



### **Timing Questions**

**1. Q: When will the funding become available?**

A: Funding is anticipated to be distributed prior to March 31, 2022. Funding may be distributed sooner, pending approval from CMS.

**2. Q: What is the time frame to spend the funding?**

A: Funding is to be expended by June 30, 2024. Once the program has been established the state will work with stakeholders to determine if exceptions are needed.

### **Eligibility and Process Questions**

**3. Q: Is the funding based on total Medicaid funds given to the provider or is it specific to a qualifying program/service?**

A: Funding is based on qualifying home and community-based services and certain Medicaid funded services provided in community mental health centers and enrolled substance use disorder providers pursuant to federal requirements.

**4. Q: Will funding be given up front or through a reimbursement process?**

A: Funding will be distributed as a one-time up-front payment. The provider will be required to attest as to how funds will be used. Payment will not be on a reimbursement basis.

**5. Q: Can funds be allocated to previous expenditures?**

A: Pursuant to federal requirements, funding must be used for expenses incurred after awards are distributed.

**6. Q: Will expenses need pre-approval?**

A: No, but all expenses must meet the allowable uses as outlined within the funding agreement.

**7. Q: Do providers who have a facility that is a dual facility but under has only one TIN, fill out one application or two? (HSA)**

A: Business owners and providers with multiple TINs must complete one application for each TIN. Each provider must note in their application all services that fall under each TIN.

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### 8. Q: For agencies that are 501c3, do these funds/monies count toward the amount for an A-133 audit?

A: Medicaid funding/Title XIX is an entitlement program and fee for service arrangements are not considered a subrecipient relationship. Funding will be provided through the normal Medicaid payment process and will need to be reported in the same manner.

### 9. Q: If the total award is not expended by our agency, is the remaining sent back to the State?

A: The State encourages providers to fully utilize this funding to enhance, expand, or strengthen HCBS services. In the event a provider does not utilize the full award, the provider must notify DSS/DHS.

### 10. Q: What is the definition of “spent”? Can the funds be obligated by June 30, 2024?

A: Funding is to be expended or obligated by June 30, 2024. Once the program has been established the state will work with stakeholders to determine if exceptions are needed.

### 11. What is the process for entities that merge with or are acquired by another company? Will the award follow the clients and employees? Which entity will be responsible for reporting?

A: When an entity merges with or is acquired by another entity, the State should be notified immediately. The State will review each situation on a case-by-case basis and would work with the new entity to ensure the funding follows the clients and employees. Similar to other cost reporting guidelines, reporting should be done by each entity (i.e. the buyer and the seller), for the reporting period in which they owned the company.

### 12. Is the FMAP funding considered a grant? If the FMAP funding is a grant, is it taxable?

A: The source of the grant funds is Title XIX/Medicaid and is not a grant. The funding is the same source of funds used to reimburse providers for the targeted HCBS services so would have the same conditions relative to taxable/untaxable as your current Medicaid funding.

## Use of Funds Questions

### 13. Q: What percentage of the funds must, or could, be used for direct care workforce? What about equipment and supplies?

A: The Certifications and Authorizations section of the application and Lines 10 and 11 of the Attestation describe the required and acceptable ways that providers will expend the funds, expressed in percentages below:

- 80% of the total funds will be spent on direct care workforce
- No more than 55% of the total funds will be used for one-time compensation adjustments
- 20% of the total funds will be spent on equipment and supplies

Hypothetical:

- A provider receives \$100,000 in one-time funding.

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- The provider must spend \$80,000 on direct care workforce, which may include, one-time compensation adjustments; temporary shift differentials; retention incentives, such as paid family leave and paid sick leave; direct care worker training and education; and other activities to recruit direct care workers.
- The provider may not spend more than \$55,000 on one-time compensation adjustments for direct care workforce.
- The provider must spend \$20,000 on equipment and supplies, which may include expenses related to COVID-19 related equipment, testing supplies, and infection control; telehealth equipment and assistive technology for providers; and other supplies and equipment that enhance the delivery of home and community-based services.

### **14. Q: What is the definition of “direct care workforce”? Does it include the front-line supervisors of those staff? Does it include nurses? What about case managers?**

A: Direct care workforce is defined as staff member or employees who are directly providing care, services, or supports to a patient or person-served on a routine basis. Direct care workforce does include front-line supervisors, nurses and others who are directly providing care, services, or supports to a patient or person-served on a routine basis.

### **15. Q: Are there any limits per person for retention or one-time compensation spending?**

A: There is no per person limit, but no more than 55% of the total funds will be used for one-time compensation adjustments.

Note: Any compensation adjustment would be included in the 55%, regardless of if it is meant to be one-time or ongoing. Additionally, the State encourages this one-time funding to be used for one-time needs.

### **16. Q: Can these funds be used to cover costs, such as, direct worker payroll, recruiter wages, newly hired direct care worker wages, raises for direct care workers, temporary staffing costs, and overtime pay for direct care workforce?**

A: Providers may only use the supplemental payment funds to supplement, not supplant, existing expenditures for Medicaid home and community-based services.

### **17. Q: Will there be a waiver process for adjusting the 80/20% for those providers with unique needs?**

A: The State is developing a waiver process and seeking approval from CMS. Details will be forthcoming.

### **18. Q: Can providers use this one-time funding to cover existing benefits like paid, sick or family leave, or can the one-time funding only be used for new benefits?**

A: If a provider already offers paid, sick, or family leave, and wants to increase or enhance these benefits, this is acceptable.

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**19. Q: Can these funds be used for capital costs/new construction of a facility?**

A: Due to the payments including federal medical assistance funds, the funds cannot be used for capital costs/construction costs.

**20. Q: If a provider facility changed ownership is the Medicaid Revenue for the facility inclusive of all of payments and not per provider?**

A: Yes.

**21. Q: For hospitals with employees providing home health care services to Medicaid patients, would these one-time funds be restricted for use to the hospital's home health/hospice department?**

A: The funding must specifically be used to enhance HCBS.

**22. Q: If a provider added new paid time off days, or something similar, starting on July 1, 2021, could this one-time funding be used to cover these new expenses?**

A: The expenses must have been incurred after this one-time funding has been awarded.

**23. Q: Are eligible expenses only those listed in the State guidance to providers (i.e. Direct Care Workforce and Equipment and Supplies), or can the award be spent on any expenditures referenced in the CMS letter to the State Medicaid Director?**

A: The federal government will not allow a supplemental payment to be made to providers for use in any of the categories listed in CMS's letter at the providers discretion. CMS required South Dakota to specify categories the funds can be used for and associated percentage caps. As such, expenses must be specific to eligible uses of funds outlined in the Zoom webinar.

**24. Q: If a provider gave a staff retention payment, but spread the payment over a few weeks, would that be considered a one-time compensation adjustment?**

A: Yes.

**25. Q: As part of the Supplies and Equipment funding category, can providers use those funds to encourage staff to get their COVID-19 vaccination by giving them a bonus for doing so?**

A: No, a bonus to staff members for any purpose is not considered supplies or equipment.

**26. Q: Are team building events an eligible expense?**

A: Funds must be used to enhance, expand, or strengthen home and community-based services. These types of expenses could be eligible if they meet these criteria and are used to retain direct care workforce.

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**27. Q: Are there other expenses, outside of paid time off, that providers can use the Direct Care Workforce funding on?**

A: Examples of eligible expenses to address direct care workforce includes, one-time compensation payments, including temporary shift differentials; a onetime compensation adjustment to direct care staff for retention; other types of retention incentives such as paid family leave and paid sick leave; and activities to recruit direct care workers.

**28. Q: Is training for staff, such as Certified Nursing Assistants, dementia, CPR, etc. an eligible expense?**

A: Training is an eligible expense, so long as it is for direct care staff and enhances home and community-based services.

**29. Q: Are case managers and support coordinators considered “direct care staff”?**

A: Direct care workforce is defined as staff member or employees who are directly providing care, services, or supports to a patient or person-served on a routine basis. Direct care workforce does include front-line supervisors, nurses and others who are directly providing care, services, or supports to a patient or person-served on a routine basis.

**30. Q: Regarding equipment, does a carpet extractor for cleaning qualify?**

A: Cleaning equipment and supplies related to COVID-19 infection control are an allowable use of funds. Providers must be able to justify how the equipment and supplies aide in COVID-19 infection control. It is not readily apparent that a carpet extractor meets this requirement.

**31. Q: Regarding equipment, can more exercise equipment be purchased, specifically for negative tested residents to use during a COVID outbreak?**

A: Funds must be used to enhance, expand, or strengthen home and community-based services. Providers must be able to justify how equipment purchased with these funds satisfies this requirement. It is not readily apparent that exercise equipment meets this requirement.

**32. Q: Is hiring an additional nurse to increase nursing coverage an eligible expense?**

A: Hiring additional direct care workforce with these one-time funds is acceptable. However, when the one-time funds are spent the provider must be able to bear the cost of the additional staff. Therefore, funding is encouraged to be used on one-time expenses only.

**33. Q: What, if any, administrative costs are allowed?**

A: No, administrative costs are not considered eligible expenses within either direct care workforce expenses or equipment and supplies expenses.

**34. Q: If we pay a bonus to direct care workers quarterly, does that fit under the 55% one-time payment?**

A: Yes

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**35. Q: Do recruitment expenses fall into the 55%?**

A: Only one-time compensation adjustment expenses are subject to the 55% threshold. Other non-compensation adjustment activities to recruit direct care workers would meet the requirements for the direct care workforce category and subject to the 80% threshold.

**36. Q: Can these funds be used to purchase vehicles?**

A: Purchasing vehicles for the purpose of providing transportation to waiver beneficiaries under the CHOICES and HOPE waivers for residential and day habilitation services is allowable. Providers should reach out to their State contacts for any questions relating to purchasing vehicles that do not meet this criteria.

**37. Q: For agencies that provide multiple services funded through both DSS and DHS or multiple programs/waivers within those agencies, do the funds have to be spent on specific staff that fall within those areas?**

A. Providers must ensure that the funding is reinvested in qualifying HCBS services.

**38. Could the one-time supplemental funds be used to build and outfit a computer lab and training space that our direct care workforce could use to enhance their skills?**

A: Federal guidance prohibits use of the funding for construction/renovation, but the funds could be used to purchase the equipment (computers, monitors, smart screen, etc.) for the lab.

**39. Under the Equipment and Supplies category, could the one-time supplemental funds be used to purchase a training doll, and catheter/other supplies and uniforms for caregivers?**

A: Equipment and supplies and staff training that enhance HCBS services are allowable

**40. Q: Would reimbursing staff members for vehicle maintenance and repair, or other vehicle costs, be an allowable expense under the equipment category?**

A: These types of expenses would not be meet the qualifications for the equipment funding, however, providers are able to spend 80% of the award on retention incentives and other activities to recruit direct care workers. Providing a stipend to direct care workers for such expenses that enhance, expand, or strengthen home and community-based services is allowable, so long as the funding is supplementing, not supplanting, existing expenditures for Medicaid home and community-based services.

**41. Q: Can the equipment funding be used to upgrade cell phones and pay for employee's cellphone bills?**

A: While upgrading equipment, including cellphones, would be an allowable expense, the provider must ensure that the funding must be used to enhance, expand, or strengthen home and community-based services. Providers are able to spend 80% of the award on retention incentives and other activities to recruit direct care workers. Providing a stipend to direct care workers for such expenses that enhance, expand, or strengthen home and community-based services is allowable, so long as the funding is

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supplementing, not supplanting, existing expenditures for Medicaid home and community-based services.

**42. Q: The payments to staff as gross wages, also includes associated benefits expense as an allowable expense, correct?**

A: Yes

**43. Q: If a provider gives an additional holiday to staff, for example Juneteenth (June 19, 2022), is that considered a one-time expense compensation adjustment or is it considered a retainment activity (non-compensation adjustment)?**

A: Retainment activity (non-compensation adjustment)

### **Reporting Questions**

**44. Q: What type of reporting will need to be done?**

A: Providers will be required to report information within the categories outlined in the agreement. The State will continue to work with providers to develop a reporting instrument. We intend to publish a reporting template by the end of April 2022.

**45. Q: How should these funds be shown on the cost report?**

A: Funding should be clearly reported and identified in the cost reports. Guidance will be forthcoming regarding specific cost reporting requirements.

### **Technical Questions**

**46. Q: How do providers know who in their organization will be receiving emails from the State on 2/9/22 and 2/14/22 and beyond? Do providers need to ensure there is accurate contact information available somewhere?**

A: For each eligible provider, the State has determined whether the provider applied for one of the State's CARES Act-related grants in 2021.

For eligible providers who did apply for one of the State's CARES Act-related grants in 2021, the State will send emails to those providers' "authorized representative" already on file.

For eligible providers who did not apply for one of the State's CARES Act-related grants in 2021, the State has communicated with those providers to establish an "authorized representative" and that representative's contact information. The State will send emails to these authorized representatives.

If the applicant's "Business Information", especially the "authorized representative" on their application is incorrect, the applicant should contact the Program Helpline at (605) 303 – 8775, or Toll Free at (866) 507 – 8463, or the Program Email at DSS.GRANTS@state.sd.us. Applicants should be prepared to provide the TIN associated with the application as well as the first name, last name, and email of the authorized representative.

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## 47. Q: Will applicants receive confirmation of receipt of a complete application?

A: Yes. Applying providers will receive various email communication updates as the application is processed.

## 48. Q: Will applying providers be able to print out the completed application in a printer-friendly format?

A: Applicants can print a completed copy of their application by utilizing the print function in their browser.

### FAQ Change Log

Version	Revision Date	Change Location	Description of Changes
1.0	05 Jan 2022	N/A	Initial FAQ
1.1	17 Feb 2022	All	Restructure of FAQ and answers in Version 1.0 into sections / groupings by type  Addition of FAQs from the 2/8/22 Provider Webinar and questions from applicants between 2/9/22 and 2/16/22
1.2	24 Feb 2022	See description of changes	Revised numbering  Revised answer to: Q: Is hiring an additional nurse to increase nursing coverage an eligible expense?  Added Question #s: 9, 10, 31, 32, 33, and 34
1.3	17 March 2022	See description of changes	Revised numbering  Added Question #s: 11, 38, and 39
1.4	11 April 2022	See description of changes	Revised numbering  Updated answers to FAQs#11, 15, and 35  Added Question #s: 12, 36-43
1.5	30 August 2022	See description of changes	Questions 2 and 10 revised with new deadline of June 30, 2024 for expenditure of one-time supplemental funds