states' ability to access enhanced funding.

As we've noted previously, if states are making changes to an HCBS program that operates under a Medicaid authority as part of their activities to enhance, expand or strengthen HCBS states should follow the applicable rules and processes that apply to the Medicaid authority. We will do our best to process these actions as quickly as possible. But we would strongly encourage states to do a few things to help expedite that process. So first, when you were requesting approval to make a change to an HCBS program, flag it as a related to a - to Section 9817 of the American Rescue Plan.

Second, when submitting your spending plans and narratives, clearly indicate if you will be requesting approval for a change to an HCBS program. And be as specific as possible about which program you are going to be requesting a change to, which authority it operates under, and when you plan to request the change. That's going to allow us as we're reviewing the spending plans' narratives to alert other divisions and groups in CMS, that a request is coming. And it will allow them to then plan for the review of that particular action.

Third, keep the amendment or waiver request solely focused on the activities related to 9817 as much as you can. So to the extent that you can, keep the request simple. And if at all possible, avoid combining them with activities that are unrelated to Section 9817. And then fourth, take advantage of the flexibilities and expedited processes associated with the public health emergency. Even if you want to implement a permanent change to an HCBS program, consider initially requesting the change through a disaster relief SPA, an Appendix K or Attachment K as appropriate.

And then finally, I just wanted to note that we know that states have a lot of questions about how to claim for the services eligible for the increased FMAP. We are working to update MBES as quickly as possible, and we will provide more information about how to claim for the increased FMAP, as it becomes available. We're also planning to cover some of the questions that we have been receiving related to claiming, including claiming for expenditures under managed care on a future All State call.

And so let's now move - let's now jump into some of the questions that we've been receiving. So I'm here with Ralph Lollar, who is the Director of the Division of Long Term Services and Support. And so we're going to run through some of the questions that we have gotten on the - that we had gotten on the last All State call. So first, we've gotten a number of questions about whether certain expenditures are eligible for the increased FMAP.

So Ralph, the first question is under Section 1115 reporting, are only certain report lines eligible for the increased FMAP? Are all 1115 demonstrations eligible for the increased FMAP?

Ralph Lollar: Sure. States can claim the increased FMAP for any of the services authorized under Section 1115 demonstrations that are identified in Appendix B of the SMDL. That's the important criteria here. As we noted previously, we're working to update MACBIS as soon as possible, and will provide more information about how to claim for the increased FMAP as it becomes available.

Jen Bowdoin: Thanks, Ralph. So the next question is - relates to beneficiaries in the new adult group. So are HCBS expenditures for beneficiaries in the new adult group eligible for the increased FMAP under Section 9817?

Ralph Lollar: Yes. There are some considerations here. States can claim the increased FMAP up to the maximum allowable of 95% FMAP for all Medicaid expenditures for the qualifying services listed in Appendix B of the SMDL for services provided to beneficiaries eligible under the new eligible FMAP in Section 1905(Y) of the act and the expansion state FMAP in 1905(Z).

Jen Bowdoin: So the next question Ralph, are breast and cervical cancer expenditures eligible to get the increased 10% FMAP?

Ralph Lollar: Again, a bit involved with an answer. If state HCBS expenditures qualify for both the increased FMAP under the ARP Section 9817 and the enhanced FMAP under 1905(B) Clause 4, the state is entitled to add both FMAPs, the increased 10 percentage points is added to the state-specific FMAP stated in 1905(B) of the Social Security Act. The FMAP for the services for the beneficiaries with breast and cervical cancers is the enhanced FMAP detailed on 2105(B) of the Act, which uses 1905(B) as its base.

The FMAP rates should be as services may not exceed 95%. The states cannot claim the HCBS increased FMAP for any services other than those listed in Appendix B of the SMDL. The senior hearing here is that it goes back to the services folks.

Jen Bowdoin: So we also have a question about CHIP expenditures. So are CHIP expenditures eligible for the increased FMAP?

Ralph Lollar: They're not. The increased FMAP under Section 9817 of the ARP is not applicable to HCBS expenditures under the Children's Health Insurance Program. States cannot claim the increased FMAP for the CHIP expenditures.

Jen Bowdoin: So we've gotten some questions about the reduced FMAP rate for electronic Visit Verification or EVV. So how does the reduced FMAP rate for EVV affect the FMAP increase of 10 percentage points under Section 9817 of the American Rescue Plan?

Ralph Lollar: Sure. To the extent that a state claims qualifying expenditures for the increased FMAP under ARP 9817 it also is assessed in FMAP penalty under 1903(L) of the Act. The two FMAPs will be added together. In other words, the increase under 9817 may be partially offset by a decrease under 1903(L). But I think the other important thing here to say is that services that are not yet EVV compliant, personal care services that are HCBS services still qualify for that 10% although they will still pay the penalty.

Jen Bowdoin: And then the last question related to expenditures eligible for the increased FMAP, is about 1115 SUD demonstration. So would services under a state approved 1115 SUD IMD waiver qualify for the enhanced HCBS FMAP, including the cost of coverage for adults in IMD facilities larger than 16 beds?

Ralph Lollar: So go back to what we've been saying already. The states are delivering any of the services identified in Appendix B through an approved 1115 demonstration, expenditures for the services listed in Appendix B would be eligible for the FMAP increase under Section 9817. However, services provided to individuals residing in an IMD are not eligible for the FMAP decrease which is for home and community based services.

Jen Bowdoin: So we've also gotten a number of questions related to the initial and quarterly spending plans and narratives. So the first question is can states add new items or projects not included in the initial spending plan and narrative?

Ralph Lollar: Absolutely. States can use the quarterly spending plan to narratives to update and modify the information reported in the initial spending class narrative, as well as in any prior quarterly submission. To expedite the review process we

recommend that states clearly identify any updates or modifications they are making to prior submissions. States should also include information on both anticipated and actual spending.

Jen Bowdoin: And the next question has to do with whether we would approve parts of spending plans but not others. So would CMS consider approving parts of the spending plan but not others so that a state could move forward with approved portions while CMS continued to review others?

Ralph Lollar: Sure. The answer there is yes. We would consider conditional or partial approval. An example is if state is still conducting stakeholder engagement activities at the time of its initial submission, we would approve any activities that meet the requirements of Section 9817 and ask the state to provide additional information that the state plans to implement in its next quarterly submission, which leads back to the earlier question.

If a state included a mix activities that can be approved and activities that cannot be approved, we would let the state know which activities are approvable, which would need more information and which are not approvable.

Jen Bowdoin: So we've gotten a number of questions from states, you know, states are concerned about the level of detail that they need to include in the spending plans' narratives. And so one of the questions that gets to this is what is the level of detail that CMS expects for the spending plan and narrative, to ensure approval?

Ralph Lollar: Yes. It's a good question. States must provide sufficient detail to demonstrate states' activities in the effort to enhance or expand HCBS under the state Medicaid program. It means that the states provide enough information to show how the HCBS spending plan projections relate to the scope of planned activities to expand, enhance, and strengthen the HCBS system.

States should also provide as much detail as possible regarding the activities it

can definitively commit to. And reserve the remaining activities that will propose after state planning, stakeholder engagement, or legislative process is completed. States can update, modify or expand their initial HCBS spending plan submission to the required quarterly spending plan submission. Remember, if you're asking us to expedite something in a review, you want to be able to tie it back to this spending plan so the details should be there.

Jen Bowdoin: And then the last question for today related to the spending plans, is that given that states will have to work with their legislatures and their initial spending plans are due on June 12th, what is the plan for updating the plans.

Ralph Lollar: We keep harkening back to the original response which is states can use the quarterly spending plan and narratives to update and modify the information reported in the initial spending plan and narrative, as well as in any prior quarterly submission. To expedite the review process we recommend that states clearly identify any updates or modifications they are making prior to submission. States should also include information on both anticipated and actual spending.

So if you're closing something out and adding something in you want to close out the expenditures on the one end while you project the expenditures on the other.

Jen Bowdoin: So Ralph, we've also gotten some questions about whether states need to continue temporary rate increases they've implemented, in order to meet the requirements to maintain HCBS prior - provider payments at a rate no less than those in place as of April 1, 2021. So if a state has enhanced rates in effect as of April 1 through an Appendix K, how does the guidance require that these enhanced rates continue? Do the MOE requirements apply to temporary rate increases approved via Section 1135 Disaster SPA Authority?

Ralph Lollar: Okay. So the answer is this. States must maintain home and community based service provider payment for Medicaid covered services listed in

Appendix C of the SMDL at a rate no less than those in place as of April 1, 2021 and until the state funds equivalent to the amount of federal funds attributable to the increased federal FMAP assisted percentage, are fully expended.

If a state has a temporary wage increase that is in effect as of April 1, 2021, and was authorized through the Appendix K template for Section 1915(C), a disaster relief state plan amendment for Sections 1915(I) or (K) or in Attachment K for HCBS services under Section 1115 demonstration, states are expected to retain the temporary wage increase for as long as that increase is approved under those authorities as of April 1st.

CMS will not apply noncompliance restrictions or penalties if the authorized temporary wage increase expires before the states' funds equivalent to the amount of federal funds attributable to the increased FMAP, have been fully expended.

So in practical terms, the state has implemented temporary rate increase through an Appendix K or disaster relief SPA, the state must continue the rate increase until the end date that was approved as of April 1st. If the state did not request this specific end date for the rate increase, the state must continue the enhanced rate for as long as the Appendix K or disaster relief SPA remains in effect.

So it's whatever was approved in the disaster relief issuance, whether it was closed or whether it was open-ended and will continue to the end of the application.

Jen Bowdoin: Thanks, Ralph. And then the final question we want to address today has to do with the activities that states can implement to expand, enhance or strengthen HCBS under Section 9817. So can you clarify that available funds may be used to support the administrative costs associated with the implementation of enhancements described in the appendices? Are there any limits to the use of available funds for administrative purposes?

Ralph Lollar: Sure. A state can implement administrative activities as long as the states can demonstrate that those administrative activities expand, enhance or strengthen HCBS under Medicaid and are included in the states' approved spending plan. We do not have any limits on the amount or portion of the funds attributable to the increased FMAP that can be used for administrative activities.

However, states should contact CMS if they have any questions about whether a specific activity is approvable.

Jen Bowdoin: Thanks, Ralph. Jackie, I think we're ready to transition back to you.

Jackie Glaze: Great. Thank you, Jen. And thank you, Ralph. So now we're ready to take your state questions. We will begin by reading the questions that we received through the chat function. So we do have a few questions already. So we ask that if you do have questions you can begin submitting them now. And then we will follow up by taking some questions through the phone lines. So Ashley, I'll turn it to you.

Ashley Setala: Okay. Thanks, Jackie. So the first question that was submitted through the chat, says in regards to the requirement to maintain rates at levels as of April 1, 2021, does this apply to state statutorily defined time limited rate increases approved by the state prior to the PHE and scheduled to end during the April 1, 2021 through March 31, 2024 period? Would the expiration of a time limited rate increase during this period, cause the state to fall out of compliance?

Ralph Lollar: If that time limited increase was documented and approved by CMS in an amendment to a plan whether it was a SPA amendment or a 1915(C) amendment, it will not be counted against the state or will not be a problem. If it was not included and approved in the plan that was in effect as of April 1st, we urge you to contact CMS and discuss the issue. It is an issue that may in fact, implicate the MOE.

Ashley Setala: Okay. The next question says what kind of detail does CMS need on how states estimated the FMAP? Should it be included within the narrative or expense plan or will that occur in questions and answers between CMS and the states?

Ralph Lollar: Can you ask the first part of that again?

Ashley Setala: Sure. What kind of detail does CMS need on how states estimated the FMAP?

Ralph Lollar: We'll need to know that the state included all - 10% FMAP for all of the services defined in Appendix B and what that estimate will be, which should - it would have to be reflected in the spending plan. If the details are added or the manner in which the state calculated that amount is included in the narrative that will give you a more robust application. Is there anything else there, Jen?

Jen Bowdoin: No. I mean, you know, the estimates are so that we can verify that the activities that the states are implementing that they - that the states are using all of the additional funds for activities that expand, enhance or strengthen HCBS. And so, you know, we will obviously be able to do checks as states claim those dollars and we confirm the actual amounts.

And so, you know, we may follow up with additional information just in terms of how states came up with those calculations, particularly if there were states that have - is delivering some of those services under managed care. We will very likely have some additional follow up questions for those states.

But the information is really there so that we can verify that the states, that the activities kind of fully cover everything that the state would need to do to meet the requirements of Section 9817. So I don't think they seem to get super detailed about how they make those calculations and if we have follow

up questions we will certainly contact the state if we need more information.

Ashley Setala: Okay. The next question says is FMAP all or nothing? For example, if our state is projected at \$100 million can we submit plans for \$50 million? Or must we claim it all and spend it all by 2024?

Jen Bowdoin: We have received that question from several states or stakeholders in some cases, and we are looking into that and we will follow up on that question.

Ralph Lollar: To be clear though, when you ask the question if the question is can I spend half the funds before 2024 and have the remaining half available to the state, that answer is you must expend the total amount you receive on strengthening and expanding HCBS. Correct, Jen?

Jen Bowdoin: Yes. That's right. So the states would - the state needs to demonstrate that, you know, all of the additional funds that they've received, an equivalent amount has been used for activities that expand, enhance, or strengthen HCBS. I think what some states have asked is whether they can claim the increased FMAP only for certain services. And we are taking that back and we will follow up on that question.

Ashley Setala: Okay. Then the next question says can you please describe whether the requirement to spend the enhanced HCBS funds by March 2024 expects that funds are fully liquidated or just obligated, for example, through a contract or a grant?

Jen Bowdoin: So we have received that question as well, and we are looking into that and we'll be following up on that question.

Ashley Setala: Okay. And the next question says if a state submits part of its plans as contingent on state legislature approval and it's not ultimately approved by the state legislature, will there be penalties or binding commitment for those unapproved parts of the plan?

Ralph Lollar: As long as that is done within the timeframe permissible, meaning before 2024, and the state can substitute an additional action for that amount that they need to expend, there will be no issues with the state doing that. It would be considered an updated and quarterly report.

Jen Bowdoin: Yes. That's right. And I think if the state is in a situation where they claim the increased FMAP in anticipation that they would get state legislative approval for certain activities, and then they're not able to fully expend those funds on activities that meet the requirements of Section 9817, they should definitely contact CMS and we will work with them to figure out how to resolve that issue.

Jackie Glaze: Thanks, Jen. Let's move to the phone lines now to see if we have any questions. Operator, could you provide instructions for the participants? And then we can take calls through the phone.

Coordinator: Yes. We'll now begin the question and answer session. If you would like to ask a - I mean over the phones, if you'd like to ask a question please press star 1. You are prompted to record your name so please be sure to unmute. your phone. Once again, if you'd like to ask a question on the phone lines, please press star 1 and record your name. We'll pause for a moment to allow those questions to start coming through. Once again, on the phone lines, if you would like to ask a question please press star 1. One moment for your first question. The first question comes from (Tricia Roddy). Your line is open. Please go ahead.

(Tricia Roddy): Hi Ralph and Jen, this is (Trish Roddy) from Maryland. Just a real quick question. On the rehab, rehabilitation expenditures one is when do you anticipate giving us guidance of where that's going to come through the CMS 64?

Jen Bowdoin: So we are working on making the updates and Anna or Rory, would you like to just jump in, in terms of when additional guidance will be available?

Rory Howe: Hi. This is Rory Howe. And (Tricia), we don't have an exact timeline yet. But what I can say is that we are working as quickly as possible to get those changes in place. And as soon as we have more information we will certainly share it with everyone.

(Tricia Roddy): Okay. I appreciate it. Just, you know, obviously Maryland's got some statute language and so it - without that information it's going to be hard for us. We're going to have to ask for a delay. An extension.

Ralph Lollar: Do you mean to the 60 day submission? Is that what you're saying?

(Tricia Roddy): Right. So, you know, Ralph as we talked about, we're mandated to give a portion of the reinvestment into our rate increase for our providers. And so we need to get our handle around that pie before we can do anything.

Ralph Lollar: Sure. Sure.

Jen Bowdoin: Yes. Just - (Tricia), just send an email to the mailbox, to request the extension. And just let us know what the date is when you plan to submit the spending plan and narrative. And, you know, obviously if this is dependent on updates to the system that you don't have yet, you know, you can be as conservative as you need to be with that request, as long as it's, you know, within 60 days.

(Tricia Roddy): Okay. Thanks a lot, Jennifer.

Jackie Glaze: Thanks everyone. So in closing, I want to thank everyone - all the presenters, for their excellent presentations and information that they shared with us today. Looking forward, we will meet with you again on June 22. The topic and invitations will be forthcoming. If you do have questions between our calls, please feel free to reach out to us. You can contact your state leads or you can bring your questions to the next call.

If you'd like to pre-submit a question for the open Q&A portion of our next

All State call, you can email it to MedicaidCOVID19@CMS.HHS.gov by 1:00 pm Eastern Time on the day of the call. Thanks again for joining us today and I hope everyone has a great afternoon. Thank you again.

Coordinator: Thank you. That concludes today's conference. Thank you for participating. You may now disconnect.

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