Centers for Medicare & Medicaid Services
COVID-19: CMCS Medicaid & CHIP All State Call
May 25, 2021
3:00 pm ET

Coordinator: Welcome and thank you for standing by. At this time all participants are in a listen-only mode. During the Q&A session if you'd like to ask a question you may press star 1 on your phone. Today's call is being recorded. If you have any objections you may disconnect at this time. I'd now like to turn the call over to Ms. Jackie Glaze. 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 everyone, for joining today's all state call. On May 13, CMCS released a state Medicaid Director Letter on how states can receive enhanced funding provided through the American Rescue Plan Act of 2021, to increase access to home and community based services to Medicaid beneficiaries.

Section 9817 of the ARP provides states with the temporary ten percentage point increase to the Federal Medical Assistance Percentage or FMAP, for certain Medicaid HCBS services from April 1, 2021 through March 31, 2022, to improve HCBS under the Medicaid program.

HCBS benefits provide critical services to millions of older adults and individuals with disabilities, allowing them to receive health services in their homes and communities rather than in nursing homes and other institutions. The guidance is a key tool to assist states in leveraging federal resources to increase health equity in Medicaid beneficiaries' access to HCBS, providing health outcomes and community integration.

Jen Bowdoin and Ralph Lollar from our Disabled and Elderly Health Programs Group and Rory Howe from our Financial Management Group, will present an overview of the guidance. After the HCBS presentation we'll take your questions.

We'll use the webinar for today's 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 with our last all state call on May 11th. Instructions for joining the new platform were sent again, with the invitation for today's call, in case you weren't able to join our last call.

With that, I'll turn things over to Jen to start our presentation on the HCBS guidance. Jen?

Jen Bowdoin: Thank you Anne Marie. And hello everyone. My name is Jen Bowdoin. I am the Director of the Division of Community Systems Transformation in the Disabled and Elderly Health Programs Group. Thanks so much for taking the time to join us today.

On today's call, as Anne Marie mentioned, we are going to discuss the State Medicaid Director Letter that CMS recently released on the implementation of Section 9817 of the American Rescue Plan Act of 2021, which provides states with a temporary ten percentage point increase of the Federal Medical Assistance Percentage or FMAP, for home and community based services.

I'm going to walk through some of the key details in the later, the latest the FMAP increase including the services eligible for the increased FMAP, requirements for receiving the increased FMAP and activities that states can implement to enhance, expand, or strengthen HCBS under Section 9817.

Rory Howe from the Financial Management Group, will then talk about the process for claiming the FMAP increase. And after that, Ralph Lollar from the Disabled and Elderly Health Program will talk about an update to the retainer payment policy that was also included in the SMBL. And then we will open up the call for questions. Next slide please.

The ten percentage point FMAP increase under Section 9817, is available for Medicaid HCBS expenditures beginning April 1, 2021 and ending March 31, 2022. However, the increased FMAP for HCBS for any state or territory, cannot exceed 95%. Additionally, it's important to note that the federal funds attributable to the FMAP increase under Section 9817, will not be applied to the territories' payment limit.

The SMDL that we released on May 13th provides states with guidance on the implementation of Section 9817. It includes information on the eligible services for which states can claim the increased FMAP; requirements for states to receive the increased FMAP including required reporting to demonstrate that the state is meeting the requirements described in the (letter); the process for claiming the increased FMAP which is based on the claiming processes for Medicaid expenditures; and examples of activities that states can implement to enhance and expand or strengthen HCBS. Next slide please.

As required by Section 9817, the increased FMAP is only available for expenditures for certain Medicaid services. In Appendix C of the guidance we provide the list of services eligible for the FMAP increase. This list is largely based on the list of eligible services that was included in the statutory language for Section 9817.

These eligible services include home health, personal care, case management, rehabilitative services, Section 1915(c) waiver program Services, 1915(i) state plan services, 1915(j) (unintelligible) services, 1915(k) community first choice, and the program for all-inclusive care for the elderly. We've also indicated that private duty nursing services delivered in a beneficiary's home, are eligible for the increased FMAP.

These services were not explicitly called out in statute, however we have added them based on the authority of the Secretary, to specify additional services eligible for the enhanced funding. Next slide please. In the guidance we also clarify that states can claim the increased FMAP for eligible services authorized under alternative benefit plans.

Eligible services authorized under Section 1115 demonstrations, (full based) services that meet the definition of eligible services, and eligible services delivered under managed care. It's important to note however, that if states are claiming the increased FMAP for services delivered under managed case, they should claim only the applicable portion of the capitation rates that is attributable to the eligible services listed in Appendix C of the guidance.

And Rory will talk about this a bit more later on in the call. I also wanted to take a moment to acknowledge the concerns that we have heard from some states that Section 1115 demonstrations that include HCBS. We understand that states are concerned about the budget neutrality implications of the HCBS increased FMAP. So we will work with states to achieve budget neutrality if they have HCBS authorized under a Section 1115 demonstration. Next slide please.

So states need two main requirements to receive the FMAP increase. The first requirement is that states must supplement but not supplant state funds

expended for Medicaid HCBS in effect, as of April 1, 2021. We understand that states may experience enrollment in utilization fluctuations that are unrelated to changes in state policies and procedures. And we definitely have seen that during the COVID-19 public health emergency.

What we didn't want to happen was to penalize states if they had to decline an enrollment service utilization or expenditures that are unrelated to changes in state policies or procedures. And so to mee the requirements to supplement but not supplant the level of state funds expended for HCBS, states must do three things.

First, they must not impose stricter eligibility standards, methodologies or procedures, for HCBS programs and services than were in place on April 1, 2021. Second, they just preserve covered HCBS including the services themselves and the amount, duration, and scope of those services, in effect as of April 1, 2021. And third, they must maintain HCBS provider payments at rate no less than those in place as of April 1, 2021.

However, as we note in the letter, if states have implemented temporary changes to HCBS eligibility covered services and/or payment rates through the Appendix K template for Section 1915(c) waivers, a disaster relief state plan amendment for Section 1915(i) or K programs or in attachment K for HCBS services under an 1115 demonstration, states are expected to retain those changes for as long as allowable under those authorities.

However, CMS will not apply penalties or noncompliance restrictions on the receipt of the increased FMAP once the authority for those temporary changes have expired or if the state needs to implement changes to comply with other federal statutory or regulatory requirements. Next slide please.

The second requirement that states need to meet is that states need to use state funds equivalent to the amount of funds, federal funds they receive as a result of the increased FMAP, to implement or supplement the implementation of one or more activities to enhance, expand or strengthen HCBS under the Medicaid program.

To demonstrate that the additional funds are spent on activities that enhance, expand, or strengthen HCBS, states must submit initial and quarterly funding plans and narratives to report on anticipated and actual spending on their activities, to expand, enhance or strengthen HCBS. And they must meet these quarterly reporting requirements until the funds attributable to the increased FMAP, are fully expended. Next slide please.

We are not requiring states to use a specific template for the spending plan's narrative. So states can submit them in a state preferred format. In the guidance we have indicated that the initial HCBS spending plan's narrative are due within 30 days of release of the guidance and that CMS will view state submissions within 30 days.

On the call today we are however clarifying that states can request an additional - can request a 30-day extension to submit the initial spending plan and narrative within 60 days. It is important to note however, that states must comply with the reporting requirements in order to receive the increased FMAP.

As a result, if a state requests and extension this will have implications for when the state can begin to claim the increased FMAP. And Rory, I think will talk about this more in a few minutes. When submitting the initial HCBS spending plan and narrative, the states should also submit a letter signed by the state Medicaid director that provides a designated state point of contact for

the quarterly spending plan and narrative submissions, along with assurances that the state is meeting the requirements of Section 9817.

These are just - these assurances the states need to include both in the initial spending plan - with the initial plan and narrative and with the quarterly submissions are listed in the guidance. And we'll just go through them quickly here.

So specifically the state will need to provide assurances that is doing five things - first, that is using the federal funds attributable to the increased FMAP to supplement and not supplant existing state funds expended for Medicaid HCBS in effect, as of April 1, 2021.

Second, that the state is using state funds equivalent to the amount of federal funds attributable to the increased FMAP, to implement or supplement the implementation of one or more activities to enhance, expand or strengthen HCBS under the Medicaid program.

Third, that it is not imposing stricter eligibility standards, methodologies or procedures, for HCBS programs and services that were in place on April 1, 2021. Four, that is preserving covered HCBS including the services themselves and the amount, duration and scope of the services in effect, as of April 1, 2021.

And finally, that it's maintaining HCBS provider payments at a rate no less than those in place as of April 1, 2021. States should submit the initial spending plan and narrative along with the letter from the state Medicaid director, to the dedicated mailbox that we have created for implementation of Section 9817.

This mailbox is included in the guidance. We've included the email address. And it's also included on the screen. But for anybody who needs it, it is HCBSIncreasedFMAP@CMS.HHS.gov. Again, that's HCBSIncreasedFMAP, and that's all one word, no spaces, no underscores, at CMS dot HHS dot gov. Next slide please.

In addition to the initial spending plan and narrative, states must also submit quarterly spending plans and narrative to report on anticipated and actual spending on their activities to expand, enhance, and strengthen HCBS. States use these submissions to update and modify the information reported in the initial spending plan and narrative, and in any prior quarterly submissions.

The first quarterly spending plan's narratives are due 75 days prior to the meeting of each federal fiscal quarter, beginning with the quarter that starts on October 1, 2021 and until the state funds in an amount equivalent to enhanced FMAP received by the state, have been expended.

As with the initial spending plan and narrative, states should provide with the quarterly submissions, assurances that they are meeting the requirement of Section 9817. And again, there are more details in the letter on specifically what states need to include for assurances.

States must comply with the reporting requirements in order to receive the increased FMAP. And as we note in the SMDL, failure to follow the required steps for receiving the increased FMAP, could result in a deferral or disallowance of certain expenditures.

To increase transparency, we plan to publicly post information reported by states on their initial and quarterly spending plan's narrative. Including the amount of funds attributable to the FMAP increase, state anticipates claiming

or has claimed any activities the state intends to implement or has - and has implemented to enhance, expand or strengthen HCBS under the Medicaid program. Next slide please.

Under Section 9817 states can implement a variety of activities to enhance, expand, or strengthen HCBS. In Appendix C and D of the guidance we provide a number of examples of activities that the states can initiate part of this opportunity. These examples are not intended to be exhaustive, but they include a broad range of activities to address COVID related concerns, to promote HCBS capacity building and infrastructure development activities, and to pursue innovative LTSS rebalancing strategies.

For example, these activities include increasing the number of HCBS waiver spots to reduce or eliminate waiting lists, increasing provider payment rates, to providing paid sick leave, paid family leave, and paid medical level for home health workers and direct support professionals. Activities to recruit the number of paying direct support professionals. COVID-19 related training for home health workers. Assistive technologies for people with disabilities. One time transition costs and other transition support, to help individuals transition from institutional settings to the community.

Providing additional caregiver support versus training and respite. And support to help individuals with HCBS needs to access COVID-19 vaccine, such as transportation to vaccine sties or the implementation of in home vaccination options. States have until March 31, 2024 to fully spend these funds on activities to enhance, expand or strengthen HCBS.

So just to be clear states can claim the increased FMAP for expenditures between April 1, 2021 and March 31, 2022. They have two full years after

that period until March 31, 2024, to fully expend the state funds equivalent to the amount of federal funds attributable to the increased FMAP.

We believe that this additional time period to expend the funds attributable to the increased FMAP will provide states with sufficient time to design and implement short term activities, to expand the - activities to strengthen the HCBS system in response to the COVID-19 public health emergency as well as longer term strategies to enhance and expand the HCBS system and to sustain promising and effective programs and services.

This time period also aligns with the two year time period during which states may claim - file claims for federal financial participation for Medicaid expenditures, which means that states will have sufficient time to demonstrate they have fully expended the funds attributable to increased FMAP for claims paid through March 31, 2022.

As part of the activities to enhance, expand or strengthen HCBS, the states are making changes to an HCBS program that operates under a Medicaid authority. States should follow the applicable rules and processes that apply to the Medicaid authorities. And we will do our best to process these actions as expeditiously as possible. And we would encourage states to flag them as 9817 actions so that we can be sure to quickly identify them and prioritize them as needed.

While states are not required to use the funds to pay for Medicaid covered services, I do want to note that states may use the funds to pay for additional Medicaid covered HCBS. And in turn, they may be eligible for the increased FMAP on those expenditure one additional time.

However, if a state has reinvested those funds once, the state should not claim the increased FMAP, a Medicaid covered HCBS for subsequent expenditures occurring between April 1, 2021 and March 31, 2022. And in the guidance we provide an example in Appendix C of how a state could reinvest the funds attributable to the increased FMAP and additional Medicaid covered HCBS to receive additional federal funds. Next slide please.

I'm now going to hand the call over to Rory Howe from the Financial Management Group, who will talk about the claiming process. Rory?

Rory Howe: Thanks, Jen. And good afternoon everyone. As Jen mentioned during her portion of the presentation, the full federal funding associated with the FMAP increases, is closely connected at the state completing the initial spend plan and narrative. And so once the state completes that initial spend plan and narrative, CMS will provide advanced grant award funding associated with the increased FMAP to states, through our regular process for state quarterly budget estimates, submitted through the Form CMS 37.

So depending upon timing of when this is completed for qualifying states, we do recognize that states might need to request this advanced funding through a supplemental grant award request which is something that we're ready to accommodate and work with states on to make sure that you get the funding as soon as you qualify.

And again, once the states have committed or have completed the initial spend plan and narrative, and are ready to request the advance funding associated with the FMAP increase through either the 37 form or through the supplemental grant award request, we are asking that states provide us with a breakout of the portion of those expenditures that are associated with the

increased FMAP when you submit your budget submission, including on the CMS 37s.

And we recently detailed this in our quarterly budget instructions that we provided to states. In addition to the advanced funding that we'll provide associated with the FMAP increase through the budget estimate process, we'll ultimately provide a final FFP and reconcile that advanced funding to expenditures reported on the CMS 64. Next slide please.

So we are currently working to modify the CMS 64 in the Medicaid budget and expenditure system to reflect the increased FMAP. Associated with this provision and incorporate modified reporting. So we're committed through incorporating these updates as soon as possible, and we're trying to make them as seamless as possible for all of our state colleagues to make sure that they're user friendly and intuitive.

So there are a few key items on the expenditure reporting that we'd like to note today. You know, first again, as we move quickly at - to update the system to align with the guidance and enable reporting, it is possible that we won't be finished the updates in time for expenditure reporting on the June 30th quarter ended CMS 64.

If that is the case states may need to work with us and submit prior period adjustments in MBES once the system updates are completed, so that we can reconcile the initial funding that we provide to states for the increased FMAP with the actual expenditures that are reported.

I did also want to note for managed care, as is noted in the State Medicaid Director letter that states will be required to allocate any qualifying managed care expenditures that - to ensure that the portion of the capitation rates

associated with HCBS services that are eligible for the increased FMAP, are allocated appropriately.

And I think finally, I did want to mention that once we've completed our updates and modifications to MBES, we do intend to provide additional technical training for states broadly, on the updated reporting and are certainly available to technical assistance through your regular CMS 64 reporting process.

And with that, I'd like to turn it over to Ralph Lollar.

Ralph Lollar: Hi folks. This is Ralph Lollar. I'm glad to be speaking with you now to share the following information regarding retainer payment policy. The COVID-19 public health emergency is unprecedented in the time period and we are now in the second year.

With that in mind, CMS updated our policy on retainer payments to allow states to offer up to three additional 30-day periods in calendar year 2021, which means that those retainer payments can be retroactively effective through January 1, 2021. And the requirement that the guardrails be in place as indicated and referenced in the frequently asked questions issued on June 30, 2020 will continue to apply to the retainer payments authorized in 2021.

And the states should affirm that in their Appendix K application for the utilization of those retainer payments or in whatever disaster application they are completing for the appropriate authority. This will allow states' funding, particularly for providers who are reopening settings and are only able to do partial attendance for periods of time, due to the need for social distancing, and in order to be respectful of the precautions to be taken during this PHE.

Thank you. Jen, I believe I turn it back to you now.

Jackie Glaze: Thank you Ralph. And thank you Rory and Jen, for your presentations. So we're ready now to move to the question session. And we have already started receiving a number of questions through the chat function. So those of you that would like to submit your questions, you may do so now, and then we'll follow with questions over the phone lines. So I'll now turn to Ashley.

Ashley Setala: Thanks, Jackie. So the first question that we received says could a state use the funds to purchase onetime items for those on HCBS waiver waiting lists but not yet enrolled in an HCBS waiver for the purpose of reducing risk of institutionalization?

Jen Bowdoin: Ralph, do you want to take that?

Ralph Lollar: Sure, Jen. I think that that is a proposal that we would certainly consider. And it's something that a state should, if they're wishing to do so, include in their plan.

Ashley Setala: Okay. Thanks, Ralph. The next question says, can a state accept only a portion of funds and not claim the full FMAP increase?

Jen Bowdoin: Rory, do you want to add anything related to this? If not, I think we can follow up on the call next week, related to this one.

Rory Howe: I think we should follow up on the call.

Jen Bowdoin: Okay. Thanks.

Ashley Setala: Okay. Then the next question says how should states handle situations where the state has an HCBS service in a state plan? For example, adult day health services that is not in the rehabilitative line but instead listed under the preventive services section of its state plan. How should a state go about obtaining the increased FMAP for this HCBS service?

Jen Bowdoin: Unless Rory wants to respond to it I think we'll need to follow up on that one as well.

Rory Howe: I think that's right. And I think just a reminder, that we are still finalizing all of the reporting requirements in the CMS 64 and do plan to provide more specific instructions in the coming days.

Ashley Setala: Okay. Then the next question says is the requirement to preserve services, eligibility standards and payments, required through March 31, 2022 or through the period in which the state is expending state funds attributable to the increase in FMAP?

Jen Bowdoin: It is until states have actually expended the funds that are attributable to the increased FMAP.

Ashley Setala: Okay. Then it looks like we have a question that's asking for the clarification - for a clarification on part of the presentation. And it says can you please repeat if states request the 60 day extension for submitting the initial state plan what was the impact on when the money could then be expended?

Jen Bowdoin: So I will clarify, states can request an extension to submit within 60 days so they can request an additional 30 days. But Rory, do you want to clarify what the impact is just in terms of when states can claim for the increased FMAP if they request an extension for submitting the spending plan and narrative?

Rory Howe: That's right. So on a quarterly basis, CMS provides state funding through budget estimates the states provide through the Form CMS 37 or through supplemental grant award requests. And in order for us to provide advanced grant award funding associated with the increased FMAP, it is a condition as outlined in the State Medicaid Director letter that states submit a completed initial spend plan and narrative.

So in order to receive that advanced grant funding that's associated with the FMAP increase, states would need to do so. So if they request an extension for their spend plan, it could affect the timing of when states can receive that advanced grant funding.

Ashley Setala: Okay. Then we have a question that says may states expend the increased FMAP to strengthen HCBS services outside the Medicaid program?

Jen Bowdoin: So the statute requires that those activities expand, enhance or strengthen HCBS under the Medicaid program. And so there have to be a direct connection to the Medicaid program. You know, as states we're certainly happy to talk with the states if they want to share more information on, you know, specifically what they have in mind and, you know, they can demonstrate to us why a particular activity would expand, enhance or strengthen HCBS under the Medicaid program.

But by statute, it is required to have a direct connection to the Medicaid program.

Ashley Setala: Okay. Then we have a question asking for a clarification on the requesting an extension on the submission of the plan. Can you please repeat what's required to request the extension?

Jen Bowdoin: States should contact the mailbox and just request the extension through there. And also just indicate, you know, when they would like the extension until. Do they want the full additional time period or did they just need an additional say 15 days? But they should just - they should be sure to contact us through the mailbox.

Ashley Setala: Okay. Then we have a question that says does the requirement around maintenance of covered benefits including scope, etc., mean only that states can't reduce the scope of their covered benefits package, or does it mean that states can't make any reductions in the benefits a person is receiving, even based on medical necessity or a reassessment of level of care needs?

Jen Bowdoin: Ralph, do you want to respond to that?

Ralph Lollar: Sure. I was just going to offer. What we can say is this - that this requirement does not require an individual to continue to receive services that the individual does not demonstrate need for and/or does not meet the level of care for.

Ashley Setala: Okay. Then we have a question that says will expenditures from Section 9817 of the ARP, be exempt from budget neutrality for states operating programs under the umbrella of the 1115 waiver? Many states are awaiting further guidance on this issue prior to making final decisions on implementation.

Jen Bowdoin: So, you know, we've included some information in the guidance related to budget neutrality. But, you know, we understand that states have a number of questions related to this. I would encourage states to reach out to the state demonstrations group and raise the questions and talk it through with them.

We are committed to helping states achieve budget neutrality. But, you know, we really need to work directly with the states on that, and so we just encourage the states to reach out to the appropriate contacts at CMS, related to questions about budget neutrality.

Ashley Setala: Okay. Thanks, Jen. Then the next question says if a state requests and is granted an extension of 30 days, it would put the initial spending plan due around July 11th. This would be within a week of when the first quarterly report is due, 75 days prior to October 1, 2021. Is it expected that a state in this circumstance will need to submit two reports or simply submit one covering both requirements?

Jen Bowdoin: Depending upon the timing, it's likely that the state would only need to submit one, but I think we'll confirm with states as they request an extension. That, you know, in terms of what the expectation would be for that first quarterly submission.

Ashley Setala: Okay. Then we have a question that says additional Medicaid covered HCBS can be reinvested once. Would this include rate increases to HCBS providers if those increases take effect between April 1, 2021 and March 30, 2022?

Ralph Lollar: Rory?

Jen Bowdoin: Rory, do you want to take that?

Rory Howe: So I mean the answer is yes. So out of the extent that the services are eligible for the increased FMAP reinvestment expenditures can qualify also to receive that increased FMAP. And I will note that if that does occur the state funds that are equivalent to the increased FMAP that is made available on those

reinvestment expenditures is also required to be reinvestment - is also required to be reinvested but that is not eligible for the increased FMAP any further.

So it's really just one time for reinvestment expenditures can a state receive the increased FMAP for those expenditures to be accepted that they qualify. And I will say that this is a particularly complicated piece of the letter and the guidance I think will include more information in reporting instructions and certainly we'll make ourselves available to states to provide technical assistance as necessary.

Ashley Setala: Okay. Then we have a question that says does the requirement around maintaining payment rates preclude any movement towards value based payment if such a change could result in lower performing providers receiving a lower payment?

Ralph Lollar: Jen, if you want me to weigh in here…

Jen Bowdoin: Yes.

Ralph Lollar: …it's Ralph. And what I would say is that that's really an issue that needs to be discussed on a case by case basis with the state, as those conditions are different based on what the state is doing and how they are effectuating it.

Ashley Setala: Okay. Then we have a question that says how does the new MOE apply in instances where a state is bringing on new managed care plans in 2022?

Jen Bowdoin: So I think, you know, I would encourage any state in that situation, to reach out to CMS and we will work with you on that. I think there are potentially a lot of variables there and so probably need to just work with the state directly in terms of ensuring that the state's able to meet those requirements.

Ashley Setala: Okay. And we have a question that says how long must the five assurances be met?

Jen Bowdoin: Until the funds are fully expended. And so if a state takes until the full period of time, until March 31, 2024, they have to continue meeting them until that time period. If a state for instance, we've gotten some questions from some states that are interested potentially in being able to do that in a much faster timeline, say during that first year, until March 31, 2022.

In that case if a state was able to do that, then those requirements would carry through until, you know, they had fully expended the funds, so in that case, March 31, 2022. But it's really going to be, you know, largely dependent on how fast the states expend the funds.

Ashley Setala: Okay. Then we have a question that says when will additional guidance about claiming and allowable activities be available?

Jen Bowdoin: Rory?

Rory Howe: Regarding claiming on the CMS 64, again we're working to implement modifications into the system as soon as we possibly can. And as soon as we have more information on timing of when that'll be available and when we'll be able to provide some additional training and information to states we will let everyone know.

Ashley Setala: Okay. The next question says, can a state submit a proposal to CMS which is contingent upon legislative approval?

Jen Bowdoin: Ralph, did you want to respond to that?

Ralph Lollar: Sure Jen. Absolutely. The state just needs to be prepared and ready should they not get the legislative approval to adjust the plan accordingly to ensure that they are doing or incorporating some other activity that will supplement not supplant. And continue to enhance HCBS. So they'll still have to meet the requirements if the - if legislative approval is not received but they can change the goal or the activities to meet those requirements.

Jen Bowdoin: And just to be clear, this has come up where we've gotten some questions. It can definitely modify their spending plans and narrative. So for instance, if a state, you know, was trying to get legislative approval to do something, didn't get legislative approval and then needed to shift to a different set of activities, they can absolutely use their quarterly spending plans and narrative to provide updates on any changes to the activities that they had planned to implement.

Ashley Setala: Okay. Then we have a question that says can a state implement onetime spending initiatives that therefore do not need to be sustained after March 31, 2024?

Jen Bowdoin: Ralph, do you want to take that?

Ralph Lollar: Sure. And the answer to that is yes, but we want to encourage states to use the money wisely and where they can, to invest in activities that can be sustained as the state moves forward in their work on ensuring the enhancement of home and communities based infrastructure and services and support.

Ashley Setala: Okay. Then we have a question that says if there are behavioral health services that are not in the rehab section of the state plan that are in the other licensed practitioner section, are they included as HCBS?

Jen Bowdoin: Unless Ralph or Rory want to jump in here, I think we'll need to take that one back.

Ashley Setala: Okay. Then we have a question that says could a state use the funds to develop infrastructure such as small waiver home for IDD?

Ralph Lollar: Can you repeat that?

Ashley Setala: Sure. It says could a state use the funds to develop infrastructure such as small waiver homes for IDD?

Ralph Lollar: If they're increasing settings, providers, or capacities to serve individuals who are receiving Medicaid funded home and community based services, the answer is yes. And it would appear that that answer to that question with that framing, would be yes.

Ashley Setala: Okay. Then we have a question. Oh, go ahead.

Jackie Glaze: I was going to say let's transition to the phone lines for a few minutes to see if we have questions there. And then we'll revert back to the chat questions. So I'll ask the operator if you could provide instructions to the participants to ask their questions over the phone lines. And then we'll take a few questions.

Coordinator: Sure. I'm not showing any questions over the phone yet. But as a reminder, if you would like to ask a question over the phone please press star 1 and record your name. Thank you.

Jackie Glaze: Operator, are you seeing any questions?

Coordinator: Yes. There is one in the queue from (Michael Love). Your line is now open.

(Michael Love): Yes, hello. Could you please clarify with respect to school based services the description in the appendix seems to reference all medical assistance services covered under Section 1905(a) that are included in the IDA plan. But then the final paragraph in that same setting seems to limit that statement by claiming that the only services that would be eligible for increased FMAP have to be included in the appendix.

By saying to be listed in the appendix, is that meant to say that they're otherwise listed in this appendix, or is the reference above to all medical assistance covered under an IDA plan sufficient?

Jen Bowdoin: So school based services that meet the definition of eligible services can be claimed. So another way to say that is if the services are otherwise listed in the appendix. So it would have to meet the requirements of one of the other services listed and then the state could claim that particular service. All school based services are not necessarily eligible for the increased FMAP.

Rory, Ralph, do you want to add anything else here?

Ralph Lollar: Jen, I think you've covered it.

(Michael Love): So I guess for clarification, what you're saying is if it's school based services that are in the nature of rehabilitative or in the nature of private duty nursing, those would be eligible but it's not a school based service otherwise captured by one of these categories, then it's not eligible. Is that right?

Jen Bowdoin: Yes. That's correct. Ralph, do you want to add anything else related to this?

Ralph Lollar: If it's not captured he's absolutely correct.

(Michael Love): Okay. Thank you.

Ralph Lollar: No problem. Thanks for the question.

Coordinator: I'm showing no further phone questions at this time.

Jackie Glaze: Thank you. So Ashley, I'll turn back to you at this point.

Ashley Setala: Okay. So we have a question about is a state able to use enhanced FMAP to fund already anticipated funding growth in qualifying HCBS as opposed to wholly new uses as it relates to ensuring services and access for new and existing HCBS recipients?

Ralph Lollar: Read the first part of the question again - to fund…

Ashley Setala: To fund already anticipated funding growth in qualifying HCBS as opposed to wholly new uses.

Jen Bowdoin: I think we would - Ralph, you may want to jump in on this but I think we would need more information from the…

Ralph Lollar: Yes.

Jen Bowdoin: …(city) just in terms of exactly what that means. And what the state would plan to do. And so, you know, the state can certainly reach out to us. Just send a question to the mailbox and we're happy to kind of handle it directly with the state.

Ralph Lollar: Yes. I absolutely agree.

Ashley Setala: Okay. Then we have a question that says please clarify the start date for claiming if a state submits the 30-day extension for submission of the initial spending plan.

Jen Bowdoin: Rory, do you want to take this?

Rory Howe: Sure. So in terms of starting to actually submit the claims in the CMS 64, typically that happens, you know, after the state makes the expenditures. So I mean I don't know that the spend plan will necessarily affect that, depending upon timing. But the bottom line is again, to qualify either for the advanced grant award funding or FFP associated with actual expenditures claim than the 64, you'll need to make sure that that initial spend plan and narrative are in.

So that sort of drives the timing and you should be requesting advanced grant award funding through budget estimates or supplemental grant awards or reporting expenditures on the CMS 64.

Ashley Setala: Okay. Then we have the question that says under Section 1915(c) are all home and community based waivers eligible for the increased FMAP or are some excluded? Are all report line impacted or just a subset that gets the increased FMAP?

Jen Bowdoin: Ralph, do you want to take this or would you like me to?

Ralph Lollar: If the funding - if it's the funding for 1915(c) services and supports, they're included in the increased FMAP. Jen? Anything further?

Jen Bowdoin: Yes. That's - yes, that's correct. So all of the 915(c) waiver services are eligible for the increased FMAP. Can you repeat the second part of that question?

Ashley Setala: Sure. It said are all report lines impacted or just a subset that gets the increased FMAP?

Ralph Lollar: Rory, I think that is a question regarding the 64 reporting lines.

Rory Howe: Yes. And if you are referring to the CMS 64 and again, we're still in progress in making the updates to the CMS 64. So once we have more information again, we'll share and provide additional details.

Ashley Setala: Okay. Then we have a question that says how should a state handle private duty skilled nursing services if they are provided through the state plan and not a home and community based waiver?

Jen Bowdoin: Those services are eligible through the increased FMAP. I'm not quite sure if I understand if there's kind of more to the question, if it's related to claiming. So Rory, is there anything just in terms of claiming that you would want to add there?

Rory Howe: Again, I don't think so at this point.

Ashley Setala: Okay. Then we have a question that says if there was a prescheduled rate reduction plan prior to the PHE and passage of the ARP, would continuing with this planned reduction jeopardize the state getting the enhanced FMAP?

Ralph Lollar: That is an issue which probably - which definitely should be handled on a case by case basis. The state should reach out to the CMS point of contact to schedule a meeting.

Ashley Setala: Okay. Then we have a question that says like many states, we need legislative authority for new Medicaid expenditures to make the investments required to qualify for the enhanced FMAP. If there are outstanding decisions on a portion of the required spending, what level of detail in the spending plan is needed to satisfy CMS requirements?

Ralph Lollar: Jen, do you want me to start and you'll…

Jen Bowdoin: Yes. Yes. Go ahead, Ralph.

Ralph Lollar: The plan should at a minimum indicate the percentage or portion that you are seeking legislative approval and - to your - the best of your knowledge, what those activities will be that you're going to seek legislative approval for. If they are unknown because you're seeking public input at this time, then you include that information and at the same time, include the percentage or amount that is being held in reserve for those activities. Jen?

Jen Bowdoin: Yes, that's right. And, you know, if - states should provide as much information as they have available. If the state is not able to provide some information or has limited details because for instance, it's waiting for legislative approval, you know, I would encourage a state to clearly indicate what the reason is why the state doesn't have full information.

And then also to indicate, you know, what the timeline is that they anticipate being able to provide more information. And if we need more details we will certainly follow up with the state to try to get more information.

Ashley Setala: Okay. Then we have a question that says, does CMS have to formally approve the HCBS spending plan? And if so, what is the anticipated turnaround of these approvals?

Jen Bowdoin: Yes. We need to approve them and we indicate in the SMDL that assuming what the state submits meets the requirements, we will review and approve those within 30 days. And so we will get back to states within 30 days of submission.

Ashley Setala: Okay. Then we have a question that says if a state has enhanced rates in effect as of April 1st through Appendix K, does the guidance require that these enhanced rates continue?

Ralph Lollar: If the state has an enhanced - has a rate increase that was defined in the Appendix K that is specific to the Appendix K, is not in the base waiver and has a termination date, that termination date will still stand.

Ashley Setala: Okay. Then we have a question that says if your waiver services already provide for variable rates cost of doing business adjustments, funding limitations, etc. can providers get paid less than they did on April 1st as long as the waiver rates and assumptions have not changed?

Jen Bowdoin: Ralph do you want to take that?

Ralph Lollar: Sure. I'm going to say that there are too many unknowns in the question for me to give you a definitive answer. I think it is going to be important to speak to CMS about that. The question appears to be if the state is adhering to their rate methodology and the components thereof, will there be a penalty if the

rate methodology - adherence to that rate methodology results in a lowering of the current rate?

We need to have that discussion with the state because there's additional information we're going to need in order to make that decision.

Jackie Glaze: Thank you, Ralph. And we did receive a lot of questions today. We appreciate your questions. We weren't able to answer all of them so we will work on getting responses out to everyone. So at this point, we're ready to - for the closing, so I'll turn to you, Anne Marie.

Anne Marie Costello: Thanks, Jackie. And I want to thank all of our presenters for their excellent presentations and information. As Jackie said, we realize we did not get to all of your questions, but we'll get back to them and provide some follow up answers in forthcoming meetings.

Looking forward, we will meet with you again on June 8th. The topic and invitation will be forthcoming. Of course as questions come up between these calls just reach out to us, your state leads, or bring the questions to the next call. If you'd like to please submit a question to the open Q&A portion of our next all state call, you can email it to MedicaidCOVID19@CMS.HHS.gov.

Again, that's MedicaidCOVID19@CMS.HHS.gov, by 1:00 pm Eastern on the day of the call. Thanks again, for joining us today and look forward to meeting with you in the future. Bye.

Coordinator: This concludes today's call. Thank you for your participation. You may disconnect at this time. Speakers please standby.

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