

Centers for Medicare & Medicaid Services
COVID-19 Medicaid and CHIP All State Call
Tuesday, August 31, 2021

3:00 pm ET

Coordinator: Welcome and thank you for standing by. All parties' lines are in listen-only mode until the question-and-answer session of today's call. To ask a question at that time over the phone, please press star 1, unmute your phone and record your name. Today's call is also being recorded. If anyone disagrees, you may disconnect at this time. It is now my pleasure to turn the call over to your host, Ms. Jackie Glaze. Thank you. And you may begin.

Jackie Glaze: Thank you and good afternoon and welcome everyone to today's All State Call and Webinar. I'll now turn to Dan Tsai, our center director, for opening remarks. Dan?

Dan Tsai: Thanks, Jackie. Hi folks. Good afternoon. We have a packed agenda today. Thanks all for joining.

As folks may have seen, there were a few pieces of guidance and other things we released from CMS yesterday. That will be the primary focus of this discussion and Anne Marie and team will introduce and walk through the details of that. They relate to both enhanced test maps, testing through a range of State Health Official letters and frankly those too will cover a very broad range of topics that we have been getting quite a range of questions on some states and other partners. So we are glad to have this opportunity.

There was also another really important document that we put out yesterday. It's in a PowerPoint form and has to do with option states have to claim within Medicaid for a range of strategies through Medicaid agencies to help promote vaccine uptake amongst the Medicaid population.

And that's a particularly important piece we want to highlight and our goal to help make sure that we both have high levels of vaccination overall and importantly parity as we think about the Medicaid population. We are - think folks are well aware that vaccination rates are lower within our Medicaid enrollees as a whole versus across similar age and other groups across the country.

A range of states have been exploring and proposing pretty interesting things to us. We have outlined a range of strategies that are in line with what some states have done and/or go beyond that that we are strongly encouraging states to consider and take up. And I would note we're open for business in case others have ideas for things that will help promote vaccine uptake through a range of creative approaches but that's a really important piece that the team will walk through.

And I believe it has been launched or will shortly be launched. NAMD is also - has a survey for states to understand state Medicaid programs have a sense of their, give or take, vaccination rates amongst the Medicaid enrollees, the extent to which a state has any connection into their IAS systems to be able to match up some data around that, the extent to which states have a sense of that for their various managed care plans, to the extent that exists.

That survey will - is critical for us to help identify some of the overall strategies that we should continue to think about together in partnership with the states and others. So we'd strongly encourage folks to take a look at that, fill up whatever piece you can on that and I'm sure we'll be making a few additional calls on that. We're grateful to NAMD for helping to manage that survey.

So anyway, there's a packed agenda. Thanks all for joining. And I'm going to turn it to Anne Marie now. Anne Marie?

Anne Marie Costello: Thanks, Dan. And yes, Dan, I understand from Jack Rollins that NAMD did launch the survey last week and folks had about a week to complete. So we're looking very much forward to getting those - and they're going to be sharing those results with us.

So anyway, hi everyone. So glad that you could join us today. As Dan mentioned, we have a few big topics to cover on today's call. First up, Jen Clark and Jeremy Silanskis from our Financial Management Group and Kitty Marx from our Children and Adults Health Programs Group will join us to provide an overview of the State Health Official letter we released yesterday to provide guidance on temporary increases to the federal medical assistance percentage available to states under a number of the provisions of the American Rescue Plan Act.

Then Melissa Harris from the Disabled and Elderly Health Programs Group will present an overview of another SHO letter we released yesterday -- big day for us -- that provides guidance on Medicaid coverage and reimbursement of COVID-19 testing, also under the ARP.

After Melissa's presentation, Sara Harshman, Teri Breskin from our Center Director's Office, Stephanie Kaminsky from our Financial Management Group and Melissa Harris will present on a number of strategies that states can consider in implementing to address COVID-19 vaccine hesitancy and, as Dan noted, try to increase uptake of the vaccine by Medicaid and CHIP beneficiaries.

This really is a critical and primary issue because just last week, the Kaiser Family Foundation released data highlighting that Medicaid beneficiaries across the nation are receiving the COVID vaccines at significantly lower rates than the general population.

In many cases, vaccination rates for Medicaid beneficiaries 30% behind vaccination rates in the general population. So this is a helpful glimpse of that information. We're hoping that the survey that NAMD is doing will give us even more granular information that will be helpful.

We hope the presentation today will give you a number of ideas that you can consider implementing in your state as we work together to increase vaccination rates.

After our vaccine presentation, we'll open the lines for your questions. We'll use the Webinar for all three presentations today. So if you're not logged in to the Webinar platform, I suggest you do so now.

But before we jump into our agenda, I wanted to highlight an opportunity to leverage funds available under Section 9817 of the American Rescue Plan to increase access to COVID-19 vaccines. As you know, under Section 9817, states can implement a variety of activities to enhance the span or strengthen HCBS.

In light of the recent FDA authorization of an additional dose of the COVID-19 vaccine, the immunocompromised individuals and the increase in COVID cases that are happening across the country due to the Delta variant, we wanted to remind states of the opportunity under the ARP to help individuals with HCBS needs, their caregivers and direct support professionals to address COVID-19 vaccine.

For example, states can use the funds attributable to the increased FMAP to provide transportation to vaccine sites, implement in-home vaccination programs, provide mobile vaccination programs, offer vaccination clinics for direct support professionals, provide direct support professionals with paid time-off for vaccine appointment or if they are experiencing side effects in a vaccine, offer incentive payments to encourage direct support professionals to get vaccinated and provide family caregivers with preservice in order to get vaccinated or if they are experiencing side effects from the vaccine.

With that, I'll turn things over to (Jen) to start our first State Health Official letter presentation. (Jen)?

Jen Clark: Thank you, Anne Marie.

So I'm going to give a high-level description of Section 9814 of the ARP. So Section 9814 of the ARP provides an eight-quarter 5-percentage point FMAP increase to a qualifying state or territory FMAP under Section 1905(b) of the Social Security Act for a state or territory that newly expands its Medicaid program by adopting the adult group.

A qualifying state is a state that has not expanded - or, I'm sorry, not expended amounts for all individuals in the adult group before the March 11th, 2021 enactment date of the ARP. The 5-percentage point FMAP increase would be available for eight quarters effective beginning with the first calendar quarter during which a qualifying state expends amounts for all individuals in the A group except for any quarter and each subsequent quarter during the eight-quarter period in which a state ceases its adult group expansion or limit the expansion to less than the entire adult group.

So generally the eight-quarter 5-percentage point FMAP increase is available for expenditures that are matched at the regular state-specific FMAP defined in the first sentence of 1905(b) of the Social Security Act which, as most of you are probably aware, is currently increased by 6.2 percentage points as provided under Section 608 of the Families First Coronavirus Response Act.

For applicable expenditure categories, a state may receive both the eight-quarter 5-percentage point FMAP increase and the temporary 6.2-percentage point FMAP increase at the same time.

There are categories of expenditures that are not eligible to receive the eight-quarter 5-percentage point FMAP increase such as disproportionate share hospital expenditures which are excluded by statute from being eligible. Also adult group expenditures matched at the newly-eligible FMAP under Section 1905(y) of the act or the expansion state FMAP under Section 1905(v) of the act are not eligible for the additional 5-percentage point FMAP increase on top of the already increased FMAP for those categories of expenditures.

In the appendix in the SHO letter, we have included a list of expenditure categories for which the eight-quarter 5-percentage point FMAP increase does not apply.

Since the statute does not provide an expiration date for this provision, the eight-quarter 5-percentage point FMAP increase would be available for eligible states that adopt the A group in future quarters.

Next slide please. In March of 2021, CMS used available expenditure data to derive a rough estimate of what the potential federal share impact could be for this provision if all eligible states qualified for the 5-percentage point FMAP

increase for all eight quarters. We came up with a rough estimate of approximately 15 billion.

We shared this information in more detail with states on the March 30, 2021 all state call. We flagged that the estimate was based on an analysis of CMS-64 expenditure data that was available to us at that time from the first three calendar quarters of 2020 without any application of any growth rates.

The estimates are intended to provide a general sense of the magnitude of the impact of Section 9814 of ARP and do not represent formal agency projections.

I will now hand it over to Jeremy to discuss Sections 9811 and 9821 of the ARP. Thank you.

Jeremy Silanskis: Hey, thanks, (Jen), and good afternoon everyone. So the focus of this portion of the presentation will be on Sections 9811 and 9821 which establish new mandatory coverage of COVID-19 vaccines and their administration for Medicaid and CHIP. These sections provide coverage to nearly all beneficiaries who receive the COVID-19 vaccines without cost sharing.

In addition, these sections provide temporary 100% federal match for vaccines and their administration under the new mandatory benefit. Within the State Health Official letter issued yesterday, we provide guidance on the new mandatory benefit and how states may appropriately claim the associated increased federal match. I will briefly highlight the key policy messages discussed within the letter.

So first there is an important discrepancy between the effective dates for the coverage of the new benefit and the available increased federal match. While

the coverage requirements were effective beginning March 11, 2021 with the passage of the ARP, the 100% federal match began on April 1, 2021.

Both provisions are temporary and end on the last day of the first quarter that begins one year after the last day of the COVID-19 emergency period which I know is a mouthful and essentially what that means is that the provisions extend approximately one year beyond the end of the PHE.

We also clarify that since COVID-19 vaccines are currently federally purchased and providers should not be billing states for COVID-19 vaccine doses, the guidance applies at this time only to vaccine administration.

In general, all COVID-19 vaccine administration services that are provided at standalone visits may be claimed at the 100% FMAP and eFMAP. However, the letter discusses potential complexities and the need to allocate when vaccine administration is provided along with other Medicaid-covered services and paid using a bundled rate or capitation rate.

In those circumstances, people need to identify the portion of the rate that is associated with the vaccine administration and allocate the rate to identify vaccine administration expenditures. We offer two options that we think are feasible for states to conduct the allocation. States may use the state plan rates paid to professional providers as a reasonable proxy for identifying expenditures associated with vaccine administration paid through bundle rates.

Alternatively, states may gather cost data from providers and use the cost of COVID-19 vaccine administration per the unit of service paid through the bundled rate to determine the expenditures that may be claimed at 100% FMAP.

As states review the information in the SHO letter and ask questions about implementation, we are happy to answer any questions and work with states on the allocation of expenditures.

And with that, I'll turn it over to Kitty Marx. Thank you.

Kitty Marx: Hey. Thank you, Jeremy. So I'm going to talk about Section 9815. And this provision extends 100% FMAP for Medicaid services provided by urban Indian organizations and Native Hawaiian healthcare systems. This provision is temporary and is time limited to eight fiscal quarters beginning April 1, 2021 to March 31st, 2023.

The SHO letter explains that the 100% FMAP will apply for expenditures for services received by all Medicaid beneficiaries through urban Indian organizations and Native Hawaiian healthcare systems.

The legislative history for Section 9815 contains no indication that Congress intended to limit 100% FMAP to services provided to American Indians and Alaska Natives or Native Hawaiians served by these entities.

CMS's longstanding interpretation limiting the application of 100% FMAP to services received by American Indian and Alaska Native Medicaid beneficiaries through Indian health service and tribal facilities remains unchanged.

This interpretation is based on the legislative history of the original 1905(b) which indicates that Congress intended that the 100% FMAP would apply only to services provided to American Indians and Alaska Natives at these facilities. Thus, states must continue to claim services received by non-tribal

Medicaid beneficiaries through Indian health service and tribal facilities at their regular state-specific FMAP.

The SHO letter also explains that 9815 is silent on payment rates to urban Indian organizations or Native Hawaiian healthcare systems. CMS is available to provide technical assistance to states that believe adjusting their reimbursement rates for urban Indian organizations or Native Hawaiian healthcare systems is appropriate and/or to answer any other questions you might have regarding this provision.

Thank you. And, Jackie, I will go ahead and turn the call back over to you.

Jackie Glaze: Thank you, Kitty, and thank you, Jeremy and (Jen), for your presentations. We will now transition to Melissa Harris and she will provide an overview of the SHO letter that was released yesterday that covers the Medicaid and CHIP coverage and reimbursement of COVID-19 testing of ARP.

So, Melissa?

Melissa Harris: Hey, Jackie, thank you. You can go to the next slide.

So let's talk testing for a couple of minutes. The American Rescue Plan added coverage mandates for COVID-19 testing in both Medicaid and CHIP programs. In Medicaid it's at Section 9811(a) of the ARP and at CHIP it's at 9821.

These testing mandates became effective on March 11th, 2021 and they went through the last day of the first calendar quarter that begins a year after the last day of the COVID-19 emergency period.

I should note that these coverage mandates for testing apply to individuals in what CMS used to refer to as the optional COVID-19 testing group. But it's especially important to note that this group only receives that coverage through the last day of the emergency period. Nothing in the American Rescue Plan extended the effective period for that group.

You can go to the next slide please. As we stated in the guidance, there are two types of testing for COVID-19 that the American Rescue Plan requires to be provided without cost sharing. And those are diagnostic and screening testing.

And we referred to a link in the letter for guidance posted by the Centers for Disease Control. They are the organization that is really issuing the scientific guidance for the definitions of both diagnostic and screening testing, the types of individuals who should be receiving diagnostic or screening testing and it's those parameters that will continue to be guiding the implementation of the mandates in the Medicaid program.

And so the mandates for diagnostic and screening testing includes coverage of screening testing required for things like back to school or back to work initiatives and requirements for travel.

It also includes all FDA-approved testing including point of care test and home test. We do state in the guidance that an individualized test result needs to be generated from the test in order for Medicaid to reimburse for the test. So a test provided to a Medicaid beneficiary generating an individualized result is the testing that Medicaid will provide.

And you'll notice in the guidance that we specifically remind states that they can apply utilization control mechanisms to these tests as long as all of the Medicaid and CHIP program requirements are met and as long as these utilization control mechanisms don't represent arbitrary barriers to accessing testing.

We can go to the next slide please. So states will need to submit state plan amendments for both Medicaid and CHIP and this applies to states even if you have already submitted a disaster SPA for provisions of testing that take you through the end of the public health emergency. Because the ARP period extends for a year beyond the PHE, you'll need to submit a non-disaster SPA to take effect upon the expiration of your disaster SPA and CMS obviously is available for technical assistance and will be issuing some additional information about SPA submissions.

Next slide please. The other topic that was included in the letter to state health officials is a discussion around coverage of habilitation services. This is temporary flexibility for the duration of the public health emergency and it affects the habilitation services that are authorized under 1915(c) waivers and 1915(i) state plan programs.

These habilitation services are often the responsibility of the education system when they are provided to children. And there is a special caveat in the 1915(c) legislation that says that habilitation services for Medicaid purposes do not duplicate what the Department of Education is mandated to provide under IDEA requirements. And so generally that there is that prohibition that is in effect.

What this language in the SHO letter indicates is that again during the period of the public health emergency, if a child is enrolled in a fee waiver and/or a

1915(i) program and that child needs habilitation services and the local education agency is not able to provide those services, then Medicaid may step in and offer reimbursement to those services.

So again, technical assistance is available if the state wants to effectuate this flexibility and we are happy to answer any questions about that at the end.

Next slide please. Okay. So now I'm going to turn it back over to Jackie and she will set up the next speaker. Thank you.

Dan Tsai: Thank you, Melissa. So next we have a team of staff that will present on the strategies to address the vaccine hesitancy. And we'll begin with Sara Harshman.

Sara Harshman: Thank you, Jackie. We can move on to the next slide. As you are all aware, state Medicaid and CHIP agencies play a critical role in the effort to vaccinate beneficiaries for COVID-19 including adolescents age 12 or older as they return to school.

As Anne Marie mentioned earlier, recent data shows that Medicaid beneficiaries are receiving the COVID vaccine at significantly lower rates than the general population. And as Delta - as the Delta variant spreads, enrollees who are unvaccinated are at an increased risk of contracting COVID-19 and of hospitalization.

CMS has put together this resource outlining a number of available federal funding and flexibilities in an effort to support states in their work to increase COVID-19 vaccination rates.

We encourage states to adopt as many of these strategies as possible but we'll add that this is not a comprehensive list of ideas. CMS is available and ready to provide technical assistance on any ideas states may have on ways to increase COVID vaccination rates among their beneficiaries.

I will now turn it over to Stephanie Kaminsky who will go over our available flexibilities around beneficiary initiative. Stephanie?

Stephanie Kaminsky: Thanks, Sara. So I want to talk about beneficiary incentives and start by saying that in looking at ways to combat vaccine hesitancy, we found that incentives can be effective in promoting vaccinations. In a recent UCLA study, 1/3 of unvaccinated participants said a cash payment would make them more likely to get a shot.

So we are pleased to share that states can request federal administrative match for state funded monetary incentives paid to Medicaid and CHIP beneficiaries such as gift cards to encourage the uptake of the COVID-19 and influenza vaccine.

States can administer a Beneficiary Vaccine Incentive program under their fee-for-service program and/or their managed care program. In Medicaid, states can request 50% federal financial participation, FFP, under Section 1903(a)(7) of the act and implementing regulations. States could establish that monetary incentives could be necessary for the proper and efficient administration of the Medicaid state plan and/or a reasonable cost of administering the CHIP state plan.

In CHIP, states can request federal match at the applicable EFMAP, which varies by state, subject to the 10% of the state's annual federal CHIP spending

limit on administrative expenditures under Section 2105(a)(1)(D)(V) of the Social Security Act in implementing that.

Payments to managed care plans for this Beneficiary Vaccine Incentive program must be paid separately as an administrative activity on an administrative cost basis not included in risk-based managed care cap rate. Payments must be paid - made under separate contracts or amendments to existing contracts if implemented through managed care plan.

Next slide please. So for states who are interested in using this authority, they must submit an amendment to their public assistance cost allocation plan to HHS, the division of cost allocation services, and must submit their proposed administrative planning methodology to CMS for review and approval.

States' proposals for vaccine incentives should include safeguards to ensure that only Medicaid and CHIP beneficiaries who received a vaccine or their guardians receive the beneficiary incentives. In addition, any claims for FFP must meet documentation requirements and are subject to audit.

Proposals will be reviewed for consistency with general principles on allowable administrative costs using our existing administrative planning criteria which are set forth in the 2003 Medicaid school-based administrative planning guide as well as federal cost allocation principles.

We may also ask states for evaluations of the impact on vaccine uptake. For links to claiming criteria, see the Medicaid Administrative Claiming page on [Medicaid.gov](https://www.medicaid.gov). All of this is laid out in the first SHO that was discussed today, the FMAP SHO. And I just want to mention of course we're available to provide technical assistance and we'll adjudicate proposals on a case-by-case basis.

Want to turn it back to Sara who will discuss additional flexibilities.

Sara Harshman: Great. Thank you, Stephanie. It has been shown that healthcare providers are the most trusted source of vaccine information especially for those who may be hesitant to receiving the COVID vaccine. When building vaccine administration payment rates for providers, states should consider the time and resources required by physicians to counsel their patients on the safety and efficacy of the COVID-19 vaccine.

States could also consider establishing payment rates for counseling services provided outside of the administration of the COVID vaccine. Although it should be noted though that these counseling services would not be eligible for the 100% FMAP included in Sections 9811 and 9821 of the American Rescue Plan but they are eligible for the FMAP otherwise available for counseling services.

As outlined in the next couple of slides, provider incentives, state directed payments and managed care plan incentives are options available to states to motivate plans and providers to increase COVID vaccinations among Medicaid and CHIP enrollees.

Federal MAP is available for states to design and provide direct provider financial incentives for achieving or increasing vaccination rates among their patients. These incentives can include bonus payments for providers who reach certain COVID-19 vaccination targets as set by the state and incentives to pediatricians and family care providers to increase vaccination rates for adolescents 12 and over.

For states hoping to pursue provider incentives through fee-for-service, states should submit a statewide amendment including updated 419(b) pages and for states who wish to pursue provider incentives through their managed care plans, state directed payments may be used to contractually require managed care plans to implement specific payment arrangements with network providers provided certain requirements under 438.6(b) are met.

States will need to send to CMS for review and approval the state directed payment preprint along with updated contracts and rates. More information can also be found on the state directed payments landing page on [Medicaid.gov](https://www.Medicaid.gov).

Next slide please. A majority of Medicaid beneficiaries are enrolled in comprehensive managed care. And as a result, Medicaid managed care plans play a major role in increasing vaccination rates and providing critical outreach to Medicaid beneficiaries who have yet to receive a COVID vaccination.

To help incentivize increased outreach and vaccinations, states could create pay-for-performance incentive arrangements focused on performance targets or thresholds based on enrollee vaccination rate.

For example, states could establish set bonus payments for plans to provide COVID vaccinations to a certain percentage of the plan's enrollees.

As states consider these various approaches related to reimbursement for the COVID-19 vaccines and incentives, they should partner with their managed care plans to develop and submit performance-based arrangement. They should also consult with their managed care plans and actuaries as appropriate for any potential impacts to their managed care plan's capitation rates.

As with the provider incentives mentioned on the previous slide, once updated contracts and capitation rates are submitted, CMS will work to prioritize and expedite CMS's review and approval.

I will now turn it over to Melissa Harris to refresh our memories on ways states can provide time-off for direct service professionals to receive a COVID vaccine.

Melissa Harris: Thanks, Sara. And this slide and the following slide is a reiteration of language that we provided to you on an off date call a couple of months ago, making you aware of some flexibilities through the 1915(c) waiver, Appendix K, to implement temporary rate increases that would account for the extra time-off needed by direct service professionals to either receive the COVID-19 vaccine or to recover from any side effects of the vaccine.

And so you see on this slide some reminders about the Appendix K flexibility. These are temporary rate increases that can be retroactive and can be time limited although the entire Appendix K infrastructure needs to cut off no later than six months after the end of the federal public health emergency.

States can implement provisions as they are utilizing this flexibility such as requiring DSPs to document that they received the vaccine, have an appointment for the vaccine, et cetera. And to get technical for a minute, the states would adjust the FTE, the full time equivalent factor, used in your current rate model to account for this payment for time-off to receive the vaccine and there's more on that on the next slide if we can go to that please.

And so here's what a state would need to submit to CMS in an Appendix K to implement this temporary payment increase. And you can see the bullets here about the content of the submission so I won't go over them.

But we are available, as always, for technical assistance for a state wanting to implement this. And if a state is wanting to utilize a similar flexibility outside of the 1915(c) waiver in your ACBS programs, we're available for technical assistance in that regard as well.

Thanks. Okay, I'm going to turn it back to Jackie.

Jackie Glaze: Thank you, Melissa. So now we're ready to take questions from the state. So we will begin by taking questions through the chat function. So we do see a few questions now.

Ashley Setala: Jackie, sorry, we actually have a few more slides to go.

Jackie Glaze: Oh, okay. All right. Sorry about that.

Sara Harshman: And this is Sara. We'll hand it over to (Teri Breskin) to talk through the next few slides.

(Teri Breskin): Hello everyone. So I will be talking about federal match for expanded community outreach. It is well known that community outreach through local trusted organizations and individuals is essential for distributing public health information. We recommend that states frequently review COVID-19 immunization messaging to make sure it reflects the latest vaccine information. Updates to the messaging should be coordinated with local partners.

States may use Medicaid and CHIP administrative matching funds for beneficiary and provider education outreach. Allowable outreach activities can be matched at 50% the federal financial participation, FFP, rate under Medicaid subject to the 10% limit on administrative expenditures.

Examples of outreach activities eligible for an administrative match include developing and/or disseminating materials to inform Medicaid and CHIP-eligible adolescents and their families about the availability of Medicaid and CHIP services such as COVID-19 vaccine administration, distributing literature about the benefits and availability of the COVID-19 vaccine to Medicaid and CHIP-eligible adolescents and their families and participating or coordinating provider trainings with enrolled Medicaid and CHIP providers regarding the benefit of Medicaid and CHIP covered services such as the COVID-19 vaccine and how to assist adolescents and their families in accessing such services.

States can also refer to the Medicaid vaccine toolkit and Medicaid vaccine updates for more information.

Next slide please. If these activities are not specified in your state's administrative claiming plans, the states can submit a modification to the plan. Please review again the Medicaid vaccine toolkit and the Medicaid vaccine updated (sub) and reach out to CMCS for any technical assistance.

Next slide please. And I will now be talking about the idea of creating No Wrong Door for beneficiaries seeking vaccine information. So when we think of vaccine outreach from the beneficiary perspective, it is incredibly helpful and important to create a No Wrong Door policy aimed at providing COVID-19 vaccination information no matter where beneficiaries interact with public programs and systems.

This information could include references on where to receive additional information on the efficacy of the COVID-19 vaccine or how a beneficiary may be able to access transportation to the vaccine appointment. Medicaid and CHIP administrative matching funds can be used to expand these No Wrong Door options.

One specific area to target is public call lines. Medicaid and CHIP administrative funds could be used to educate call line staff or update call line automated voice systems or Web sites. Like the community outreach activities, states who wish to pursue these updates can submit a modification to their state's administrative claiming. Please reach out for technical assistance if you have any questions.

And with that, I am going to turn it back over to Sara Harshman to talk about the Connecting Kids to Coverage campaign.

Sara Harshman: Great, thank you. The COVID-19 pandemic disrupted both in-person learning and routine well-child visits for many children over the past year. As a result, too many children have fallen behind on receiving recommended vaccines and other important care. This year CMS has utilized our Connecting Kids to Coverage National Campaign. It's a campaign that focuses on the enrollment and retention of eligible children in Medicaid and CHIP to promote adolescents to COVID-19 vaccinations.

The Connecting Kids to Coverage campaigns conducted several planned activities including a Webinar with CDC in June that discussed strategies to help kids safely return to school.

The campaign also promoted COVID-19 vaccinations for adolescents through a Back to School Radio Media Tour, social media content and newsletter and some graphics.

Next slide please. States that wish to have more information on the messaging used in the Connecting Kids to Coverage campaign can go to [InsureKidsNow.gov](https://www.insurekidsnow.gov) to sign up for e-mail updates and can also access our outreach tool library to see various online and print materials, toolkits, fact sheets and other public service announcements.

Next slide. As we mentioned earlier, CMS stands ready to provide any needed technical assistance and additional information to states as they look for ways to increase COVID vaccination rates among their beneficiaries.

I'll now turn it back over to Jackie to help facilitate questions. Thank you.

Jackie Glaze: Thank you, Sara and team, for your presentation. So now we are ready to take the state questions. So we will follow the format that we have used in the past by taking questions through the chat function. I do see a few questions now and then we'll follow with questions over the phone line.

So I'll now turn to you, (Ashley).

Ashley Setala: Thanks, Jackie. So we have a couple of questions that have come in around FMAP reporting. And the first question says, "Can CMS provide states with an estimate of when they will be publishing specific MBES/CBES guidance regarding how the 100% FMAP for vaccine administration should be presented on the CMS-64/21 and will it be a new line on the existing form or a new form within the suite of forms?"

Rory Howe: Good afternoon. This is Rory Howe with the Financial Management Group. And that's a very good question. We are actively working to develop the updated forms within MBES and CBES. We do not have an exact timeline at this point but I can assure you we're working to finalize those as soon as possible and in a way that is as administratively easy for states and as clear as possible.

And once those are ready, we do intend to provide some training to states on those new forms and how to report and, as always, are available to provide technical assistance on an ongoing basis.

Ashley Setala: Okay, thanks, Rory. Then we have a question around vaccine beneficiary incentives. And it says, "Do guardians of a CHIP beneficiary need to be Medicaid eligible in order to receive the incentive payment for receiving a qualified vaccine?"

Stephanie Kaminsky: So this is Stephanie Kaminsky and I believe the answer to that is no, they do not, the payment to the guardian as the guardian of the Medicaid - or CHIP beneficiary. That's how the vaccine incentive - the beneficiary incentive - that's how we're thinking about the beneficiary incentive payment at this point but of course interested to hear more what the state is considering.

Ashley Setala: Okay, great. Then we have a question that says, "For states that are considering managed care directed payments as a strategy for increasing COVID-19 vaccine rates among Medicaid beneficiaries, is CMS considering an expedited review and approval process for those directed payments?"

Stephanie Kaminsky: So this is Stephanie again and I'm hoping that perhaps my colleague, John Giles, is available to try to help with that question. I think that, you know, this area is a new area for our team. And of course we are trying to promote these

flexibilities as quickly as we can. But maybe - and I am a little unclear what the directed payment - if what's meant by that is the administrative claiming that I discussed or if it's one of the other strategies that Sara discussed.

Alexis Gibson: Hi. Hey, Stephanie, it's Alexis Gibson, John's deputy. John is actually out of the office this week.

Stephanie Kaminsky: Oh, that's right.

Alexis Gibson: So CMS will - obviously the MCP and our partners will work as quickly as possible to process any directed payments connected with this. So as expedited as we possibly can, yes.

Ashley Setala: Okay. Thanks, Alexis. Then we have a question that says, "With regards to the vaccine incentive, states have the option to distribute the incentive after each shot or after the beneficiary has been fully vaccinated, correct?"

Stephanie Kaminsky: This is Stephanie again and I would say that's potentially correct. Again we're working one on one with stations. So, you know, we're looking for proposals that are reasonable and that are appropriate, et cetera. But I think there's within that a lot of flexibility and we're excited to review individual state proposals. So I would say that that is correct.

Ashley Setala: Okay. Then we have a question that says, "Can vaccines or testing be mandated for Medicaid members?"

Melissa Harris: Hi, (Ashley). This is Melissa Harris. And that is a fairly relevant question. We have been getting either questions from states or notifications from states that providers are looking to mandate either or testing or vaccines and that is on our radar screen to be taking a look at. I don't have anything

final for you today in terms of a readout but we are taking a look at it. And I'm happy to share the position when we get it finalized. So it's a question that we know will have relevance really across the country.

Ashley Setala: Okay. Thanks, Melissa. So we have a question around testing that came in that essentially says, "Can you confirm, so Medicaid will pay for all testing?"

Melissa Harris: I'm sorry, this is Melissa and I couldn't get myself off mute fast enough. So we will pay for both types of testing, diagnostic and screening, and the floor of coverage is that states have to abide by the CDC recommendations for who gets the type of testing we're talking about, either diagnostic or screening. If a state wants to exceed those parameters of what CDC recommends, then that's a conversation that we would want to have with the state to make sure we understand what the state is thinking about and can talk about, you know, relevant coverage parameters.

But certainly it is a broad mandate in the ARP to cover both testing - excuse me, both diagnostic and screening testing for both children and adults without cost sharing for a variety of scenarios. It is worth reinforcing to states though to keep abreast of the CDC recommendations as those will evolve as the pandemic continues to evolve and will continue to represent the minimum expectations for compliance with the mandate. But if the state wants to go beyond CDC, we're happy to have a conversation about that.

Ashley Setala: Okay. Then we have a question that says, "Can states pay more than the Medicare rates of vaccine administration and still receive 100% FFP?"

Man: Yes. I mean, the short answer to that is yes. I think you understand how your payment rates are consistent with economy and efficiency. So, you know, we

would have questions around how you create or restructure but there is no, you know, upper limit at Medicare for vaccine administration.

Ashley Setala: Okay. Then we have a question that says, “Is the federal match for provider incentive limited to COVID-19 vaccination only or similar to the beneficiary incentive? Does it apply to the influenza vaccination as well?”

Woman: I’m sorry, (Ashley), could you repeat that question?

Ashley Setala: Sure. It says, “Is the federal match for provider incentives limited to COVID-19 vaccination only or similar to the beneficiary incentives? Does it apply to influenza vaccination as well?”

Man: So the 100% match that’s available under 9811 and 9821 is for COVID-19 vaccine administration only.

Anne Marie Costello: I think this is in regards - and this is Anne Marie Costello, in regards to incentives. I’m not sure we’ve been asked that question by the state before. So why don’t we also just take it back and circle back with everyone next week?

Ashley Setala: Great. Thanks, Anne Marie. Jackie, do we want to open the phone lines now and see if anyone has questions over the phone?

Jackie Glaze: Yes, I think that’s a good time to do that. So Operator could you give instructions to the participants to register their questions and open the phone lines?

Coordinator: Thank you. If you’d like to ask a question over the phone, please press star 1. Please ensure your phone is unmuted and record your name to ask your

question. Again that is star 1 to ask a question. One moment while we wait for any questions to come in. Our first question comes from (Rene Marlow). You may go ahead.

(Rene Marlow): Hi, thanks so much. Hi. This is (Rene) with California. And I have a quick question regarding the 100% FMAP for urban Indian organizations. Is the 100% FMAP for all Medicaid beneficiaries whether they're Native Americans or Alaskan, Indians or Hawaiian natives? Is it available for just those populations or for all Medicaid populations that are seen in those settings? Thank you.

Kitty Marx: Hi, (Rene), this Kitty Marx with Tribal Affairs at Cap. And yes, as we explained in the SHO letter, for urban Indian organizations and Native Hawaiian healthcare system, the 100% FMAP will be available for all Medicaid beneficiaries served by those entities.

(Rene Marlow): For the affected quarters that were identified in the policy guidance?

Kitty Marx: Right because 9815 is temporary. So, right, 100% FMAP for all Medicaid beneficiaries that receive services through an urban Indian organization or a Native Hawaiian healthcare system.

(Rene Marlow): Okay, very good. And then you guys will provide us with guidance for how we do the claiming for that? Or would we just make the adjustments in our CMS report?

Woman: Rory...

((Crosstalk))

Woman: ...can you jump in?

Woman: Yes, thank you.

Rory Howe: Hi, (Rene). This is Rory. So we do plan to have more information out about the MBES process for claiming federal matching, the CMS-64. And we'll share that as soon as it's available and provide more detailed instructions to states as well.

(Rene Marlow): Okay great. Thanks so much. I appreciate that.

Jackie Glaze: We have time for one more question. Do we have any additional questions in the queue?

Coordinator: Yes, just one moment. Next one is from (Arlen Golon). You may go ahead.

Arvind Goyal: Yes, I'll pronounce my name right. It's Arvind Goyal, Medical Director in Illinois Medicaid Program. I just wanted to say that incentives are good at certain times. However, freedom to stay healthy which costs the Feds and the state a lot of money and effort and everything else is probably not indicated, reminds me as a kid when I won't eat my veggie until I saw ice cream on the table.

I really wanted to have CMS very quickly develop a sustainable strategy for preventing vaccine especially in times of pandemic health emergency. I think this is extremely important because we've seen events such as polio, mumps, measles, rubella, flu every - almost every season and then of course H1N1 and now this.

I think we can probably help our people. We can help all of us and reduce this extra effort because it certainly should be a sustainable strategy. We can't deal with it and learn with every pandemic or every high incidence of any disease. So I just would request CMS to make it a high priority.

Jackie Glaze: Thank you for your comments. So in closing today, I'd like to also thank the team for their presentations and looking forward we will meet again on Tuesday, September the 14th. The topic and invitations will be forthcoming.

If you do have questions before the next call, please reach out to us, your state lead or you can bring your questions to the next call. If you decide to do that, you can do a pre-submission and you can send the questions through the Q&A portion and that would be through the medicaidcovid19@cms.hhs.gov by 1:00 pm, Eastern Time, on the day of the call.

We thank you again for joining today and we hope everyone has a good afternoon. Thank you.

Coordinator: Thank you for joining. You may now disconnect. And have a wonderful rest of your day. Speakers please stand by.

END