Centers for Medicare & Medicaid Services

COVID-19 Medicaid & CHIP All State Call

January 25, 2022

3:00 pm ET

Coordinator: Today's call will now begin. All lines have been placed on a listen-only mode until the question-and-answer session. At that time if you would like to ask a question, you would press star 1 and record your name when prompted. If you need to withdraw that question, you would press star 2. Today's call is being recorded. If there are any objections, please disconnect. And I will now turn the call over to Jackie Glaze. Thank you. You may begin.

Jackie Glaze: Thank you and good afternoon, everyone, and welcome to today's All State Call-In Webinar. I'll now turn to Anne Marie Costello, our Deputy Center Director for opening remarks. Anne Marie?

Anne Marie Costello: Thanks, Jackie, and hi, everyone. Excuse me. Welcome to today's all state call. First up, Stephanie Kaminsky from our Financial Management Group will provide an overview of administrative claim and requirements for the new Medicaid State Plan option authorized by the American Rescue Plan to provide community-based mobile crisis intervention services.

Rachel Dressel from our State Plan Amendment Process Improvement Team will present an overview of the new process for certain key state plan amendment submissions to CMS that will be effective on February 1st. Finally, Sara Harshman from our Center Director's Office and John Giles from our Disabled and Elderly Health Programs Group will present a couple of additional frequently asked questions that CMS has received since the December announcement that CMS is now requiring states to cover certain Medicaid COVID-19 vaccine counseling visits in which healthcare providers talk to families about the importance of kids vaccination.

After the vaccine FAQs, well open the lines for your questions. Well use the webinar for our Mobile Crisis Plan - Mobile Crisis Claiming and SPA portal submission presentations today. So if you're not logged in to the webinar platform, I suggest you do so now.

Before we start today's presentation, I wanted to share a couple of announcements. First, on a previous all state call, we had noticed that expenditures for services delivered in IMDs are not eligible for the increased federal medical assistance percentage or FMAP for home and community based services under Section 9817 of the American Rescue Plan.

Today, we're clarifying that if a state is appropriately claiming for their services under the Rehabilitative Services Benefit or another authority in Appendix B of the State Medicaid Director letter 21-003, such as an approved Section 1115 demonstration, authorizing federal reimbursement of services provided to individuals and IMDs that these services are eligible for the increased FMAP.

This is because the ARP identified specific benefit categories such as rehabilitative services as eligible for the increased FMAP without any differentiation by place of service. The only exception to this is private duty nursing delivered in the beneficiaries home, which was not identified in the statute as eligible for the increased FMAP, but instead was included in Appendix B at the discretion of the Secretary of Health and Human Services.

However, we are further clarifying that activities focused on or implemented in IMDs or other institutional settings are generally not approvable in states ARP Section 9817 Spending Plan as activities to be funded through state funds equivalent to the amount and the increased FMAP unless the state can

demonstrate that the activity supports institutional diversion or community transmission, or otherwise support the intent of ARP Section 9817.

If states have questions about whether a particular activity is approvable, please contact your spending plan reviewer or email us at HCBSincreasedFMAP@cms.hhs.gov.

Then we also wanted to let you know that CMCS recently released a resource for states entitled, The State Guide to CMS Criteria for Medicaid Managed Care Contract Review and Approval that outlines the standards by which we review state managed care contract.

The intention of this guide is to provide transparency on the criteria that CMS uses for contract approvals that help states verify that their contracts comply with federal requirements before seeking CMS approval. The guide has been updated to incorporate changes to the federal managed care regulations that are occurring as a result of the 2020 Managed Care Final Rule, which includes revisions pertaining to pass-through payments, state directed payments, network adequacy standards, risk sharing mechanisms, appeals and grievances and requirements for beneficiary information.

The state guide describes each federal requirement the type of managed care plans to which the requirement applies and the requirement effective date. This guide is an update to the 2017 state guide and applies to contract action with the effective start date on or after December 14, 2020. The updated state guide has been posted on the Managed Care Contract Review Guidance Page on Medicaid.gov.

With that, I'll turn things over to Stephanie to start her mobile crisis administrative claiming presentation. Stephanie?

Stephanie Kaminsky: Thanks, Anne Marie. So hello, everybody. Good afternoon. Today we are going to talk about or I'm going to talk about a continuation of a presentation that was made two weeks ago about mobile crisis intervention services.

As you are likely aware, we issued a Medicaid show letter back in December at the end of last year that explained our outlook that's in the next slide that Section 9813 of the ARP authorizes a new Medicaid state option to provide community-based mobile crisis intervention services. And that's from April 1, 2022 to March 31, 2027. The law authorizes 85% FMAP for expenditures on qualifying community-based mobile crisis intervention services for the first 12 fiscal quarters within the five-year period.

Next slide, please. So as I was saying, we put out a show December 28, 21 and in that show we set forth Medicaid guidance on the scope of and payments for qualifying community-based mobile crisis intervention services authorized under Section 1947 of the Act.

And just big picture, the components of the effective crisis system include 24/7 crisis line, 24/7 mobile crisis response and crisis stabilization program.

Next slide. So the - one of the interesting things, at least from my perspective, about the mobile crisis, there are many interesting things about the sho, but one of them is that the administrative claiming match for state Medicaid agency cost is available, and these are for costs associated with establishing and supporting community-based mobile crisis intervention services for people with mental health conditions, including SUD, substance use disorders, and operating state crisis access lines such as triaging calls and dispatching mobile crisis teams as needed to assist Medicaid beneficiaries.

And what was not said in the letter but what we're going to talk about today is that when we're talking about operating state crisis access lines, we are including connecting to the 988 National Suicide Prevention Hotline, which we'll talk about a little bit more in a moment.

And just a reminder that Section 1903-A7 of the Act, direct payment of FFP at 50% for amounts for administrative costs, which are found necessary by the Secretary to the proper and efficient administration of the state plan. So essentially, what we're saying here is that there's a new state plan service and there can be some administrative costs associated with that service and there can be a match for that administrative cost.

Next slide, please. So a little background on the National Suicide Prevention Lifeline, that's a national network of approximately 185 local and state-funded crisis centers. Currently, it provides free and confidential emotional support 24 hours a day, seven days a week to people in suicidal crisis or emotional distress anywhere in the U.S.

It fielded an old statistic here, 2.2 million calls, texts and online chats in 2020. And remember that 2.2 in the moment. The lifeline routes calls to local crisis centers, but redirects those calls to other crisis centers if there's insufficient local capacity to field a call in real-time.

Next slide. So in 2020, in July 2020, the FCC adopted rules to establish a new 988 nationwide easy to remember phone number for Americans in crisis to connect with suicide prevention and mental health crisis counselors 24/7. And in this coming July, in a few months, the current National Suicide Prevention Lifeline will be accessible by dialing 988 from any landline or cell phone in

the U.S. and dialing 988 will connect individuals to a staff trained to answer calls related to mental health crisis and substance use-related emergencies.

And there will be, you know, specially trained individuals to help veterans, LGBTQ plus individuals and other underserved groups with their specific challenges. And this 988 line is expected to receive 24 million calls, texts and online chat requests by 2027, so we're expecting quite a bit of growth there.

Next slide, please. So what are the funding sources? How are we, how are state going to be funding all of this activity? State and local governments are braiding different sources of funds, Medicaid, federal grant funds, state and local funding. There are grants that are providing large amounts of the funding, some private donations, Medicaid VA, grants, contract moneys from SAMSHA, Community Health Center funding from HRSA; a number of sources.

And the 988 federal law allows states to require a surcharge on wireless telecommunications services and various states are in various stages of moving state legislation through to allow that type of surcharge.

Next slide. So what are the considerations for Medicaid claiming here, especially administrative claiming? So as I said, states may want to claim as Medicaid administrative expenditures, costs of operating the local call centers, things like connecting to the - oh, I'm sorry, connecting local call centers to the national line and staffing costs and all the other pieces that we'll get into that are part and parcel of standing up one of these local and operating one of these local call centers.

And so I say here CMS will review state allocation methodology proposals, which is true. But before I say that, I'd like to insert that as many know, in

order to claim (mid-match), states must submit for what we call PACAPs, Public Assistance Cost Allocation Plans to the program - PSC, the HHS PSC Program Support Center who has the responsibility to review and approve those admin-claiming proposals.

In addition, states should submit to CMS Medicaid administrative claiming proposals, as states do with all other administrative cost proposals and claiming that they do. We will review state allocation methodology proposals using our usual administrative claiming criteria and so it will cost allocation principles as are set forth in 45 CFR 75.

And the basics of the cost principles are that the Medicaid expenditures must be reasonable, allowable and allocable. Administrative expenditure claims may not duplicate costs that have been, or should have been paid from another source. And that's kind of important here because as I said in the last slide, we anticipate that states will be braiding a lot of funding sources.

So it's going to be important to be able to differentiate whether some of the costs have been handled by other sources before engaging in any type of allocation methodology.

Allowable costs must also be allocated in accordance with the relative benefit received by the Medicaid program. Medicaid can support crisis call response functions only to the extent and proportion of these functions for Medicaid beneficiaries.

Next slide, please. So what's allowable when it comes to administrative claiming? Allowable costs for administrative claiming, which should be claimed on the CMS 6410 may include screening through state crisis access lines to triage and determine that.

For example, the person does not need mobile crisis services but may need a referral to a behavioral health practitioner. The person needs mobile crisis services and dispatch connect to a mobile crisis team, or the situation is truly dangerous, for example, firearm or other weapon involved and or someone who has already been hurt and engaged 911 or law enforcement.

So those are the kinds of things that we consider to be administrative in nature. 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 claims should exclude behavioral health counseling, clinical assessments and case management services; all things that can be claimed under the new mandatory benefit at the enhanced FMAP rate.

Next slide. So continuing with our thinking around allocation, most of the crisis call centers have multiple lines of business, at least we're aware that many do. For example, you could have a state hotline, local domestic violence call center, a homeless emergency, substance use, a variety of different sorts of hotlines may all be kind of within the same call center.

And so what's important is that the supported service, whatever the claiming, the admin claiming is going to be for, 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 in their care.

Okay. Next slide. So again, same point, different way of saying it. One of the things that the show letter discussed is that SAMSHA has determined that 5% of its mental health block grants must be set aside to support evidence-based crisis systems. And those include the regional or statewide crisis call centers.

So any administrative claiming methodology must exclude the states SAMSHA block grants, the mental health block grant funds from the administrative am ounts claimed. And this is, of course, because, as we all know, Medicaid is the payer of last resort. So the point here is that we have to identify and allocate the costs for Medicaid beneficiaries that are not covered by or duplicative of other funding sources.

Next slide. So how do we do that? 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. What are the steps? We identify all the costs incurred direct and indirect, and then develop and apply some sort of allocation ratio.

Next slide. And this is just a nice way to lay out kind of the mathematical or the arithmetic steps, if you will, that have to happen. The identification of 100% of all costs incurred minus any offsets or unallowable items, unallowable items. And then a state would apply the indirect cost methodology, which we'll talk about and that equals what's allowable.

All of this is to get to what are your allowable costs. And then the state would multiply the allowable cost by this allocation ratio that we would work with you on to develop, and that would equal the allowable administrative costs. And that gets multiplied by the Medicaid administrative, the FMAP percentage to get the FFP for a Medicaid claimable administrative cost.

Next slide. So this idea of formulating the cost pool, figuring out what all the costs are, all of that, we laid out - we put together here an example. I want to stress that this is just for illustrative purposes. Obviously, any direct costs that are identified by the state will depend on the state's cost objectives. But these

are some ideas of what might be considered direct costs for call center, admin claiming sort of situation.

So one important piece, as they know from the other types of admin claiming like in school-based services, et cetera, is to identify the eligible workforce and this means paid staff. From our understanding, from our research, about half the centers rely on volunteers as a portion of the workforce, although of course that varies state to state.

So the idea here is that the direct costs would have to be for paid staff. And states would need to identify the total salary and benefits of the paid staff. But there would be other types of items that we think could potentially be, you know, considered direct cost: phone bills, equipment, chest test technology, expenses related to reliable phone systems, a lot of different pieces that go into the puzzle of setting up a call center. And again, as I've said, states would need to remove other offsetting federal funds.

Next slide. And then, of course, there are indirect costs which can't be kind of correlated to only one particular cost objective. Again, this is illustrative only, just an example to get the juices flowing as states are considering how to put together these proposals. But overhead administrative costs technology such as software platforms for data gathering, IT personnel supporting the system, these kinds of things, especially if there are multiple lines of business, could be considered indirect costs.

Next slide. So when claiming for allowable administrative activities for a population consisting of both Medicaid and non-Medicaid payments may only be made for the percentage of time directly attributable to Medicaid eligible individuals. But when somebody calls it a crisis, the call center may or may not likely not immediately ask for insurance from inquirers.

So we need a way to determine the proportion of activities that are for Medicaid benes, i.e., that the proportional share of Medicaid beneficiaries to the total number of callers. This is the Medicaid eligibility ratio or discount ratio; lots of different names for it.

Next slide. So again, how do you come up with an allocation approach for this situation? States are familiar with random moment time studies. Many use those already for other types of administrative claiming. Those rely on statistical sampling to estimate the total worker effort based on a limited number of worker observation.

But there are other ways. Sometimes time studies can be a little bit complicated and burdensome and may not be the right thing for this situation. There can be the case counts of Medicaid visits to total visits, direct hours, other quantifiable measures. So that's sort of generic thinking.

Go to the next slide, we can look at a little bit more specific to maybe what a state might want to do in this situation. We suggested in the (SMD) or the sho letter, the (SMD), I think, that identifying the numerator as the percent of residents with mental disorders, including SUD and intellectual developmental disabilities who are enrolled in Medicaid over a denominator of all residents in the state who use or have access to the hotline might be a way to appropriately determine a ratio for doing some type of cost allocation.

Next slide. Other ideas, and again, we are very open to lots of ways of doing this. There's no one right way at all; I want to emphasize. Number of emergency department, mental health visits in the region over the number of callers or even conducting a survey of crisis hotline callers, sort of after the fact to determine their Medicaid eligibility after the crisis has abated.

Next slide. So the other thing that's to mention is just that states can refine their cost pool a little bit more for more accurate allocation so they could find an allocation ratio and then multiply that towards by some defined service, such as a high intensity mental health case might be a different cost than a low intensity type of case.

So they do these types of things for accurate allocation and other settings, and we thought they could be brought over here if the state wanted to think about it that way.

Next slide. So, as with any administrative claiming, documentation is very important, there are many documentation requirements. They're all listed here or some of them are listed here, requiring states to maintain accounting systems, supporting fiscal records to assure that all claiming is in accordance with federal requirements and there are all types of retention rules as well.

So everything that is claimed for (FFP) must meet documentation requirements and are subject to audit and is subject to audit. And I think folks know that already, but it always bears repeating.

Next slide. Okay, and states can submit MAC Medicaid administrative claiming methodologies to CMS immediately and public assistance cost allocation plans to HHS programs support center plus outpatient services immediately and CAS will determine the effective date in its (TACAP) approval consistent with the requirements for effective dates of allocation plans, which are set forth in 45 CFR 95.515.

Next slide. So that's sort of the high overview. If you have questions, I and Stephanie Kaminsky, and I'm more than happy to talk to any state who is

thinking about how to put this type of proposal together. And (Sharon Brown), my colleague in FMG, who's a real experts expert in administrative claiming, is also available for assistance.

And I think that is all I have. I want to turn it back over to Jackie.

Jackie Glaze: Thank you so much, Stephanie. So next up is Rachel Dressel, and she'll provide an overview on the (1MAC) submission portal. So I'll send it over to you, Rachel.

Rachel Dressel: Thanks, Jackie. We wanted to take just a few minutes today to talk about the (1MAC) launch and the ongoing effort. As part of the ongoing effort, over the past several years to improve the spot in 1915 waiver review process, CMS released a CMCS informational bulletin on the updates to the intake process for safe submissions to CMS on November 23, 2021.

The CIB provides direction to state Medicaid and CHIP agencies on a process for certain key state submissions to CMS that will be effective February 1, 2022. On February 1st, CMS will be ending the use of the regionally-based mailboxes for the submission of certain paper-based Medicare spots 1915B and 1915C waiver actions, as well as the use of the CHIP SPA mailbox for the submission of paper-based CHIP SPAs.

As outlined in the CIB, state submission for paper-based Medicaid and CHIP files and 1915 waiver actions that would have gone to these mailboxes will now be submitted through the centralized (1MAC) submission portal. The CIB also identifies updates for the submission of some managed care actions. Our focus today will only be the new (1MAC) submission portal, so please refer to the CIB for those additional process updates.

Slide, please. Many of you have already been using the (1MAC) system as part of our pilot piece over the last year. If you're unfamiliar with (1MAC), it allows states and CMS to collaborate online for certain state submissions. These will create their documents as they do today, and those documents will be uploaded into the portal, along with inputting basic information about the submission.

Appendix B of the CIB provides an overview of the fields that states will need to complete for each submission, as well as instructions on how to enter and upload information into the portal. States will continue to include the required permission document today, consistent with what's outlined in regulation guidance for each authority. These submissions in (1MAC) will be considered the official submission and states will receive an electronic confirmation that the commission was received.

(1MAC) is only for certain paper-based Medicaid SPAs. The 1915b waiver actions, Appendix K 1915c waiver amendment that counts as a formal request for additional information for these SPA waiver actions and state requests for temporary extensions for 1915b and c waivers.

SPA waiver actions that are currently submitted to other CMS electronic systems such as the Medicaid and CHIP Program Portal known as MACPro. The Medicaid model data lab known as MMDL, and the waiver management system known as WMS, will continue to be submitted to the system. Appendix A of the CIB provides a crosswalk of Medicaid and CHIP submission type to the appropriate CMS electronic system of entry.

At this time, (1MAC) does not support editing of submissions during the review process. States will work with their CMS point of contact and review

team when there's a need to supply revised submission or additional submission documents during the review process.

Slide, please. Securing your (1MAC) registration is a two-step process. State users will need to register for an IDM account first and then complete their (1MAC) registration. They'll receive an email notification from each system when you've completed your registration successfully. You must use your official state email address for both systems.

When you register for your IDM account, you'll register for the state (1MAC) user role, regardless of your user role that you'll be registering in the (1MAC) system, all state users will be a state (1MAC) user in IDM. Once your IDM account has been created, you'll - you will complete your (1MAC) registration for either state system administrator or state submitter role.

In (1MAC) there's no scenario where state user would need to register for both a state's systems administrator and a state submitter role. The state system administrator role is responsible in reaching out to your state colleagues with the proper submission authority, alerting them to register for (1MAC).

State system administrators are also possible for reviewing and acting on all state submitter role requests in (1MAC). In addition to managing state user access, state system administrators have all the rights in the system that state submitters do, so the state users do not need to register for multiple roles in (1MAC). The submitter role will be able to create new submissions and submit packages for some waiver actions to the portal.

State submitter role requests are managed by state system administrators who will either grant or deny access or, if necessary, revoke access for state submitters.

Slide, please. Can you go to the next? Thank you. The CMS (1MAC) DNA helped them sending ongoing emails to identify state contacts and registered (1MAC) users. These emails will continue to be sent throughout the end of this week and contain valuable resource documents such as IDM instructions for (1MAC) users, a welcome to (1MAC) guide and quick start guide for both state system administrators and state submitters that include an overview of how to register for your (1MAC) user role, as well as how to submit SPA and waiver actions in (1MAC).

This box includes a link to the (1MAC) FAQs, which can be found at the top of the (1MAC) login screen. Be sure to check out Medicaid.gov for future updates and additional resources for (1MAC) starting this Friday.

And with that, I'll turn it back over to Jackie.

Jackie Glaze: Thank you so much, Rachel. So next step is Rachel - excuse me, next step is Sara Harshman and John Giles and they'll discuss several FAQs regarding the pediatric vaccine counseling visit. So I'll turn now to Sara and John.

Sara Harshman: Great. Thank you, Jackie. And hi, everyone. We wanted to take some time this afternoon just to answer a couple of managed care related questions we've received from states regarding our recent pediatric vaccine counseling announcement.

And as a reminder, we provided an overview of this policy during the December 9th all state call and a slide deck with more information can be found on Medicaid.gov.

All right. John, first question. How is CMS reviewing COVID-19 vaccine

counseling as part of the managed care contract? And are there any actions needed from states to ensure services provided through managed care received the 100% enhanced FMAP for COVID-19 vaccine administration?

John Giles: Hi. Hi, everyone. So in accordance with the federal regulations, 42 CFR 438.206, all states must ensure that all services covered under their Medicaid state plan, including vaccine counseling, are available and accessible to all enrollees of managed care plans in a timely manner.

If they choose to include vaccine counseling under their Medicaid managed care programs as a covered Medicaid benefit, states should carefully analyze their managed care plan contracts for any possible changes to include vaccine counseling as a covered service under the contract.

If changes are needed to include the vaccine counseling service under their contract, CMS would recommend that states submit the appropriate amendments as soon as practicable for CMSs review and approval in accordance with 42 CFR 438.3a.

Sara Harshman: Great, thank you. Also, is it possible for managed care organizations to claim for COVID-19 vaccine counseling retroactively in both cases where capitation rates may be found, found and where adjustments to capitation rates are needed?

John Giles: Yes. So in accordance with 42 CFR 438.3, as well as for 438.4, the final managed care competition rates must be actuarially sound and based only upon services that are covered under the Medicaid State Plan or Waiver Authority and represent a payment amount that is adequate to allow managed care plans to efficiently deliver services to Medicaid eligible individuals in a manner that is compliant with their contractual requirements.

If states are amending their managed care contracts to include vaccine counseling as a covered service under the contract, states must work with their actuaries to determine if the actuarially sound capitation rates need to be changed. If states, in consultation with their actuaries, determine that a retroactive adjustment to their capitation rates under one or more of the managed care contracts is necessary to be actuarially sound capitation rate, retroactive adjustments must be certified by the actuary in a revised recertification and submitted as a contract amendment in accordance with 42 CFR 438.7c2.

The recertification must describe the rationale for the adjustment in the data, assumptions and methodologies that were used to develop the magnitude of that adjustment. If a state's actuary indicates that a rate amendment is not necessary to the actuarially sound capitation rates such as the programmatic change would not have a material impact on rate development. This should be documented when the state submits their relevant contract amendments.

CMS would remind states that if a state intends to claim federal financial participation for capitation rates, the state must comply with the time limit for filing claims for FFP specified in Section 1132 of the Act, as well as the implementing regulations at 45 CFR part 95 states that timely submit rate certifications, including any rate amendment to help CMS mitigate any timely filing concerns.

Sara Harshman: Great, thank you so much, John, for helping answer these couple of questions, and that's all we have for now. Jackie, I'll turn it back over to you.

Jackie Glaze: Thank you, Sara, and thank you, John. So now we're ready to take your questions, so we'll begin with the chat function so you can begin submitting

your questions now, and then we'll follow by taking phone questions. So we'll just wait for your questions, and then we'll start working through those.

Ashley Setala: So it looks like we have one question that has come in, and it says, What is the status on timing or timing for release of the SPA template; example is for post-partum Medicaid coverage and COVID lab testing and treatment requirements.

Kirsten Jensen: Hi, this is Kirsten Jensen. And those templates are very close to being released. They were - as part of their PRA process, they were in the Federal Register and the comment period closed on Friday. So we just have a few more a week or two or three here until we can get them through the final review and get them issued for everybody to use.

Kirsten Jensen: Okay. Thank you, (Kirsten). And then we have a question that says, does (1MAC) apply to disaster relief as well?

Jackie Glaze: Rachel, can you respond to that?

Rachel Dressel: Yes, I apologize. Yes. All of the old paper-based Medicaid and CHIP SPAs and Appendix K 1915c waiver amendments, which would also be in response to the disaster relief. Well, we'll go through (1MAC).

Ashley Setala: Okay, thanks, Rachel. It does not look like we have any other questions in the chat right now.

Jackie Glaze: Why don't we move to the phone lines, so I'll ask the operator if you can provide instructions for registering the questions and then we will que those up.

Coordinator: Yes. If there are any questions over the phone lines, please press star 1 and record your name when prompted. If you need to withdraw your question, you would press start 2. And at this time, I show no questions in the phone queue.

Jackie Glaze: Thank you, so, Ashley, I'll turn back to you. (Unintelligible) has a question.

Coordinator: We do have two that just came in. One second.

Jackie Glace: Okay, okay. All right.

Coordinator: The first question comes from (Laura). (Laura), your line is open.

(Laura): Hi, thanks. This is (Laura) from Illinois. I had a quick question on the vaccine counseling guidance for the COVID 19 vaccine counseling.

From the last call, CMS refers states to the American Academy of Pediatrics lists of potential codes that could be used for vaccine counseling, and it included CPT codes for vaccine counseling in the range of 99401 to 99404, which was great because we had chosen 99402. But then we realized that it stated that that range of codes is not included on CMS list of approved telehealth services and on the all state call, CMS said vaccine counseling could be delivered via telehealth.

And so we were wondering if that code range was still available to us or that maybe we could allow telehealth for it or is not being on the approved telehealth service list meant that that range wasn't an option. The only other CPT code options within the AAP potential list were, you know, codes 99201 through 99215, which we can't distinguish from non-vaccine counseling visit which would create some extra complication for the federal match claiming or the other code that's 99311 through 99412 for group counseling.

So we thought that that first step was the best one except for the telehealth issue. And sorry for the long question.

Kirsten Jensen: This is Kirsten Jensen. We can try to find out some information for you about the relationship of telehealth to that code. But I am not sure that we're in a position to give coding advice, but we can try to find out some background information for you, if that's helpful.

(Laura): Okay, yes, that would be great. It was, I mean, it was more an issue of - yes, that would be great. Thank you.

Kirsten Jensen: And if I could ask, would you kindly send me in an email the code sets you just described just so I have them for reference. And my email is, kirsten.jensen@cms.hhs.gov.

(Laura): Yes, I will do that right now. Thank you.

Coordinator: And our next question comes from John Morgan with Virginia Medicaid. John, your line is open.

John Morgan: Same scenario that you just heard about trying to figure out how to both ensure access to vaccine counseling services for any and all vaccines for all EPSDT eligible members and simultaneously capture and distinguish those services that were performed for COVID vaccines that are therefore eligible for increased FMAP.

Ill kind of approach navigating this tricky situation with a slightly different question, which is can you share whether states are expected to cover standalone vaccine counseling codes in order to satisfy this requirement that

counseling be available for all EPSDT eligible members for all vaccines? And I guess the kind of the counterfactual would be or does covering codes like a 90201, 99215 or well-child visit, this coverage of those codes, would that suffice to meet CMS requirement that counseling be available for all vaccines for all ESPDT eligible members?

Stephanie Kaminsky: Kirsten, this is Stephanie. Do you want me to try some of that piece? I think I can identify - I can respond to a piece of it.

Kirsten Jensen: Okay.

Stephanie Kaminsky: So we did share last time, I don't think that a state has to have a separate HCPC code or any type of code to meet the counseling requirement generally. The place where the separate coding becomes more important is when we're talking about trying to tease out the counseling for the pediatric COVID vaccines, which is eligible for the 100% FMAP because if you don't have that, it becomes a bit of an allocation, you know, challenge. And also a lot of provider instructions challenge.

We just think that it's cleaner and easier for everybody involved specifically for that piece, claiming 100% for the pediatric counseling, COVID counseling during this ARP period.

But, you know, we did kind of say in the past when we have time when we were talking about this stuff that they didn't have to have a separate code in order to - you know, counseling can be part and parcel of what happens in a, you know, a well-child visit. And I'll defer to Kirsten about the requirement to have counseling be part of your, you know, the counseling requirement itself.

But I think we're we were making where we were emphasizing the importance

and the convenience of coding or the convenience isn't quite the right word, but where we think it's a good idea has to do with, you know, where we're pulling out certain types of counseling for that enhanced match.

John Morgan: And if I can add, I don't disagree at all. In fact, we completely agree. I'd say in an ideal scenario, there would be, you know, kind of two obvious counseling codes kind of available or a counseling code with a dedicated modifier because we would love to frankly be able to cover kind of standalone COVID counseling and have it be built under a 9941b and then having a separate code that is dedicated to COVID counseling, 9941a, I realize that these letters are kind of placeholders.

But what I think we are finding is I think most states are is that there only maybe seems to be one obvious option for covering standalone counseling. And if it's used for all vaccines, to your point, it's impossible to parse out what fraction is eligible for 100 percent FMAP. And so what I think we have considered as options are, A, to try to repurpose an existing modifier, which we're reminded is always very messy from our internal staff standpoint.

Or secondly, use one of these standalone counseling codes only and kind of really open it only for COVID vaccination and rely on the fact that we allow our providers to counsel members on vaccines and counted towards their e-numbers. The well-child checks as kind of our way of satisfying CMS as a requirement that'd be available.

So I'll just say that's kind of second scenario is, I think one direction that our state is heading in, if only to ensure that we can easily distinguish what gets what 100 percent FMAP or not. But I'll say it's far from ideal, and I would love there to be another obvious code that would be available and or a modifier to distinguish services that are definitively COVID.

And I know some states have kind of repurposed, you know, emergency modifiers to that end. But in as much as it's ever a food for thought, that kind of coding tools would be invaluable for us.

Stephanie Kaminsky: So, I mean, this is very helpful information for us. So I appreciate you sharing it. I mean, the only piece that kind of stands out from what you just said and again defer to Kirsten is that it's not a question of allow, you know, individuals to counsel. Just that the counseling piece would have to be I think part of - it doesn't have to happen every time, but it has to be sort of embedded there because that counseling piece is now required.

So it's a little bit of a needle being thread there. But you know, it's I don't know that you don't code, but it is a required service.

Kirsten Jensen: Yes, I agree with you, Stephanie. The - for children, the standalone vaccine counseling where the vaccine is not administered as is now required for COVID-19, and the important piece here is the availability of the 100% match. And so that's right, that's why the coding becomes very important here. And then in the future, it's also required for all other pediatric vaccines as well. And that's not at the extra match.

And so, you know, I don't know how states will make operational decisions to support those two scenarios, but they are a little bit different just because of the match associated with the COVID-19 piece. So we're looking into the coding issues as much as we can and talk with people who may know about coding CMS and see what we can find out for you.

Jackie Glaze: Thank you, operator, are there any additional questions? Ashley, I'll turn to you to see if you have any questions in chat.

Ashley Setala: Okay. We have two others that have come in through the chat. So the first is on the (1MAC) SPA submission portal, and it says if we have already submitted the SPA but we'll have open items with CMS and need to resubmit the SPA store after February 1st. Will that SPA be resubmitted through(1MAC)?

Man: You should continue to use - you should use the (1MAC) system for all future submissions if you have an existing SPA. I may even misunderstand the question. You have an existing SPA, you'd like to resubmit.

Ashley Setala: Yes, they need to. Yes, resubmit the SPA.

Man: If you're responding to an RAI, you should use the (1MAC) system. You will be able to enter the existing SPA ID into the system and any accompanying materials.

Ashley Setala: Okay, great. Then we have a question on today's mobile crisis administrative claiming presentation, and it says regarding administrative claiming for 988 call centers. Is this only available for states that don't already have legislation to support the funding?

Stephanie Kaminsky: I think, you know, if I'm understanding the question. No, not necessarily, because legislation to support the funding may be a part of this state match which is only 50% from the federal government. So states need come up with their share and however, they're coming up with it.

So, you know, I don't think that the legislation, I mean, it depends what legislation says I suppose, everything always depends. But there's no - there's

- this is not targeted to states that don't have legislation. I think that the administrative claiming is widely available.

Ashley Setala: Okay. Thanks, Stephanie. Then we have one other question that's come in through the chat, and it says many states have offered gift cards for completing vaccinations through their managed care organizations. Does Medicaid have a policy on this?

Stephanie Kaminsky: We do. I don't know, John, if you want to jump in on this, I can talk maybe at the tail end about the beneficiary incentives piece. That's not through managed care.

John Giles: You know, this is John. So I'm not sure, Ashley, on the question. Did it say whether plans were voluntarily providing gift cards or states were requiring it, does it make that distinction?

Ashley Setala: It did not.

John Giles: So I think a couple of things. I think, you know, we did put some guidance out on this. Gosh, Stephanie, was it - a couple of months ago. We've had some guidance out on this topic

Stephanie Kaminsky: August. In August.

John Giles: In August, yeah, we put out some written guidance in August. So I think broadly, what we would say and what we mentioned in that guidance is that, you know, we recognize that some managed care plans will provide, you know, those kinds of gift cards voluntarily as like a value added service. And that's certainly something that is permissible under our managed care regulations.

However, there is a distinction between, you know, managed care plan sort of voluntarily providing those kinds of incentives and a state specifically contractually mandating that their plans fund such an incentive and then passing the costs through the capitation rate, which is not permissible.

But what states can do if they're interested in funding gift cards for these kinds of things under the Medicaid program, there is an administrative claiming vehicle that may be available to states. And I think, Stephanie, that's where you were perhaps going to fill in a little bit on that if a state wanted to go through that process and seek CMS approval under an administrative claiming option.

Stephanie Kaminsky: That's exactly right, John, and that is what the August SHO letter talked about. It was a SHO that was combined with other topics that came out at the end of August. I think it was with the 100% FMAP for vaccines through the ARP, even before we were talking about pediatric vaccine counseling.

And we have been looking at some proposals from states that are putting together programs to pay or to provide some sort of gift card or some kind of incentive to beneficiaries. Again, this is through the administrative claiming match vehicle.

So similar to some of the things we talked about today in a different context, the mobile crisis intervention call centers, we would require a Medicaid administrative claiming methodology submission from a state as well as there would need to be a (TACAP) amendment by the state.

And there were certain program integrity types of considerations that we have been working on with the states that are pulling together this type of a

program. And we're happy to continue to work one on one with states thinking through what these initiatives could look like and what kind of safeguards need to be there.

Jackie Glaze: Thank you, Stephanie and John. So in closing today, I want to thank the team for their presentations. Looking forward, our next call will be on Tuesday, February the 8th from 3:00 pm to 4:00 pm Eastern Standard Time. The topic and invitation for our next call will be forthcoming.

Of course, as questions come up between these calls, feel free to reach out to us, your state leads or bring your questions to the next call. So we thank you again for joining us today, and we hope that everyone has a good afternoon. Thank you.

END