HCBS Stabilization Grants

Frequently Asked Questions

January 24, 2022

Grant Period

1. What period of time does the grant cover and for which allowable expenses may be claimed as support for the grant?

   Per State Medicaid Directors Letter # 21-003 RE: Implementation of American Rescue Plan Act of 2021 Section 9817: Additional Support for Medicaid Home and Community-Based Services during the COVID-19 Emergency, the grant period begins April 1, 2021 and allowable expense may be claimed through March 31, 2024.

Grant Amount

2. How was the grant amount of 7% - 8% determined?

   The process of determining the individual grant amount of each provider begins with the eligible total Medicaid claims for each provider for an annual period. FSSA is electing to use the higher of total claims for services delivered during the calendar year periods ended December 31, 2019 or December 31, 2020. For example, if a provider had $23,000 in total Medicaid claims for services delivered during the year ended December 31, 2019 and only $12,000 in claims for the year ended December 31, 2020, their eligible total Medicaid claims for the calculation of the grant amount would be $23,000.

   FSSA has done an estimated calculation for what is believed to be each of the eligible providers to arrive at an estimated statewide total for eligible total Medicaid claims. The total funding available of $173 million was divided by the estimated statewide total eligible Medicaid claims to estimate a percentage of grant funding of 7% - 8% per provider.

   However, if not all of the providers apply for funding and sign the attestation, it is possible that this percentage may be understated. In other words, if the estimated total eligible Medicaid claims is $2.4 billion and every provider applied, the available $173 million in grant funding would provide a grant amount of 7.2% of each provider's eligible Medicaid claims. However if not every eligible provider applies and the total eligible Medicaid claims of those that do apply is only $2 billion, the grant funding percentage would 8.65%. For providers who do the early attestation, if enough providers do not apply and the difference in funding is of a

significant amount, FSSA may issue a second payment to these providers of a small amount to true up the percentage paid.

3. For purposes of determining grant amounts, are you using amounts paid during the annual period or the services provided during that annual period regardless of when those services were paid?

   FSSA intends to utilize services provided during the appropriate period, not the total of claims payment during that period for determining the grant amounts.

4. What if I am a new provider who only began providing services in 2021, how will my grant amount be determined?

   I.

   II. For providers that were only active in CY2021, FSSA will use CY2021 claims expenditures as the baseline.

   III.

5. My company closed in late 2020 but was a provider of services in 2019 and 2020. Is my company eligible for grant funding?

   IV.

   V. In order to be eligible, a provider number must have been active in 2021, submitted at least one claim in 2021 and remain active at the time of the grant.

Attestation

6. Do some providers need to submit multiple attestations if they have multiple programs that they believe are eligible for the grant?

   Each provider billing number will require a completed attestation in order to receive their grant funds. If a provider has multiple services billed under one provider number, the provider only needs to file an attestation for the one provider number.

7. My company has several different eligible provider numbers that should receive grant amounts. Can we aggregate these grant awards into one larger amount and track expenses to support this larger amount?

   Yes if one company under the same tax identification number has several grant awards under this program, they may aggregate these awards and treat them as one award for the purposes of tracking and documenting eligible expenses for reporting and audit purposes.

Eligible Services

8. Can you please describe eligible services?

   These grants are intended to support Home and Community Based Services Programs and not other types of services including any institutional services such as nursing homes or group homes. While some individuals may live in

congregate settings such as independent living apartments and/or assisted living, their services may still be eligible if they are provided by home health agency, waiver provider or one of the other types of providers listed below.

Eligible Medicaid services are those that are billed by the following types of providers:

- 05 (Home Health Agency)
- 11 (Behavioral Health Provider)
    - Specialty 111 (Community Mental Health Center) – for Medicaid Rehabilitation Option (MRO) services
    - Specialty 115 (Adult Mental Health and Habilitation)
    - Specialty 611 (Children's Mental Health Wraparound)
    - Specialty 612 (Behavioral and Primary Healthcare Coordination)
- 12 (School Corporation)
- 32 (Waiver)
- Program of All-Inclusive Care for the Elderly (PACE) programs

Any services billed to Medicaid by these types of providers is eligible. It is important for each provider to check their provider type on file to ensure it is one of the eligible provider types.

Eligible Employee

9. Can you please define "Frontline Staff?"

Consistent with the US Department of Treasury Final Rule that implements the Coronavirus State Fiscal Recovery Fund and the Coronavirus Local Fiscal Recovery Fund established under the American Rescue Plan Act, "frontline staff" are employees that provide eligible services which involve:

(i) Regular in-person interactions with patients, the public, or coworkers of the individual that is performing the work; or

(ii) Regular physical handling of items that were handled by, or are to be handled by patients, the public, or coworkers of the individual that is performing the work.

In addition to direct support professionals and home health workers, the above description also includes support staff (such as cafeteria servers, housekeepers, activities personnel, therapists, case managers, etc.) that consistently interact with the individuals being served or their co-workers that have these interactions. Also, consistent with the above, direct supervisors of employees that have

regular in-person interactions with the staff serving individuals or their families or have direct interactions with individuals or their families are considered eligible.

10. Can funds be used for management and administrative staff?

    No these funds may not be utilized for management and administrative staff. In accordance with the American Rescue Plan Act of 2021 section 9815 and State Medicaid Directors Letter # 21-003, these grant funds are intended to support direct support professionals, home health workers and others that have regular in-person interactions with patients, their families or co-workers that provide these services. Other staff that do not have regular interactions with the people being served are not eligible.

Allowable Expenses for 75% Passthrough to Frontline Workers

11. What types of expenses are considered allowable for the 75% passthrough to frontline workers?

    In accordance with State Medicaid Directors Letter # 21-003, providers may passthrough compensation and wages including bonuses, hazard pay, overtime pay, and shift differential pay for frontline workers as long as it has not been claimed as an allowable expense to support a grant or other support (e.g. Provider Relief Funds, State Coronavirus Relief Fund grants, etc.)

    FSSA is not specifically advising on how compensation and wages passed through to frontline workers should be structured as these are facts and circumstances specific with various providers or provider types having different issues.

12. Are benefits and payroll taxes allowable as part of the 75% passthrough to frontline workers?

    In general, if an employee's wages and salaries are an eligible use of these grant funds, recipients may treat the employee's covered benefits and payroll taxes as an eligible use of grant funds. For purposes of these funds, covered benefits include costs of all types of leave (vacation, family-related, sick, military, bereavement, sabbatical, jury duty), employee insurance (health, life, dental, vision), retirement (pensions, 401(k)), unemployment benefit plans (federal and state), workers compensation insurance, and Federal Insurance Contributions Act (FICA) taxes (which includes Social Security and Medicare taxes). contributions for employees whose wages and salaries are an eligible use of grant funds.

13. If a company has both eligible provider types and other provider types that are not eligible but provide bonuses or other allowable expenses to all of their frontline staff regardless of provider type, can these expenses be counted towards the grant?

No, only allowable expenses passed through to eligible employees of eligible provider types are considered allowable grant expenditures.

14. Do we have to wait to receive the grant funds to spend them?

    No, since the eligible grant period began on April 1, 2021, providers do not have to wait for grant funding to provide additional compensation and wages or benefits to eligible employees. Any eligible expenses for eligible employees from April 1, 2021 through March 31, 2024 may be considered allowable grant expenditures as long as they have not been paid for by or claimed against another funding source.

Allowable Expenses for the 25% Other Allowable Expenses

15. Can you provide examples of allowable expense that would count towards the 25% of the grant that is not considered a passthrough to employees?

    Examples included in Appendix C of State Medicaid Directors Letter # 21-003, include:

    - Provide paid sick leave, paid family leave, and paid medical leave for home health workers and direct support professionals that are not already included in the service rate/rate methodology.

    - Purchase PPE and routine COVID testing for direct service workers and people receiving HCBS, to enhance access to services and to protect the health and well-being of home health workers and direct support professionals.

    - Conduct activities to recruit and retain home health workers and direct support professionals. Offer incentive payments to recruit and retain home health workers and direct support professionals.

    - Provide training for home health workers and direct support professionals that is specific to the COVID-19 PHE.

    - Make physical, operational, or other changes to safely deliver services during the COVID-19 PHE.

    - Support family care providers of eligible individuals with needed supplies and equipment, which may include items not typically covered under the Medicaid program, such as PPE and payment as a service provider.

    - Provide assistive technologies (including internet activation costs necessary to support use of the assistive technologies), staffing, and other costs incurred during the COVID-19 PHE in order to mitigate isolation and

ensure an individual's person-centered service plan continues to be fully implemented.

- Facilitate individuals transitioning from an institutional or another provider-operated congregate living arrangement (such as a group home or homeless shelter) to a community-based living arrangement in a private residence where the person is directly responsible for his or her own living expenses. One-time community transition costs may include payment of necessary expenses to establish a beneficiary's basic living arrangement, such as security deposits, utility activation fees, and essential household furnishings, for example.

- Provide transition coordination services to eligible individuals who had to relocate to a nursing facility or institutional setting from their homes during the COVID-19 PHE, or moved into congregate non- institutional settings as a result of the COVID-19 PHE, as well as for temporary relocation of residents from various types of congregate settings to community-based settings to reduce the risk of COVID-19 infection during the COVID-19 PHE.

- Assist eligible individuals in receiving mental health services, substance use treatment and recovery services, and necessary rehabilitative services to regain skills lost during the COVID-19 PHE.

- Recruit additional behavioral health providers, implement new behavioral health services, increase pay rates for behavioral health providers, expand access to telehealth, or make other changes to address increases in overdose rates or other mental health and/or substance use disorder treatment and recovery service needs of Medicaid beneficiaries receiving HCBS during the COVID-19 PHE.

- Assist with scheduling vaccine appointments. Provide transportation to vaccine sites. Provide direct support services for vaccine appointments. Develop and implement in-home vaccination options. Education and outreach about the COVID-19 vaccine.

16. If a company has human resources and other recruiting programs that cover both eligible provider types and other provider types that are not eligible, can the administrative costs of designing and implementing these programs be considered an allowable expense?

    Yes, if a company is designing and implementing new recruiting and retention programs that cover both HCBS and non-HCBS services, they may claim the administrative costs of these efforts. Examples of administrative costs include

designing new benefit programs, compensation consulting fees, additional human resources employees to support eligible employees, etc. The actual costs of programs (e.g. retention bonuses, payments to employees under new leave programs, etc.) should be allocated to each program based on the employees who benefit from these programs.

Audits

17. Can you tell us what the audit requirements will be?

    At this point, audit procedures and requirements have not been defined. These funds are not considered Federal Coronavirus Relief Funds but are considered Medicaid Supplemental Payments subject to Medicaid audit requirements. Any audits performed by FSSA auditors or their contractors will review compliance with the terms of the Attestation including a review of allowable expenditures in accordance with the terms of the grant. As with many of the other grant programs during the Public Health Emergency, providers who receive these funds are expected to retain documentation for a three year period after the end of the grant period to support allowable expenditures for any amounts received.