All-State Medicaid and CHIP Call

January 11, 2022

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Agenda

- Refresher of COVID-19 American Rescue Plan (ARP) Testing Requirements Under Medicaid and CHIP
- Medicaid Guidance on the Scope of and Payments for Qualifying Community-Based Mobile Crisis Intervention Services
- Oral COVID Drug Update
- Vaccine Counseling FAQs
- Open Mic Q and A

COVID-19 ARP Testing Requirements Under Medicaid and CHIP Refresher

- States are required to cover, without cost sharing, both diagnostic and screening testing, as recommended by the Centers for Disease Control and Prevention (CDC).
- This includes coverage of screening testing required for return-to-school or return-to-work initiatives, and travel requirements.
- **As described in the August 30, 2021 State Health Official Letter #21-003 posted on Medicaid.gov, all types of FDA-authorized COVID-19 tests must be covered under the ARP's COVID-19 testing coverage requirements, including, for example, "point of care" or "home" tests that have been provided to a Medicaid or CHIP beneficiary by a qualified Medicaid or CHIP provider of COVID-19 tests**.
  - Home tests include those where a specimen is collected at home and then sent to a clinical laboratory or other certified testing site for testing, and those that are entirely performed at home, meaning the test system includes the ability to perform the test without involvement of a laboratory. This includes, for example, over the counter COVID-19 tests available at a pharmacy.

COVID-19 ARP Testing Requirements Under Medicaid and CHIP

- While states have the ability to set clinical guidelines as part of their utilization management:
  - States are strongly encouraged to do so in ways that do not establish arbitrary barriers to accessing COVID-19 testing coverage, but that do facilitate linking the reimbursement of a covered test to an eligible Medicaid or CHIP beneficiary.
- Some States have asked for technical assistance for how to address provisions in their state laws that require prescriptions for these type of Medicaid covered services. If prescriptions are required, CMS notes that states could issue a standing order for pharmacies for tests, including over-the-counter tests, as opposed to requiring a prescription per person.
- States have also indicated a range of operational considerations and challenges they are working through to provide coverage for at-home tests. CMS is available to provide technical assistance to States and encourages States who have identified operational solutions to share best practices with other States.

Overview of Section 9813 of ARP

- Section 9813 of the American Rescue Plan Act of 2021 (ARP) amends Title XIX of the Social Security Act to add a new section 1947.
- Section 1947 authorizes a state option to provide qualifying community-based mobile crisis intervention services for a period of up to five years, during the period starting April 1, 2022, and ending March 31, 2027.
- Section 1947 ***does not*** establish a new Medicaid benefit.

Overview of Section 9813 of ARP - continued

- States with approved coverage and reimbursement authority may receive an 85 percent federal medical assistance percentage (FMAP) for expenditures on qualifying community-based mobile crisis intervention services for the first 12 fiscal quarters within the five-year period provided through:
  - The state plan;
  - Section 1915(b) waiver with corresponding authority;
  - Section 1915(c) waiver; or
  - Section 1115 demonstration.

Overview of Section 9813 of ARP - continued

- Section 1947 permits states to disregard Medicaid requirements for:
  - Statewideness,
  - Comparability,
  - Free choice of provider, and
  - Provider agreement requirements with "every person or institution providing services under the State plan."

Qualifying Services and Provider Qualifications

- Qualifying community-based mobile crisis intervention services are defined under section 1947(b) of the Social Security Act as items and services for which medical assistance is available under the state plan or a waiver of the plan and that meet the conditions described in section 1947(b)(1) through 1947(b)(3).

Qualifying Services and Provider Qualifications - continued

- Under section 1947(b)(1), services must be provided to individuals who are:
  - Medicaid eligible either through the state plan or a waiver of such plan;
  - Experiencing a mental health or SUD crisis; and
  - Outside of a hospital or other facility setting

Multi-Disciplinary Team

- Under section 1947(b)(2), services must be delivered by a multi-disciplinary team.
  - Team must includes one licensed behavioral health professional and other professionals or paraprofessionals (including peer support specialists) with expertise in behavioral health care.
  - Team members must be trained in: trauma informed care, de-escalation strategies and harm reduction.

Multi-Disciplinary Team- continued

- Teams are able to respond to crises in a timely manner, as established by the state.
- Teams provide, where appropriate:
  - screening and assessment;
  - stabilization and de-escalation; and
  - coordination with and referrals to health, social and other services and supports, as needed, and health services as needed.

Multi-Disciplinary Team- continued

- Teams maintain relationships with relevant community partners, including medical, behavioral health and primary care providers, community health centers, crisis respite centers, and managed care organizations (if applicable).
- Teams maintain privacy and confidentiality of patient information, consistent with federal and state requirements.
- Under section 1947(b)(3), community-based mobile crisis intervention services must be available 24 hours a day, every day of the year.

Provider Payment and Delivery Systems

- Community-based mobile crisis intervention services may be provided through either a fee-for-service (FFS) or managed care delivery system.
  - State plan services through a FFS delivery system must have approved Attachment 4.19-B pages.
  - For managed care delivery systems, in addition to an approved Medicaid authority, services must be specified in managed care plan contracts and included in corresponding managed care capitation rates.

Maintenance of Effort

- Additional federal funds for qualifying community-based mobile crisis intervention services attributable to the increased FMAP must supplement and not supplant the level of state funds expended for such services in the federal fiscal year prior to April 1, 2022.

Maintenance of Effort- continued

- States must:
  - Not impose stricter standards for receipt of community-based mobile crisis intervention services than those in effect on September 30, 2021;
  - Preserve or exceed the amount, duration, and scope of community-based mobile crisis intervention services in effect on September 30, 2021; and
  - Maintain community-based mobile crisis intervention services provider payments at a rate no less than those on September 30, 2021.

Increased FMAP and Claiming

- CMS will implement changes to the automated Medicaid Budget and Expenditure System/CHIP Budget and Expenditure System (MBES/CBES) to ensure that states will be able to accurately report budget estimates and expenditures related to increased FMAP for qualifying community-based mobile crisis intervention services, consistent with requirements of section 1947.

Administrative Claiming

- Federal administrative match may be available for state Medicaid agency costs associated with establishing and supporting delivery of community-based mobile crisis intervention services for people with mental health conditions or SUD.
- Allowable administrative activities could include operating state crisis access lines and dispatching mobile crisis teams as needed to assist Medicaid beneficiaries.
- Additional detail on approaches to administrative claiming will be presented at the 1/25/22 All State Call.

Medicaid Coverage, Payment and Service Delivery System

- If states do not cover community-based mobile crisis intervention services or need to make changes to the benefit, payment or service delivery mechanism, states will need to submit necessary changes to the applicable authority:
  - A state plan amendment (SPA),
  - 1915(c) HCBS waiver application,
  - 1915(b) waiver with corresponding authority,
  - And/or an 1115 demonstration application.
- States must follow processes for the selected Medicaid authority.

Planning Grants

- State planning grants are authorized at section 1947(e) of the Act.
- CMS awarded planning grants to 20 states on September 20, 2021.
- States did not need to apply for and/or receive a planning grant in order to provide qualifying community-based mobile crisis intervention services.

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Oral COVID Drug Update

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Vaccine Counseling FAQs

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Questions