CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

All-State Medicaid and CHIP Call

January 25, 2022

Agenda

- Mobile Crisis Intervention Centers Administrative Claiming
- OneMAC Submission Portal State Onboarding
- Vaccine Counseling FAQs
- Open Mic Q and A

Mobile Crisis Intervention Centers Administrative Claiming

ARP Establishes Section 1947 of the Act

- Section 9813 of the American Rescue Plan Act of 2021 (ARP) (Pub. L. 117-2) authorizes a new Medicaid state option to provide community-based mobile crisis intervention services during the period starting April 1, 2022, and ending March 31, 2027

- **85 percent FMAP** for expenditures on **qualifying community-based mobile crisis intervention services** for the first 12 fiscal quarters within the five-year period

SHO # 21-008 Community-Based Mobile Crisis Intervention Services

- SHO # 21-008 published 12.28.21: https://www.medicaid.gov/federal-policy-guidance/downloads/sho21008.pdf

- Set forth Medicaid guidance on the scope of and payments for Qualifying Community-Based Mobile Crisis Intervention Services authorized under Section 1947 of the Social Security Act (the Act)

- Components of effective crisis systems include:
    - 24/7 crisis lines,
    - 24/7 mobile crisis response, and
    - Crisis stabilization programs

Background: SHO # 21-008 Community-Based Mobile Crisis Intervention Services

- The mobile crisis SHO letter describes the *administrative claiming match* for state Medicaid agency costs associated with:
  - establishing and supporting community-based mobile crisis intervention services for people with mental health conditions including SUD; and
  - operating state crisis access lines – **including connecting to the 988 National Suicide Prevention Hotline** – triaging calls, and dispatching mobile crisis teams as needed to assist Medicaid beneficiaries

- Section 1903(a)(7) of the Act directs payment of FFP at **50 percent for amounts** for administrative costs "found necessary by the Secretary for the proper and efficient administration of the State plan." See also 42 CFR 433.15(b)(7)

988 National Suicide Prevention Lifeline

- The National Suicide Prevention Lifeline is a national network of approximately 185 local- and state-funded crisis centers
- Currently the National Suicide Prevention Lifeline provides free and confidential emotional support 24 hours a day, 7 days a week to people in suicidal crisis or emotional distress, anywhere in the United States
- The Lifeline fielded 2.2 million calls, texts, and online chats in 2020
- The Lifeline routes calls to local crisis centers, but redirects those calls to other crisis centers if there is insufficient local capacity to field a call in real time

988 National Suicide Prevention Lifeline

- On 7/16/20, the FCC adopted rules to establish 988 as the new, nationwide, easy-to-remember phone number for Americans in crisis to connect with **suicide prevention and mental health crisis counselors,** 24 hours a day, seven days a week.

- By July 2022, the current National Suicide Prevention Lifeline will be accessible by dialing **988 from any landline or cell phone in the U.S.**

- Dialing 988 will connect individuals to staff trained to answer calls related to mental health crisis (including risk for suicide) and substance use related emergencies.
  - Centers handling 988 calls also employ staff specifically trained to help veterans, LGBTQ+ individuals, and other underserved groups with challenges that may specifically impact them

- Expected to receive <u>24 million calls, texts, and online chat requests</u> by 2027

Funding Sources

- State and local governments are braiding Medicaid, federal grant funds, and state and local funding as part of 988 implementation
  - State government grants and contracts provide between 60% and 70% of all funding, with private donations constituting between 15% and 30% of funding
  - Medicaid, Veteran's Administration, grant and contract monies from SAMHSA, and
  - Community health center funding from the Health Resources and Services Administration

- The federal law that established 988 allows states to require a surcharge on wireless telecommunications services
  - Four states have passed legislation requiring a surcharge to finance 988 call response functions;
  - An additional eight states have pending 988 legislation – some which will include a surcharge.

Considerations for Medicaid Claiming

- States may want to claim as Medicaid administrative expenditures costs of operating local call centers – (e.g., connecting local call centers to national lines, staffing costs, etc.)

- CMS will review state allocation methodology proposals using existing administrative claiming criteria, as well as federal cost allocation principles. See 45 CFR 75 et. seq.

- Reported Medicaid expenditures must be "reasonable, allowable, and allocable." See 45 CFR 75.403- 405

- Administrative expenditure claims may not duplicate costs that have been, or should have been, paid through another source

- Allowable costs must also be allocated in accordance with the relative benefits received by the Medicaid program
  - Medicaid can support crisis call response ***functions only to the extent and proportion that these functions serve Medicaid beneficiaries***

Allowable Costs for Administrative Claiming

- Allowable costs for administrative claiming, which should be claimed on the CMS 64.10, may include screening through state crisis access lines to triage and determine that:
  - The person does not need mobile crisis services, but may need a referral to a behavioral health practitioner/service;
  - The person needs mobile crisis services and dispatch/connect to a mobile crisis team; or
  - The situation is truly dangerous (e.g. firearm or other weapon involved and/or someone has already been hurt) and engage 911/ law enforcement.

- Allowable costs **cannot** reflect the cost of providing a direct medical or remedial service which should be claimed on the CMS 64.9. For example, administrative cost claiming should exclude:
  - Behavioral health counseling
  - Clinical Assessment
  - Case management services

Allowable Costs

- Most of the crisis call centers have multiple lines of business, e.g.,
  - State hotlines (e.g., 211 in Maryland)
  - Local domestic violence center calls,
  - homeless emergencies,
  - substance use
  - A hotline operated by a managed care provider
  - 311
  - A local line that serves a city or county
  - A regional call center

- The supported service must be related to a covered Medicaid service to be eligible for administrative matching funds under the Medicaid program
  - States must allocate across the above cost objectives and claim the portion of the hotline that supports Medicaid beneficiaries and their care

Allowable Cost Considerations- Exclude: SAMHSA Mental Health Block Grant Set-Aside

- Importantly, states that want to claim for administrative costs for local crisis hotlines must have a methodology to **identify and allocate costs for Medicaid beneficiaries that are not covered by or duplicative of other funding sources**
  - For example, at least 5% of state SAMHSA Mental Health Block Grant (MHBG) allocation must be set aside to support evidence-based crisis systems
  - States and territories must use these resources to fund some or all of a set of core crisis care elements including, among other items, **regional or state-wide crisis call centers** that coordinate mental health services in real time
- Any administrative claiming methodology must exclude a state's SAMHSA MHBG funds from the administrative amounts claimed
- Medicaid is the payor of last resort

Medicaid Administrative Claiming

- States are responsible for developing and documenting an appropriate methodology to ensure that specific costs are allocated in a manner compliant with Medicaid administrative claiming principles

- Steps to determine amount to claim include:
  - Identifying all costs incurred (direct and indirect)
  - Applying an allocation ratio

Deriving FFP Amount

	-100% of All Costs Incurred
• Less:	-Adjustments (offsets, non-allowable items)
• Apply:	-Indirect Cost Methodology (multiply by indirect rate)
• Equals:	-Allowable Costs
• Multiplied by:	-Allocation Statistic
• Equals:	-Allowable Administrative
• Multiplied by:	-Medicaid Administrative %
• Equals:	-FFP for Medicaid Claimable Administrative Cost

First Step: Identify Costs Incurred Direct Costs*

***The following examples are provided for illustrative purposes Will depend on a state's cost objectives**

- DIRECT COSTS
  - Identify eligible workforce --***paid staff***
    - **NOTE**: About half the centers rely on volunteers as a portion of the workforce – although the proportion of volunteers varies
  - Identify total salary and benefits of staff (see 45 CFR 75.430)
  - Phone bills
  - Equipment
  - Tech expenses related to reliable phone systems
  - Remove "other" off-setting federal funds
    - Mutually exclusive cost pools – no duplication

First Step: Identify Costs Incurred Indirect Costs *

***The following examples are provided for illustrative purposes**
Will depend on a state's cost objectives

- INDIRECT COSTS
  - Admin/overhead
  - Technology, e.g.,
    - Software/platforms for data gathering
  - IT personnel supporting the system

Allocation

- When claiming for allowable administrative activities for a population consisting of both Medicaid-eligibles and non-eligibles, **payment may only be made for the percentage of time directly attributable to Medicaid-eligible individuals**

- **Call centers may or may not ask for insurance from inquirers**

- Need a way to determine the proportion of activities that are for Medicaid beneficiaries (i.e., the proportional share of Medicaid beneficiaries to the total number of callers).
  - Also known as the "Medicaid eligibility rate (MER), Medicaid percentage, or discount ratio

Allocation Approaches

- Time studies capture how staff spend their time at a selected moment
  - Random Moment Time Study (RMTS) sampling
    - relies on statistical sampling to estimate total worker effort based on a limited number of worker observations.
  - Case Counts Medicaid visits/total visits
  - Direct Hours of Medicaid employees
  - Other quantifiable measures of employee effort or outcomes

Allocation Approaches

- States could assess the appropriate allocation of costs to Medicaid by:
  - Identifying numerator as the percent of residents with mental disorders including SUD, and intellectual developmental disabilities who are enrolled in Medicaid, since these populations are more likely to need crisis stabilization services
  - Identifying the denominator as all residents in the state who use/have access to the hotline

Allocation Approaches

- Alternative methods for cost allocation could include:
  - Number of Emergency Department mental health visits in region/number of callers
  - Conducting a survey of crisis hotline callers to determine Medicaid eligibility

Application of Allocation Statistic

- Could further refine cost pools for more accurate allocation
- For example, a state could multiply the allocation ratio with the AVERAGE length of a case, e.g.,
  - High intensity mental health cases = avg 60 mins.
  - Low intensity SUD cases = 15 minute avg

Claiming Documentation

- Any claims for FFP must meet documentation requirements and are subject to audit.

- Documentation must clearly demonstrate that the activities directly support the administration of the Medicaid or CHIP program.
  - 42 CFR 433.32(a) and 457.226(a) (requiring that states maintain an accounting system and supporting fiscal records to assure that claims for federal funds are in accord with applicable federal requirements), and
  - 42 CFR 433.32(b) and (c) and 457.226(b) and (c) (establishing retention periods for records that support claims for federal funds).

Effective Dates

- States may submit Medicaid Administrative Claiming Methodologies to CMS and Public Assistance Cost Allocation Plans (PACAP) to the HHS Program Support Center's Cost Allocation Services (CAS) immediately.

- CAS determines the effective date in its PACAP approval consistent with the requirements at 45 CFR 95.515

Technical Assistance

- For additional questions, please contact:
  - Stephanie.Kaminsky@cms.hhs.gov and
  - Sharon.Brown@cms.hhs.gov

OneMAC Submission Portal State Onboarding

CMCS Informational Bulletin

The CIB provides direction to state Medicaid and CHIP agencies on a new process for certain key state submissions to CMS that will be effective February 1, 2022. Specifically, the CIB outlined:

- Changes for the submission of paper-based Medicaid & CHIP SPAs and 1915 waiver actions that will now be submitted through the centralized OneMAC portal
- New centralized mailboxes for other state managed care actions not performed in the OneMAC portal

<u>Updates to Intake Process for State Submissions to CMS</u> – November 23, 2021

Be sure to check out Appendix A & Appendix B of the CIB for valuable resources on CMS electronic systems of entry (OneMAC, MACPro, WMS, MMDL) and details on how to access the OneMAC portal

What is OneMAC?

OneMAC is the new system for paper-based submissions for certain State Plan Amendments (SPAs) and 1915 waiver actions.

OneMAC offers many valuable features that are not available in the traditional paper-based state plan and waiver format:

- Ability for state users to track a submission through the review process
- Ability for state users to view all submissions associated with their state
- Automated feature that routes each package directly to the appropriate Intake Team

The Submission Process in OneMAC is quick and intuitive for State users.

OneMAC allows CMS and states/territories to collaborate online to process SPAs and 1915 waivers more efficiently and effectively.

The OneMAC Submission Portal Goes Live For All States
February 1, 2022!
https://onemac.cms.gov/

State OneMAC User Roles

State OneMAC Role	System Utilization	Role Approver
State System Administrator	Reviews and acts on State Submitter user role requests, system access and has all State Submitter permissions (below)	CMS Role Approver
State Submitter	Creates new paper-based submissions and submits packages to CMS for review: • Medicaid State Plan Amendments – those not in MACPro or MMDL • CHIP State Plan Amendments – those not in MMDL • 1915(b) waivers – those not submitted through WMS • 1915(c) Appendix K waivers • Formal Responses to RAIs for all items submitted through OneMAC • 1915(b) & (c) waiver Temporary Extension Requests	State System Administrator

State users must take action to set up their IDM and OneMAC accounts. CMS will not automatically onboard state users. However, CMS has reached out to each state to provide instruction for the onboarding process.

State users will need to set up an IDM account with a State OneMAC User role prior to setting up their OneMAC access.

State System Admins are responsible for onboarding their team, including granting, denying or revoking State Submitter roles.

OneMAC Resources for States

CMS OneMAC Help Desk emails for state users included valuable resources for states, such as:

- IDM Instructions for OneMAC Users
- Welcome to OneMAC Guide & OneMAC FAQs
- OneMAC Quick Start Guides for State System Administrators and State Submitters

The OneMAC FAQs can also be found at the top of the OneMAC login screen at https://onemac.cms.gov. Check out the FAQ page for additional OneMAC resources.

Need Help?
Contact the OneMAC Help Desk
at OneMAC_HelpDesk@cms.hhs.gov or (833)228-2540

Vaccine Counseling FAQs

Questions