1-27-26 CMCS All-State Call & Webinar Transcript

January 27, 2026, 8:02PM

Wallace, Nick (CMS/CMCS) 0:40

Hi everybody and welcome to the first Allstate call of the Year 2026.
My name is Nick Wallace.
I'm the office of the center director here at CMCs and wherever you are, we hope that you're staying warm and finding it easy enough to move around to shovel your sidewalks and your driveways, and staying safe before we get started.
Just wanted to quickly mention that this is the first Allstate call that CMCs is hosting on the team's platform, so we're hoping for a smooth transition.
But bear with us, just in case we experience any technical difficulties.
And now I'd like to turn it over to Dan for opening remarks. Dan.

Brillman, Dan (CMS/CMCS) 1:20

Everyone for those that I haven't met, my name is Dan Brillman and I'm the deputy administrator and center director for CMCs and great to be with you all for today's Allstate call.
Since our last Allstate call, there's been a lot of important work underway at CMCs, and today's agenda reflects the key administration and center priorities. I want to start by highlighting a major milestone for CMCs and CMS more broadly.
You've seen this out there, but the launch of the rural Health Transformation program and.
The official establishment of the Office of Rural Health Transformation within CMCs, the new office reflects a long term commitment to strengthening access, quality and sustainability of care in rural communities and to supporting states as key partners in that work. On today's call, you're going to hear directly from.
The rural Health transformation team about the program, including how it will support all 50 States and really excited to begin the next phase of collaboration with you all.
You'll also hear an update on our continued implementation of the Working Families tax cut legislation since our last meeting, CMCs has released the first tranche of funding to states to support implementation of the eligibility related provisions and the necessary systems changes including community engagement requirements. We

know how.
Important, timely resources are for for the states that we're working actively towards releasing the 2nd tranche of funding as soon as possible. As you know this work is ongoing.
I appreciate your partnership and we remain focused on making implementation as clear, predictable and coordinated as possible with everyone.
The team also continues to make progress across several fronts and we have a few additional updates to share with you today.
As always, appreciate the partnership, the feedback and the ongoing and frequent engagement from states as this work moves forward.
So thank you all for joining us today.
And with that, I'm going to turn it back to Nick to walk through our great agenda.
Thank you all.

Wallace, Nick (CMS/CMCS) 3:14
Thanks Dan.
Hopefully folks are seeing this.
So let's walk through today's agenda. So as Dan mentioned in December, CMS announced that all 50 states will receive awards under the Rural Health Transformation Program that was established under the Working Families tax cut legislation to strengthen and modernize healthcare in rural communities across the country. Alina
The director of the newly formed Office of Rural Health Transformation.
In CMC mess is here today and she's going to give an overview of the program and the recently announced funding allocation after Elena's update.
Elaine Salyers and Kristen Pasik from the children and adult Health Programs Group are going to tag team a presentation about a newly released SIB related to the prohibition on the termination of enrollment due to incarceration that is related to section 205 of the Consolidated Appropriations Act.
Of 2024.
And finally, Curtis Cunningham from our Medicaid benefits and health programs group is going to walk us through section 7/11/21 of the Working Families tax cut legislation, which creates a new 1915 C option for states beginning on July 1st, 2028.
After our final update.
We will open your line to questions before we officially get started.

I want to let folks know that we're using the webinar platform to share slides today. So if you're not already logged in, we encourage you.
So if you have any questions throughout the presentation, you can put it into the chat function at any time.
And with that, I am pleased to introduce and turn things over to Alina to get us started. Alina.

Pedersen, Alina Czekai (CMS/CMCS) 4:55
Thanks Nick and thanks everyone. We can go to the next slide please.
I'm very pleased to formally introduce myself.
I've had the pleasure of meeting a number of state leaders over the last five months.
My name is Alina Czekai and I'm the director of the office.
Sorry, having technical issue right here.
Nick can, can you hear me?

Wallace, Nick (CMS/CMCS) 5:32
Yes, we can hear you.

Pedersen, Alina Czekai (CMS/CMCS) 5:33
Oh great.
OK.
So I'm I'm the director of the Office of Rural Health Transformation, which again is as Dan and Nick mentioned is the new office here at CMS leading the rural Health Transformation program?
Rural health is is super important to me personally and the granddaughter of a 12th generation farmer up here in upstate New York and I rejoined CMS.
From a digital health company back in September.
Also previously was at CMMI and was an advisor to former administrator Seema Verma.
Also joined here today by our Office's deputy Kate Sapra, who has joined CMCs after a wonderful nine year career leading models at CMMI.
So again, as Dan mentioned, we have created a new office of Rural Health transformation to oversee the program.
I'm very honored to direct it and as as many of you are are aware.
The awards for the Rural Health Transformation Program will be managed as

cooperative agreements.
And the rational there really is to ensure close partnership between CMS and the states.
And of course, managed within the Center for Medicaid and Chip Services also just given the center's close relationships with states.
And we also work very closely with other department offices and agencies.
Our office is staffing up and I'm very pleased to share that we will have a full staff soon, including sixteen program officers.
Who will be directly working with the states?
Excuse me.
Each program officer will have between 3:00 to 4:00 states that they're directly responsible.
Responsible for working with over the five year program and then we also will have a number of data analysts, policy advisors and other support staff as well supporting this important work.
Our hope really is is that the rural health transformation program will help States and local communities unleash the innovation necessary to give Americans access to high quality care, regardless of where they live.
And we can go to the next slide please.
So quick high level overview though I'm sure many of you are are familiar with the program.
The rural Health Transformation Program was authorized by the president's working families Tax Cuts Act, signed into law in July 2025, and really presents a unique opportunity to deliver dependable care to rural communities across the country and is closely aligned with the making America healthy again.
Again, agenda. The funding awarded by Congress enables the rural Health Transformation program to really put states on a path to ensuring every American has access to affordable, high quality care through sustainable healthcare innovation and its purpose is to help state governments support rural communities by improving healthcare access.
Quality and outcomes.
Again, we were very pleased that all 50 states submitted excellent applications.
And we'll we'll get into some of the details of the the themes of their applications.
But essentially for the program over five years, $50 billion of funding will go directly to the states.

Half of that funding will go evenly to all states with approved applications, so that means each state receives at least $100 million of funding each year. Since all 50 states were approved.
And then the other half is competitive and based on three general criteria.
So first the individual state metrics around virality and a state's health system.
This also includes factors like if there's Frontierland in the state, distance from facilities, number of rural facilities.
And for this definition we used HRSA's definition of virality.
And then the second is currently implemented or commitments to state policy actions that enhance access and quality of care in rural communities.
So with this piece of the rubric, we saw a number of states showcasing their their existing state policy actions, but also making commitments toward things like reinstating the presidential fitness test.
Limiting.
Or reducing certificate of need requirements in the state. We also saw a lot of momentum around SNAP waivers as well as scope of practice.
So a lot of momentum around rural focused state policy actions.
And then the third is of course the application details on funded initiatives or activities that.
That reflect the greatest potential for and scale of impact on the health of rural communities.
So this is where all of the states brought forward their best ideas in their rural health transformation plans and sketched out the initiatives and the goals that they have over the next five years.
Also wanted to note that the applications were assessed in a very data-driven approach and the transformation plan.
That the state submitted were reviewed and scored in a merit review process which is consistent with basically all other HHS grant making activities.
So the the scores were then inputted into a formula which is outlined in the notice of funding opportunity to determine the final awards amount.
So our office and the agency more broadly, you know.
Thinks about the integrity of this process.
At the center of everything that we're doing, so you know, also worth reiterating that politics did not play a role in the final decision amounts. And we're really proud of the integrity. You know throughout this process. So we can go to the next slide

please.
So I mentioned the goals of the program.
So each state was able to really highlight, you know what, what their state is focused on for the rural health transformation program.
With the kind of mindset of, we believe that the states know their communities best.
They know their rural communities especially best, and so we encourage the states to bring forward their ideas in these.
These five key goals.
So first make rural America healthy again.
So this is a focus on preventative care, behavioral health, nutrition, chronic disease, root cause of disease.
2nd sustainable access.
So this one focuses on how do you provide the necessary range of healthcare services in an efficient and sustainable way?
3rd is workforce development.
So as we all know, this one is a.
A very significant upstream pain point in rural communities.
We need to build a strong pipeline of local healthcare talent in rural America and a strong workforce is of course the backbone of rural care. And and we also know it's one of its greatest challenges.
And then 4th innovative care so as a healthcare system, we really want to focus on moving from quantity to quality in a way that makes sense for rural communities.
So this is where you can think about.
Different payment models, alternative payment models shifting toward value based care, and then finally 5th is technology innovation.
So leveraging advances in tech such as telehealth, remote care services.
Enhanced interoperability, different types of consumer facing tech, as well as technology that can support the administrative demands on a clinical workforce.
It's already strapped.
You know our perspective is that especially on the tech piece for too long, rural communities have really been left out of tech conversations, even though it's likely that they stand to benefit the most from high tech solutions.
So again, while our office did not score the applications, we did read all of them.
Were of course now, you know, gearing up to work directly with.
The states throughout the implementation, but on the next slide just wanted to

highlight some key themes that really stood out to me and my team in terms of where the states are focusing the most.
The first saw a a general big focus around driving structural efficiency and empowering the workforce.
So saw states thinking really differently and creatively around how their.
Rural providers, how their rural facilities can partner either with larger facilities, you know, those closer to urban centers in Havana spoke models. We saw a number of rural regional centers of excellence being.
Ideated in in this program.
Also saw just generally an appetite towards sharing data and ensuring that.
All providers in a in a rural system or rural community are kind of speaking the same language. Data wise. You know they're sharing information, they're sharing access.
And leveraging different tools to allow them to do so.
Also saw some establishments of certified community behavioral health clinics.
Mention technology, but we saw some really cool proposals around technology around the country.
Again, focus on the whole spectrum of a delivery system.
So patients, physicians, facilities, you know, technology in the communities, technology in hospitals.
Very different focuses here and creative, so very interested to see that a lot of excellent programs around chronic disease and pop health.
I would say maternity care and behavioral health really stood out as two of the most common themes I would say, at least half of the states have some sort of a focus on maternal care and behavioral health.
Valley based care generally seeing a greater appetite toward BBC and in rural communities.
One state is proposing a Medicaid ACO.
We're also seeing a couple states wanting to test out Medicaid reimbursement for different types of care, like care from doulas.
And then finally key theme is of course that states all really leaned into the power of partnerships here.
So that means states are really thinking creatively about how they can partner both within the rural communities and outside.
So neat partnerships with schools, businesses, farms was very pleased to see a number of states working very closely with tribes, both in formal tribal consultations,

but also.
Building out many rural health transformation programs with tribes or or setting up tribal set asides as well.
We can go to the next slide.
So just wanted to highlight.
A bit more on where we are.
So right now, hard to believe that January is coming to an end, but.
All states have been working on revising their rural health transformation budget.
So again, all states submitted hypothetical budgets in the amount of 200 million.
And now are reworking their budgets to match their final award amount, as well as addressing any concerns that the Grant's office might have had on specific initiatives or line items in their budgets.
Later this week on Thursday the 29th at 3:00 PM Eastern, we have a welcome webinar with the state.
You all are welcome to join all of the. Of course, you know points of contact for the application and the program have registered and have that information. All 50 states have registered, which is great to see.
And then states will be meeting soon with their project officers getting the support they need to begin implementation.
Our office is also working on.
And finalizing details around reporting and rescoring. And our goal is to have another webinar later in February.
So all states have the information that they need.
Knowing how they'll be rescored each year as well as providing the necessary information on reporting requirements, and then finally we will have a rural health summit in conjunction with the CMS.
Quality conference in March.
And again, all 50 states will be attending that conference.
A great way for the states to hear updates from the Agency on Implementation Technical Assistance, but also to share insights.
You know, share any, any roadblocks they're facing for support and also just generally to hear from one another.
You know how their plans are going and to offer that cross state support.
For the rest of the year, we'll also be focused on visiting States and site visits, setting up learning collaborative so we can double click on specific initiatives and parts of

the plans.
And then of course, technical assistance and deep engagement with the states along the way.
OK, so I will turn it back to Nick and team.
Thank you for the opportunity today.

Wallace, Nick (CMS/CMCS) 21:12
Thanks, Alina.
And we are going to move to our next presentation.
Alina I think you're up.

Salyers, Eleni (CMS/CMCS) 21:19
Thank you, nick. Hi everyone.
My name is Alaini Salyers and I'm with the division of Medicaid eligibility policy.
And today I'm going to be highlighting some recent eligibility changes that affect incarcerated individuals.
Next slide please.
All right. So as of January 1, 2026, states may no longer terminate someone's Medicaid or chip eligibility when they become incarcerated.
This change comes from Division G Title One, Section 205 of the Consolidated Appropriations Act of 2024, which became law in March of 2024 to support states with the implementation of this requirement, CMS released a Center for Medicaid and Chip Services Informational Bull.
Or sib.
On December 23rd, 2025.
Five next slide please.
This change builds upon policy that states should be somewhat familiar with already.
Since 2021, states have been required to suspend rather than terminate Medicaid coverage for eligible juveniles during incarceration.
This requirement was established by the Support Act of 2018 and the Consolidated Appropriations Act of 2024 builds upon this policy to apply the suspension requirements to all Medicaid eligible individuals, including both juveniles and adults.
The SIB that we released provides information about the history of the suspension policies and Medicaid and chip, the various suspension strategies that are available to States and other operational considerations for incarceration's impact on

eligibility, in particular, the SIBMI states that Medicaid does not cover most benefits for.
Inmates, which is also referred to as the inmate payment exclusion and just as a reminder, the payment exclusion was not changed by the suspension policy.
Also want to highlight that unlike Medicaid.
Chip does not have the same payment exclusion, but my colleague Kristen will be covering all the nuances of the chip program in a couple minutes.
Also for the Medicaid program, states are not do not need to submit a state plan amendment or a SPA to implement these strategies that are necessary to effectuate this requirement.
Next slide please.
One section of the SIB that we wanted to highlight today are the two suspension strategies that states may use to implement the suspension requirement.
Those are the eligibility suspension or benefit suspension. States can choose either strategy to ensure that eligible individuals are not disenrolled when they are incarcerated and that systems are in place to prevent unauthorized claiming for services that are subject to the inmate payment exclusion.
So an eligibility suspension effectively pauses an individual's eligibility.
During periods of an eligibility suspension, states may conduct regular renewals or redeterminations but are not required to.
However, the state must ensure that the individual's eligibility has been redetermined within the applicable eligibility period before the suspension is lifted, and this applies both at release and if the individual needs to access the Medicaid covered services.
The limited benefit package that they have access to during.
Incarceration.
Alternatively, states could use a benefit suspension or the state continues to conduct regular renewals for the incarcerated individual, but Medicaid coverage is limited to services that are not subject to the inmate payment exclusion.
Finally, we'd like to remind you all that placing an individual into a suspended status is still considered an adverse action and a decision that affects an individual's eligibility. Therefore, states are required to provide notice to beneficiaries that it's consistent with Medicaid regulations.
At 42 CFR part 431, Subpart E and 42 CFR section 4:35 9/17.
And with that, I will now turn things over to my colleague Kristen and the Division of

state coverage programs to discuss the changes that the CAA of 2024 made to the chip program.

Pacek, Kristin (CMS/CMCS) 25:25
Next slide please.
All right. And thanks, Laney.
I'm Kristen Pacek.
I'm from the division of state coverage programs and I'm just going to take a a minute here to talk about how these requirements impact chip.
So unlike Medicaid, incarceration status continues to be a factor of eligibility for separate chips, children and pregnant women who are inmates of a public institution have historically been excluded from the definition of a targeted low income child or pregnant woman who's considered eligible for a separate chip.
But beginning effective January 1st, 2025, states were prohibited from terminating chip coverage for otherwise eligible children solely because they're an inmate of an of a public institution, which is a requirement under section 5121 of the Consolidated Appropriations Act of 2023 section.
205 of the CAA 2024 building this policy by applying the same prohibition..
Targeted low income pregnant women and chip who become inmates.
Institution states retain the option to suspend chip coverage or to continue to provide chip state plan services to children and pregnant women who are incarcerated. States that elect suspend coverage may utilize any of the suspension options available under Medicaid, which Elaine just went through. But since and his.
Chip, as Eleni mentioned, since Chip doesn't have the same inmate payment exclusion, the scope of the benefits during a chip suspension may differ from Medicaid.
And as a result.
States may continue to provide chip state plan services that are not otherwise provided by the carceral facility, as long as that child or pregnant woman remains eligible for chip while they're incarcerated.
Four separate chips that cover targeted low income pregnant women.
A chip spa. Unlike Medicaid, a chip spa will be required to demonstrate compliance with section 205 requirements.
We're currently revising the CS31 eligibility template.
In one Mac that will include chip pregnant women.

And it's still working its way through the clearance process, but chip project officers will contact states that have.
Targeted low income pregnant women and we'll give you further details once that template is available. And with that now I'm going to hand it over to my colleague Curtis to talk about section 7/11/21 of the Working families tax cut act.
Thanks.

Cunningham, Curtis (CMS/CMCS) 27:53
All right.
Well, thank you very much, Kristen.
I'm here to talk today about section 7/11/21 of the Working Families tax credit legislation, and what I consider one of the most significant enhancements to the ability to provide HCBS to Medicaid members.
That is maybe since HCBS has been created.
So next slide.
So section 7/11/21 actually has three provisions in it.
It has a provision which establishes a new waiver option to provide home and community based services to individuals who do not meet the traditional institutional level of care under 1915 C.
It provides $50 million for implement CMS for implementation and then it provides $100 million to states to support.
Home and community based services under section 1915.
C And Under 1115 demonstration waivers.
Next slide.
So this waiver option will be available.
We'll be able to approve these types of waivers July 1 of 2028.
And basically these waivers allow a state to identify instead of using an institutional level of care, to utilize needs based criteria to determine eligibility for this waiver type.

Wallace, Nick (CMS/CMCS) 29:16
Wait, wait.

Cunningham, Curtis (CMS/CMCS) 29:33
It does require, though that the.

Needs based criteria not be.
As stringent as the institutional level of care or another way to think about this is that the needs based criteria needs to be for a less acute population than an institutional level of care population.
And then finally, it does have kind of a provision to protect the institutional level.
Care programs by by having a provision that that will not result in the increase in wait time for people at an institutional level of care. When you're establishing this new 1915-C11 waiver.
Next slide.
Also, states will need to we do in the normal 1915 CA test that the average per capita expenditure will not exceed the institutional care average per capita expenditure.
And then they will also need to provide the number of individuals whom the state makes the 1915 C 11 services available.
I think the significance of this, this provision.
Is that states can identify needs based populations that could benefit from the from receiving home and community based services, and they can identify the population based on need as well as geographic service area.
So you can really hone in on whether it's, you know, elderly to just need a a small amount of support to stay in their home so that they don't.
Utilize all their assets or.
Or maybe a behavioral health population that could benefit from some some home and community based services.
That really gives states some options to.
Provide those unique home and community based services to improve the care going to the next slide.
We went in.
We'd be remiss if we would not receive some data from states once they implement these services.
So there are provisions that require the cost of services be reported broken down by service type. The length, event time individuals receive each type of HCBS comparison between now we have 3 categories. The people receiving 1915 C 11 services, people that are meeting institutional level of care.
And then.
People that are receiving.
Are in institution.

So, and then finally, the number of individuals who have received 1915 C 11 during the preceding year.
So so that gives you a broad overview of the new 1915 C 11 authority and then the last slide, next slide.
Really just notes that there is 50 million appropriated for the CMS to carry out and implement this legislation, and we'll be, you know, providing more guidance and trainings and and other feedback opportunities as we.
Move through this process and then there is 100 million that will be distributed in federal fiscal year 27.
To support state HCBS systems.
There is.
A kind of a A stated distribution methodology in the legislation that says the proportion of the population of the state receiving HCV S under section 1915 C and section 1115.
As compared to all states. So we are working on that calculation and we'll be reaching out to states to talk more about that.
And with that, I think that's the end. So nick?

Wallace, Nick (CMS/CMCS) 33:45
Thanks, Curtis. And to all of our panelists for their presentations.
We are ready to transition to the Q&A portion of the call. And as a reminder, while our team is going to try to answer the questions that are asked today, it's possible that we don't have the right staff or that we need a little bit more.
Time to take this back.
So just a caveat there.
The CMCs team is hard at work to provide more guidance related to the working families, tax cut legislation, and we're going to try to answer all of your questions as soon as we can.
I'm going to invite all of our panelists to come onto camera and we can officially get the Q&A portion started.
So folks are welcome to put AQ and A or excuse me, excuse me. A question into the chat.
Flagging it looks like we have one question from Sean related to the definition of qualified alien as it relates to. I believe that is section 7/11/09 of the Working family's tax cut legislation. We can take this one back and noting that we don't have the.

Right Member of the team on the call, but also hoping for at least more guidance soon.
Thank you for your question.
Curtis, maybe we'll punt this one to you.
There's a question about when will CMS start approving 1915-C11 waivers?

Cunningham, Curtis (CMS/CMCS) 35:47
We have the authority to approve the new waiver option July 1, 2028.

Wallace, Nick (CMS/CMCS) 36:03
Thanks, Curtis, and invite folks to keep the questions coming.
Also wanted to acknowledge another question from Krista related to education data sources as it relates to community engagement requirements.
Again, our team is hard at work at implementing community engagement requirements and is thinking intentionally about this question.
And so we will take this one back and make sure we address it in a future meeting.
So thank you.
Questions from folks.
We'll give it another 30 seconds or so, just in case anybody's queuing something up.
Curtis looks like we've got another question for you from EVE in preparation for submitting an application for the new 1915 C.
Can the other requirements such as public notice, be completed prior to seven 128?

Cunningham, Curtis (CMS/CMCS) 37:51
I will say currently we are trying to get things out so that we would people would be able to submit an application that we could approve on the July 1 date, but that.
Further guidance will be coming out regarding all the timing of all.

Wallace, Nick (CMS/CMCS) 38:11
Thanks, Curtis. And another one for you, will the new 1915 C require?
372 reporting and quality reporting.

Cunningham, Curtis (CMS/CMCS) 38:21
Well, I think we'll have to take that back because obviously there's.
You know. Yeah, I think we need to take that back and consider it in the construct of

all the requirements under the 1915 C authorities.
Especially as it relates to some of the access rule work.

Wallace, Nick (CMS/CMCS) 38:43
Thanks, Curtis and Alina.
Looks like we have a couple of teed up for you related to the Royal Health Transformation Program.
One can you give any details on the rural Health transformation program as it relates to the Quality conference?

Pedersen, Alina Czekai (CMS/CMCS) 38:58
Sure. So we have a third day of the quality conference dedicated to the rural Health Transformation program.
So this invitation went out to all of our points of contacts working on the RHTP. Each state is invited to send up to four representatives.
And our program for the day will be introductions to the office staff kind of.
You know, overview of the office.
Updates on the program from a reporting rescoring perspective, and then we'll have a number of different panels where we'll be excited to hear from a handful of states on, you know, progress toward their initiatives.
And we'll also just generally use it as an opportunity for early lessons learned, requests for additional support from our office.
Technical assistance, things like that.
So we do have an inbox.
For the summit, I'm trying to find it really quick. The e-mail address.
It is RHTP summit at CMS dot A2 test Gov.
And again, that the audience is pretty limited to those working on the program. So I would encourage you to connect with your colleagues in the state who might already be registered to attend.

Wallace, Nick (CMS/CMCS) 40:37
Thanks, Alina. On tagging on to that? Emma asked.
Does the limit of the four staff apply to both the Quality Conference and the specific role Health Transformation Program Day?

Pedersen, Alina Czekai (CMS/CMCS) 40:48
Sorry, could you say that again, Nick?

Wallace, Nick (CMS/CMCS) 40:50
It says to the limit of four staff applied to both the Quality Conference and the Rural Health Transformation Program.
So I guess the question is, is go ahead.

Pedersen, Alina Czekai (CMS/CMCS) 40:58
Oh, I see.
Nope, that that 44 Max per state is limited to the rural health summit only.
I do believe.
There is a website for the CMS Quality conference.
I'm happy to send that to you so you can post it in the chat.
But I know that's a much, much, much larger conference than what my office is putting on.

Wallace, Nick (CMS/CMCS) 41:29
Thanks, Alina and another from Kristen for the Royal Transformation program.
Do you anticipate the spending for the zero year to start as soon as the CA is signed?
I'm sorry, Alina, if you're speaking, we can't hear you.

Pedersen, Alina Czekai (CMS/CMCS) 41:55
Oh, I'm sorry.
I thought that was a question for Kristen.
I'm sorry, could you repeat that, Nick?

Wallace, Nick (CMS/CMCS) 42:00
Oh, sorry. Do you anticipate the spending for the zero year to start as soon as the CA is signed?

Pedersen, Alina Czekai (CMS/CMCS) 42:09
As soon as the CA is signed, so states are again right now working on amending their first year budgets. So for year one of the program.

States have until.
End of October to expend their funds or distribute awards.
To any.
Vendors or contractors through procurement.
So, you know, states are all going to be on very different timelines in terms of when they start spending their money. One that will depend on when they finalize their budgets, have the necessary information to provide to the Grant's office to allow them to draw down fund.
But all funds have been distributed, you know, to the state accounts and the states are working with the Grant's office.
To be in a position to start spending.
Our goal is to do everything we can to support States and spending those funds because we want those dollars to be used, put to good work in the rural communities and have no risk of, you know, unspent funds which would be qualified for, for drawback at the.
End of the year.

Wallace, Nick (CMS/CMCS) 43:34
Thanks, Alina.
Kristen, it looks like this one for you is for you, for section 205. If your separate Chip population is only the fsep population, will you still be required to submit the revised CS31 forms?

Pacek, Kristin (CMS/CMCS) 43:51
That's a good question. And the answer to that is no.
It's only if you have a targeted low-income pregnant woman.

Wallace, Nick (CMS/CMCS) 44:02
Listen.
Thanks to everyone for your questions.
Those are ones we have queued.
We'll, we'll pause again for another 30 seconds or so to see if any more come in.
Pausing for justice a few more seconds before we potentially wrap.
See if any others come in at the end here.
The silence is deafening.

I think we can call it.
Thank you everybody for the discussion.
As a reminder, the slides from today's presentation will be posted on mediccave.gov in the next couple of days and then moving forward for the cadence for the rest of the year, you can put in your calendars that the Allstate calls will be held on the 4th. Tuesday of each month moving forward for 2026, which means that the date of the next Allstate call will be Tuesday.
February 24th leading up to that day.
We will send a call announcement with the agenda items for that meeting and of course between now and then feel free to reach out to us or your state leads or bring any questions to the next call.
Thank you again for joining and Marv, I think we can officially adjourn. Thanks, everybody.

Davis, Marvelyn (CMS/CTR) stopped transcription