Iowa Helping Community Policy Group

Advancing federal and state policies that value and support those in the helping communities – paid and unpaid – in their vital roles.

THE AMERICAN RESCUE PLAN ACT AND ADDITIONAL FEDERAL FINANCIAL PARTICIPATION FOR HOME AND COMMUNITY-BASED SERVICES: KEY DOCUMENTS

Part of the American Rescue Plan Act provides an increase in the federal match (federal financial participation – FFP) for home and community-based services under Medicaid, with a maintenance of effort for states to effectively use the increased federal funding to expand or enhance those services. This is for a one-year time period, but there are other proposals from the Administration to provide federal funding to expand support for home-and-community-based services, so the planning work around use of these funds should recognize long-term needs and opportunities as well as specific actions to use the new federal funding.

The Iowa Department of Human Services has requested feedback from the public on how Iowa can improve the quality and access to Medicaid Home and Community-Based Services.

This document provides three source documents for making such comments and for tracking and seeking to impact Iowa activities related to Medicaid and home and community-based services:

IOWA DEPARTMENT OF HUMAN SERVICES REQUEST FOR COMMENT

Feedback Requested for Iowa Medicaid's American Rescue Plan Act Funds

On March 11, 2021, U.S. President Joe Biden signed the American Rescue Plan Act (ARPA) of which provides qualifying states with a temporary increase in federal funding for certain Home- and Community-Based Services (HCBS) from April 1, 2021 through March 31, 2022. Under ARPA, states can implement a variety of activities using this funding, including enhancements to HCBS services, eligibility, infrastructure, and reimbursement methodologies, to enhance, expand, or strengthen Medicaid HCBS.

The time-period allowed to expend funds attributable to the increased federal funding will provide Iowa with sufficient time to design and implement short-term and sustainable activities to strengthen the HCBS program in the state.

Due to the specific needs of the Iowa program, the Department is soliciting ideas from the public for strategies to improve the quality and access to Medicaid HCBS utilizing the following three levers:

- **Increased Training and Support** HCBS providers work diligently to provider comprehensive training to their staff, however there may be spaces in which training is needed to provide more specialized care and expand services to individuals with more complex needs. Training can be challenging to find and expensive for provider agencies to seek out individually. Investment in a statewide training system may provide consistent, innovative, and more efficient training opportunities to staff in all areas of the state and across provider types.

- **Expanded Access** Provider and service access across the state can be a barrier for a number of reasons. Providers may be willing to expand services geographically or enhance services for those individuals with complex or specialized needs but lack the up-front investments and resources needed to do so. Utilizing this funding to invest in sustainable provider expansion is critical at a time where need is increasing.

- **Workforce Support** While workforce is a substantial concern for a number of sectors, this is an area of particular concern for HCBS providers across the state that has only been made worse by the pandemic. Investing in meaningful and sustainable solutions to attracting and retaining individuals to the important work of HCBS is critical.

The Department is requesting feedback from the public for strategies to improve the quality and access to Medicaid HCBS utilizing the three levers listed above.

Please provide feedback by Wednesday, July 7, 2021, to IMECOVID19@dhs.state.ia.us.

Additionally, the Department will hold a virtual town hall on **Thursday, July 8, 2021, from 3:30 to 4:30 p.m.** to discuss strategies to improve HCBS. Those interested in attending the meeting can register online. Meeting details will be emailed to registered guests the day of the meeting.

FEDERAL STATUTORY LANGUAGE FOR ENHANCED MEDICAID HOME AND COMMUNITY-BASED SERVICES

SEC. 9817. ADDITIONAL SUPPORT FOR MEDICAID HOME AND COMMUNITY-BASED SERVICES DURING THE COVID–19 EMERGENCY.

(a) INCREASED FMAP.—

(1) IN GENERAL.—Notwithstanding section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) or section 1905(ff), in the case of a State that meets the HCBS program requirements under subsection (b), the Federal medical assistance percentage determined for the State under section 1905(b) of such Act (or, if applicable, under section 1905(ff)) and, if applicable, increased under subsection (y), (z), (aa), or (ii) of section 1905 of such Act (42 U.S.C. 1396d), section 1915(k) of such Act (42 U.S.C. 1396n(k)), or section 6008(a) of the Families First Coronavirus Response Act (Public Law 116– 127), shall be increased by 10 percentage points with respect to expenditures of the State under the State Medicaid program for home and community-based services (as defined in paragraph (2)(B)) that are provided during the HCBS program improvement period (as defined in paragraph (2)(A)). In no case may the application of the previous sentence result in the Federal medical assistance percentage determined for a State being more than 95 percent with respect to such expenditures. Any payment made to Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa for expenditures on medical assistance that are subject to the Federal medical assistance percentage increase specified under the first sentence of this paragraph shall not be taken into account for purposes of applying payment limits under subsections (f) and (g) of section 1108 of the Social Security Act (42 U.S.C. 1308).

(2) DEFINITIONS.—In this section:

(A) HCBS PROGRAM IMPROVEMENT PERIOD.—The term ‘‘HCBS program improvement period’’ means, with respect to a State, the period— (i) beginning on April 1, 2021; and (ii) ending on March 31, 2022.

(B) HOME AND COMMUNITY-BASED SERVICES.—The term ‘‘home and community-based services’’ means any of the following: H. R. 1319—214

(i) Home health care services authorized under paragraph (7) of section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)).

(ii) Personal care services authorized under paragraph (24) of such section.

(iii) PACE services authorized under paragraph (26) of such section.

(iv) Home and community-based services authorized under subsections (b), (c), (i), (j), and (k) of section 1915 of such Act (42 U.S.C. 1396n), such services authorized under a waiver under section 1115 of such Act (42 U.S.C. 1315), and

such services through coverage authorized under section 1937 of such Act (42 U.S.C. 1396u–7).

(v) Case management services authorized under section 1905(a)(19) of the Social Security Act (42 U.S.C. 1396d(a)(19)) and section 1915(g) of such Act (42 U.S.C. 1396n(g)).

(vi) Rehabilitative services, including those related to behavioral health, described in section 1905(a)(13) of such Act (42 U.S.C. 1396d(a)(13)).

(vii) Such other services specified by the Secretary of Health and Human Services.

(C) ELIGIBLE INDIVIDUAL.—The term ''eligible individual'' means an individual who is eligible for and enrolled for medical assistance under a State Medicaid program and includes an individual who becomes eligible for medical assistance under a State Medicaid program when removed from a waiting list.

(D) MEDICAID PROGRAM.—The term ''Medicaid program'' means, with respect to a State, the State program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) (including any waiver or demonstration under such title or under section 1115 of such Act (42 U.S.C. 1315) relating to such title).

(E) STATE.—The term ''State'' has the meaning given such term for purposes of title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(b) STATE REQUIREMENTS FOR FMAP INCREASE.—As conditions for receipt of the increase under subsection (a) to the Federal medical assistance percentage determined for a State, the State shall meet each of the following requirements (referred to in subsection (a) as the HCBS program requirements):

(1) SUPPLEMENT, NOT SUPPLANT.—The State shall use the Federal funds attributable to the increase under subsection (a) to supplement, and not supplant, the level of State funds expended for home and community-based services for eligible individuals through programs in effect as of April 1, 2021.

(2) REQUIRED IMPLEMENTATION OF CERTAIN ACTIVITIES.— The State shall implement, or supplement the implementation of, one or more activities to enhance, expand, or strengthen home and community-based services under the State Medicaid program. H. R. 1319—215

CMS LETTER TO STATE MEDICAID DIRECTORS PROVIDING GUIDANCE ON FUNDING

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services 7500 Security Boulevard, Mail Stop S2-26-12 Baltimore, Maryland 21244-1850 SMD# 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

May 13, 2021

Dear State Medicaid Director:

On March 11, 2021, President Biden signed the American Rescue Plan Act of 2021 (ARP) (Pub. L. 117-2). Section 9817 of the ARP provides qualifying states with a temporary 10 percentage point increase to the federal medical assistance percentage (FMAP) for certain Medicaid expenditures for home and community-based services (HCBS). States must use the federal funds attributable to the increased FMAP to supplement, not supplant, existing state funds expended for Medicaid HCBS in effect as of April 1, 2021, and states must use state funds equivalent to the amount of federal funds attributable to the increased FMAP to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program.

The purpose of this letter is to provide guidance to states on the implementation of section 9817 of the ARP, as well as to describe opportunities for states to strengthen the HCBS system in response to the COVID-19 Public Health Emergency (PHE), increase access to HCBS for Medicaid beneficiaries, adequately protect the HCBS workforce, safeguard financial stability for HCBS providers, and accelerate long-term services and supports (LTSS) reform under section 9817 of the ARP. This increased federal funding can help states increase community living options for people with disabilities, in accordance with Title II of the Americans with Disabilities Act, 42 U.S.C. §§ 12131–12134, as interpreted by the Supreme Court in Olmstead v. L.C., 527 U.S. 581 (1999), which requires public entities to administer services to individuals with disabilities in the most integrated setting appropriate to their needs. In addition, this letter updates Medicaid retainer payment policy for HCBS providers during the COVID-19 PHE.

Section 1: Increased Federal Medical Assistance Percentage (FMAP) under Section 9817 of the ARP

Section 9817 of the ARP temporarily increases the FMAP by 10 percentage points for certain Medicaid1 HCBS expenditures beginning April 1, 2021, and ending March 31, 2022 (see Appendix A). To receive the increased FMAP, states and territories must meet certain requirements, referred to as "Program Requirements" below. It is important to note that the increased FMAP for HCBS for any state or territory cannot exceed 95 percent. Additionally, any payment made to Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa for expenditures on medical assistance subject to the FMAP increase must not be taken into account for purposes of applying payment limits under subsections (f) and (g) of section 1108 of the Social Security Act (the Act).

A. Eligible Services

As required by section 9817 of the ARP, the increased FMAP is only available for expenditures for certain services provided under title XIX of the Act. Appendix B provides a brief description of eligible services under section 9817 of the ARP and includes the corresponding Form CMS-64 claiming line for these services. Later in this letter is a further discussion of Form CMS-64 and the increased FMAP claiming process. States can contact HCBSincreasedFMAP@cms.hhs.gov if they have questions about the services for which they can claim the increased FMAP.

A state may not claim the increased FMAP for any HCBS expenditures other than those listed in Appendix B. For example, Medicaid administrative claiming for HCBS activities performed by state No Wrong Door systems and state long-term care ombudsman programs are not eligible for the increased FMAP.2 These HCBS activities are administrative in nature and are not considered HCBS services as defined under section 9817(a)(2)(B) of the ARP and as described in Appendix B of this letter.

B. Program Requirements

In accordance with section 9817(b) of the ARP, states must comply with two program requirements to receive the increased FMAP for HCBS expenditures: (1) federal funds attributable to the increased FMAP must be used to supplement existing state funds expended for Medicaid HCBS in effect as of April 1, 2021; and (2) states must use the state funds equivalent to the amount of federal funds attributable to the increased FMAP to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program. Requirements are effective retroactively to April 1, 2021. In other words, states cannot use the state funds equivalent to the amount of federal funds made available by the increased FMAP to pay for HCBS that is available under the Medicaid program as of April 1, 2021. **These state funds must be used to enhance, expand, or strengthen HCBS beyond what is available under the Medicaid program as of April 1, 2021**. Additional information is provided later in this subsection related to the requirements for states that have implemented temporary changes to their HCBS programs in response to the COVID-19 PHE.

States will be permitted to use the state funds equivalent to the amount of federal funds attributable to the increased FMAP through March 31, 2024, on activities aligned with the goals of section 9817 of the ARP. **This time period to expend funds attributable to the increased FMAP will provide states with sufficient time to design and implement short-term activities to strengthen the HCBS system in response to the COVID-19 PHE, as well as longer term strategies to enhance and expand the HCBS system and to sustain promising and effective programs and services.** It also aligns with the two-year time period during which states may file claims for federal financial participation (FFP) for Medicaid expenditures. This time period will ensure that states have sufficient time to demonstrate that they fully expended the state funds equivalent to the amount of federal funds attributable to the increased FMAP for claims paid through March 31, 2022.

to support these programs as part of their efforts to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program.

CMS expects states to demonstrate compliance with section 9817 of the ARP, beginning April 1, 2021, and until the state funds equivalent to the amount of federal funds attributable to the increased FMAP

are fully expended. To demonstrate compliance with the requirement not to supplant existing state funds expended for Medicaid HCBS, states must:

• Not impose stricter eligibility standards, methodologies, or procedures for HCBS programs and services than were in place on April 1, 2021;

• Preserve covered HCBS, including the services themselves and the amount, duration, and scope of those services, in effect as of April 1, 2021; and

• Maintain HCBS provider payments at a rate no less than those in place as of April 1, 2021.

Please note that these requirements do not supersede other statutory or regulatory requirements that apply to section 1915(c) waivers, or other requirements under other provisions authorizing HCBS, including requirements set forth in Special Terms and Conditions under section 1115 demonstrations and managed care authorities under which states are delivering HCBS. For example, if states have implemented temporary changes to HCBS eligibility, covered services, and/or payment rates through the Appendix K template for section 1915(c) waivers, a disaster relief state plan amendment for section 1915(i) or (k) programs, or an Attachment K for HCBS services under a section 1115 demonstration, states are expected to retain those changes for as long as allowable under those authorities (e.g., according to the end date approved under an Appendix K but no later than 6 months post PHE). However, CMS will not apply penalties or non-compliance restrictions on the receipt of the increased FMAP once the authority for those temporary changes has expired or if the state needs to implement changes to comply with other federal statutory or regulatory requirements.

States should contact CMS about anticipated eligibility or other changes to their HCBS programs that could take effect before the state funds equivalent to the federal funds attributable to the increased FMAP are fully expended to ensure that the changes will not result in non-compliance with these requirements.

To demonstrate compliance with the requirement to use state funds equivalent to the amount of federal funds attributable to the increased FMAP to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program, states must spend the state funds on HCBS-related services and infrastructure, as discussed further in this letter. States may use these funds to pay for additional Medicaid-covered services listed in Appendix B and, in turn, may be eligible for the increased FMAP on those expenditures one additional time. However, once the state has reinvested state funds equivalent to the amount of federal funds attributable to the increased FMAP for additional Medicaid-covered services listed in Appendix B, the state should not claim the increased FMAP for subsequent expenditures occurring between April 1, 2021, and March 31, 2022, on Medicaid-covered HCBS. Please see Appendix E for an example of how a state could reinvest the funds attributable to the increased FMAP in additional Medicaid-covered HCBS to receive additional federal match.

CMS understands that states may experience enrollment and utilization fluctuations unrelated to changes in state policies and procedures, especially during the COVID-19 PHE. CMS will not apply penalties or non-compliance restrictions on the receipt of the increased FMAP if states experience reductions in HCBS enrollment, service utilization, or expenditures that are unrelated to changes in state policies or procedures.

C. Activities to Enhance, Expand, or Strengthen HCBS

Under section 9817 of the ARP, **states can implement a variety of activities, including enhancements to HCBS services, eligibility, infrastructure, and reimbursement methodologies, to enhance, expand, or strengthen Medicaid HCBS.** CMS understands that some states may have an immediate need to address the continued impact of the COVID-19 pandemic while also furthering longstanding state priorities to build HCBS capacity and to pursue innovative rebalancing strategies to reform LTSS systems. The funds attributable to the increased FMAP described in section 9817 of the ARP are available to assist states to engage in simultaneous short-term and longer-term implementation activities.

Examples of activities that states can initiate as part of this opportunity are provided in Appendices C and D. These appendices include **activities to address COVID-related concerns, to promote HCBS capacity building and infrastructure development activities, and to pursue innovative LTSS rebalancing strategies.** CMS recognizes that states are in a unique position to identify and tailor activities that align with state goals and priorities, and accordingly, these examples are not exhaustive. CMS will determine whether a state's activities meet the requirements of section 9817 of the ARP through the required reporting discussed under Required Reporting on Activities to Enhance, Expand, or Strengthen HCBS under the Medicaid Program.

States should follow the applicable rules and processes for section 1915(c) waivers, other Medicaid HCBS authorities, including section 1115 demonstrations, and other managed care authorities (as applicable), if they are making changes to an HCBS program and intend to use state funds equivalent to the funds attributable to the increased FMAP to pay the state share of the costs associated with those changes. If states make programmatic changes to comply with section 9817 of the ARP, states should monitor section 1915(b) waiver expenditures. For example, states should evaluate if activities to demonstrate compliance with section 9817 of the ARP (e.g., expanding the amount, duration, or scope of existing HCBS services provided in a managed care delivery system or increasing the HCBS provider payment rates) will increase expenditures above the projections approved in a section 1915(b) waiver. If states have concerns about exceeding cost effectiveness projections, states should consider a waiver amendment, as. CMS notes that increasing FMAP for HCBS services rendered through a section 1915(c) waiver generally will not have any adverse effect on demonstrating cost neutrality under a section 1915(c) waiver, but when states add HCBS to a section 1915(c) waiver, they must calculate the impact on cost neutrality prior to submitting the amendment. Section 1115 demonstrations must be budget neutral, which means that the proposed demonstration cannot cost the federal government more than it would absent the demonstration. CMS will work closely with states to determine the feasibility of their budget neutrality models and suggest changes as necessary.

We note that states are not limited to using state funds equivalent to the amount of the increased FMAP for services that are otherwise covered in Medicaid; however, FFP is only available for covered services. Please also note that, regardless of whether a state intends to claim FFP, the state should follow the reporting requirements described below under Required Reporting on Activities to Enhance, Expand, or Strengthen HCBS under the Medicaid Program for approval of the activity under section 9817 of the ARP.

States are encouraged to review guidance and information from CMS to learn more about activities to enhance, expand, and strengthen HCBS under the Medicaid program. Recently released CMS documents include a Long-term Services and Supports Rebalancing Toolkit, a State Health Officials letter regarding

Opportunities in Medicaid and CHIP to Address Social Determinants of Health (SDOH), and the Medicaid Long Term Services and Supports Annual Expenditures Report for Federal Fiscal Years 2017 and 2018. **CMS recognizes the importance of effective stakeholder engagement processes that can provide states with varied perspectives on how to expand, enhance, and strengthen HCBS. States may want to consider engaging a broad community of stakeholders—Medicaid and other state agency leadership, participants in HCBS programs, residents in long-term care facilities, HCBS providers, family members and other caregivers, the aging and disability network, health plans, and the direct support workforce—to provide insight, ideas, and feedback to inform the state's approach to developing and implementing activities under section 9817 of the ARP.** Further, CMS expects that states will offer, in good faith and in a prudent manner, a public notice process, including tribal consultation as applicable, when implementing changes to their HCBS programs.

D. Required Reporting on Activities to Enhance, Expand, or Strengthen HCBS under the Medicaid Program

CMS requires participating states to submit both an initial and quarterly HCBS spending plan and narrative to CMS on the activities that the state has implemented and/or intends to implement to enhance, expand, or strengthen HCBS under the Medicaid program to demonstrate that the state is supplementing, but not supplanting, existing state funds expended for HCBS. 3,4 Spending plans and narratives may be submitted in a state preferred format. The state must submit the initial HCBS spending plan and narrative within 30 days of the release of this guidance. Please submit all HCBS spending plans and narratives to HCBSincreasedFMAP@cms.hhs.gov. CMS will review and approve the initial state spending plan and narrative within 30 days of a state's submission if the submission adheres to the terms of this SMDL. CMS will provide an electronic approval notification.

- **Initial HCBS Spending Plan Projection**: The initial HCBS spending plan projection should estimate the total amount of funds attributable to the increase in FMAP that the state anticipates claiming between April 1, 2021, and March 31, 2022, as well as the anticipated expenditures for the activities the state intends to implement to enhance, expand, or strengthen HCBS under the state Medicaid program between April 1, 2021, and March 31, 2024. The spending plan projection is the primary place for quantitative information.

- **Initial HCBS Spending Narrative**: The initial HCBS spending narrative is intended to provide information on the state's required ARP section 9817 activities and the connection between the spending plan projection and the scope of the activities. States must provide sufficient detail to demonstrate that the state's activities enhance, expand, or strengthen HCBS under the state Medicaid program. States should explain how they intend to sustain such activities beyond March 31, 2024.

When submitting the initial HCBS spending plan projection and narrative, the state should also submit a letter signed by the State Medicaid Director that provides a designated state point of contact for the quarterly spending plan and narrative submissions and an assurance of the following:

- The state is using the federal funds attributable to the increased FMAP to supplement and not supplant existing state funds expended for Medicaid HCBS in effect as of April 1, 2021;

• The state is using the state funds equivalent to the amount of federal funds attributable to the increased FMAP to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program;

• The state is not imposing stricter eligibility standards, methodologies, or procedures for HCBS programs and services than were in place on April 1, 2021;

• The state is preserving covered HCBS, including the services themselves and the amount, duration, and scope of those services, in effect as of April 1, 2021; and

• The state is maintaining HCBS provider payments at a rate no less than those in place as of April 1, 2021.

States also must submit a quarterly HCBS spending plan and narrative for CMS review and approval. States may update their initial spending plan submissions through the quarterly spending plan submissions. Updates and/or modifications to the quarterly HCBS spending plan and narrative should be highlighted for ease of CMS review. The reporting interval is based on federal fiscal year quarterly reports. States must report on a quarterly basis until funds are expended. As part of the reporting cycle, two documents to be submitted:

• Quarterly HCBS Spending Plan: The quarterly HCBS spending plan should estimate, by quarter and in total, the amount of funds attributable to the increase in FMAP that the state has claimed and/or anticipates claiming between April 1, 2021, and March 31, 2022, as well as anticipated and/or actual expenditures for the state's activities to implement, to enhance, expand, or strengthen HCBS under the state Medicaid program between April 1, 2021, and March 31, 2024. States must submit the quarterly projected spending plan 75 days prior to the beginning of each federal fiscal quarter beginning with the quarter that starts on October 1, 2021, and until the state's funds in an amount equivalent to the enhanced FMAP received by the state have been expended.

• Quarterly HCBS Spending Narrative: Similar to the narrative that was submitted with the initial HCBS spending plan, a shorter narrative for progress reports serves to provide activity updates. A state may also choose to provide information on activity outcomes, lessons learned, challenges, or any other information that the state deems as relevant and important to advancing HCBS. States should explain how they intend to sustain such activities beyond March 31, 2024. States must submit the HCBS spending narrative 75 days prior to the beginning of each federal fiscal quarter beginning with the quarter that starts on October 1, 2021, and until the state's funds in an amount equivalent to the enhanced FMAP received by the state has been expended.

CMS will publicly post summary information reported by states on their initial and quarterly spending plans and narrative, including the amount of funds attributable to the FMAP increase that the state anticipates claiming or has claimed and the activities the state intends to implement and has implemented to enhance, expand, or strengthen HCBS under the state Medicaid program.

The initial and quarterly spending plans and narrative should be inclusive of any additional federal funds attributable to increased FMAP that the state expects to receive by reinvesting the state funds equivalent to the amount of federal funds attributable to the increased FMAP as state share for

additional Medicaid-covered HCBS between April 1, 2021, and March 31, 2022. As noted previously, states may reinvest state funds equivalent to the amount of federal funds attributable to the increased FMAP for additional Medicaid-covered services listed in Appendix B once, and states should not claim the increased FMAP for subsequent expenditures occurring between April 1, 2021, and March 31, 2022 on Medicaid-covered HCBS. In the initial and quarterly spending plans and narratives, states should demonstrate that the subsequent expenditures are for activities for which the state does not receive the increased FMAP.

When submitting the quarterly HCBS spending plan and narrative, the designated state point of contact should attest to the following via email:

- The state is using the federal funds attributable to the increased FMAP to supplement and not supplant existing state funds expended for Medicaid HCBS in effect as of April 1, 2021;
- The state is using the state funds equivalent to the amount of federal funds attributable to the increased FMAP to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program;
- The state is not imposing stricter eligibility standards, methodologies, or procedures for HCBS programs and services than were in place on April 1, 2021;
- The state is preserving covered HCBS, including the services themselves and the amount, duration, and scope of those services, in effect as of April 1, 2021; and
- The state is maintaining HCBS provider payments at a rate no less than those in place as of April 1, 2021.

These reporting requirements are based largely on those of the Balancing Incentive Program,5 which also provided a temporary FMAP increase for Medicaid HCBS. CMS has purposefully developed simplified reporting processes for section 9817 of the ARP to expedite the release of funds and to minimize state administrative burdens. CMS has also aligned time-frames for reporting with state FMAP claiming periods. These operational requirements, combined with using the Form CMS-64 for states to claim the increased FMAP for HCBS expenditures, provide a pathway for states to quickly access funding to implement activities to expand, enhance, and strengthen state HCBS systems. By providing quicker access to the funding, states are in a stronger position to address the impact of the COVID-19 pandemic on Medicaid HCBS beneficiaries and the providers who serve them.

Please note that these initial and quarterly HCBS spending plan and narrative requirements do not supersede any authorization requirements that apply to section 1915(c) waivers, other Medicaid HCBS authorities, including section 1115 demonstrations, and managed care authorities. States should follow the applicable rules and processes of those authorities if they are making changes to an HCBS program that operates under section 1915(c) or another Medicaid authority and intend to use the funds attributable to the increased FMAP to pay the state share of the costs associated with those changes. For example, if a state seeks to expand HCBS services, the state will need to explore whether an amendment to an HCBS authority is needed. Additionally, if the HCBS services will be provided in a managed care delivery system, a Medicaid managed care authority is needed to authorize those approved service(s), and changes to the state's contracts with its managed care plans to operationalize any programmatic changes may be needed. States and their actuaries will also need to determine if the

actuarially sound capitation rates need to be revised and if a corresponding rate amendment is necessary (i.e., to address any expansion of these services or the amount, duration, or scope of these services or increasing the HCBS provider payments). Additionally, states that seek to contractually require their managed care plans to increase HCBS provider payments must adhere to federal requirements for state directed payments in accordance with 42 C.F.R. § 438.6(c), including prior approval as required.

States should reach out to their CMS contact if they have any questions about how to request approval under Medicaid authorities. In order to facilitate the review process, it is highly recommended that states submit amendments solely focused on the activity required to meet the needs in the CMS approved initial and/or quarterly HCBS spending plan and narrative. Depending on the nature of proposed actions, and the timeframes for their implementation, Disaster Relief state plan amendments, Appendix K updates, or an Attachment K for HCBS services under a section 1115 demonstration, may be submitted, and/or traditional state plan amendments, waiver amendments, or section 1115 demonstration amendments. To the extent feasible, CMS will prioritize review and approval of these requests.

E. Claiming FFP at the Increased FMAP on the Form CMS-37 and Form CMS-64

FFP associated with the increased FMAP is available for qualifying expenditures for the HCBS services listed in Appendix B on a quarterly basis through Form CMS-37 and Form CMS-64 submissions in the automated Medicaid Budget and Expenditure System (MBES). The increased FMAP is available for qualifying HCBS expenditures incurred on or after April 1, 2021, through March 31, 2022.6 Failure to follow the required steps could result in CMS initiating action to defer or disallow certain expenditures.

• Obtaining FFP associated with the increased FMAP through the Form CMS-37: Once the state completes the initial HCBS spending plan and narrative and, in subsequent quarters, the quarterly HCBS spending plan and narrative described in section D of this letter, CMS will provide FFP associated with the increased FMAP to states through the process described in 42 CFR § 430.30(b) for state quarterly budget estimates submitted through the Form CMS-37.

• Obtaining FFP associated with the increased FMAP through the Form CMS-64: Once the state completes the initial HCBS spending plan and narrative and, in subsequent quarters, the quarterly HCBS spending plan and narrative described in section D of this letter, CMS will provide FFP associated with the increased FMAP to states through the process described in 42 CFR § 430.30(c) for allowable state quarterly expenditures submitted through the CMS-64. By claiming FFP at the increased FMAP, the state agrees to use an equivalent amount of state funds, attributable to the increase from section 9817 of the ARP, only for purposes of providing new or expanded offerings of HCBS and related supports and infrastructure described but not limited to Appendices C and D. Funding must be used to supplement not supplant existing services.

• MBES Modifications: We are working to modify MBES/CBES as soon as possible to reflect each state's increased FMAP.7 Once MBES/CBES is reprogrammed to utilize the increased FMAP, the system will enable state entry of expenditures at the increased FMAP, and apply such FMAP for the actual claimed expenditures that are incurred. Expenditure reporting associated with the increased FMAP for the third quarter of fiscal

year (FY) 2021 may be delayed. In those cases, states may need to report expenditures associated with the increased FMAP through prior period adjustments in subsequent quarters of the FY.

• Other Expenditure Reporting Information: States should follow existing federal requirements regarding the applicability of a particular match rate available for a given quarter (see Appendix A). The applicable FMAP is based on date of payment, not date of service for current quarter original expenditures. The FMAP applicable to expenditures for prior period adjustments should be the FMAP at which the original expenditure was claimed, for both private and governmental providers. All states are responsible for reporting Medicaid collections and overpayments on the CMS-64. States must report overpayments and collections at the same match rate at which the expenditures were originally claimed, including when the original rate incorporated the 10 percentage point FMAP increase. Recoveries of FFP must be returned at the same match rate at which they were originally claimed. Therefore, if a Medicaid expenditure was claimed using the increased FMAP, the federal share of any recoveries associated with that expenditure would have to be returned using the same increased FMAP. Consistent with existing requirements, states must document expenditures to ensure a clear audit trail, including by isolating expenditures that are matched at increased FFP rates. CMS will conduct oversight to ensure that the state expenditures are allowable and accurate, including with respect to the matching rate claimed.

• Claiming the Increased FMAP for Managed Care Expenditures: States should report expenditures eligible for the 10 percentage point increase on the Form CMS-64. The portion of the capitation rate that is attributable to only services in Appendix B and upon which an increased match may be claimed should be determined with the data utilized to develop the applicable capitation rates. The use of this claiming methodology is solely for FFP claiming purposes and does not negate the requirements that Medicaid capitation rates be actuarially sound and must be developed in compliance with federal requirements under 42 C.F.R. part 438. States have used similar claiming methodologies for FFP for services and populations such as family planning, section 1915(k) benefits, and the new adult group. States may be required to submit their managed care claiming methodologies for the increased FMAP under ARP section 9817 to CMS for review and approval.

Section 2: Medicaid Coverage of HCBS Retainer Payments during the COVID-19 PHE

Retainer payments allow certain providers to continue to bill for individuals who are enrolled in an HCBS program or who otherwise receive personal care services authorized under sections 1915(c), 1915(i), 1915(k), or 1115, as specified in their person-centered service plan, when circumstances prevent the individual from receiving the service. Previously, CMS had indicated that states may authorize up to three 30-day episodes of retainer payments for an individual during the period of the COVID-19 PHE using the Appendix K template for section 1915(c) waivers, a disaster relief state plan amendment for section 1915(i) or (k) programs, or an Attachment K for HCBS services under a section 1115 demonstration. Due to the duration of the COVID-19 PHE, which has spanned two calendar years, CMS is authorizing states to choose to offer up to three additional 30-day periods in calendar year 2021. CMS

notes that these additional episodes may assist states and providers in reopening services while limiting access to buildings to allow for proper social distancing.

These additional days of retainer payments may be retroactively effective to January 1, 2021. States are encouraged to submit an Appendix K, section 1115 demonstration Attachment K, a disaster relief state plan amendment, or section 1115 demonstration amendment to implement any additional days of retainer payments. Guardrails contained in the retainer payment guidance reflected in Frequently Asked Questions issued on June 30, 2020, 8 continue to apply to retainer payments authorized in 2021; this additional flexibility is additive to that guidance.

For states that are seeking to contractually require managed care plans to make retainer payments to providers where the authorized service is covered under the managed care plan contracts, states must seek approval under 42 C.F.R. § 438.6(c) for state directed payments. In order for states to seek approval under 42 C.F.R. § 438.6(c), the retainer payments must be authorized as part of the section 1915(c) HCBS waiver, section 1115(a) demonstration for section 1915(c) HCBS services, or other Medicaid authority. Once the retainer payments are authorized under one of these authorities, a state directed payment preprint must also be submitted to effectuate the state directed retainer payments under a state's contract(s) with its managed care plans. For technical assistance on state directed payments, please contact us at statedirectedpayment@cms.hhs.gov.

Closing

CMS remains committed to supporting states with strengthening and enhancing their HCBS systems and helping to ensure that Medicaid beneficiaries receive high quality, cost-effective, person-centered services in the setting of their choice. Section 9817 of the ARP provides states with additional federal funding for Medicaid HCBS that states can use to enhance, expand, or strengthen HCBS in response to the COVID-19 PHE, accelerate LTSS reform, and address other state-specific HCBS needs and priorities, such as Olmstead planning. As detailed below, CMS is available to provide continued technical assistance to states when implementing this provision.

Programmatic and financial questions and state HCBS spending plans and narratives for section 9817 of the ARP can be submitted to HCBSincreasedFMAP@cms.hhs.gov.

For specific information about using section 1115(a) demonstration authority to support state efforts related to section 9817 of the ARP, contact Teresa DeCaro, Acting Group Director, State Demonstrations Group, at Teresa.DeCaro@cms.hhs.gov.

For questions about retainer payments during the COVID-19 PHE, contact Ralph Lollar at Ralph.Lollar@cms.hhs.gov.

Sincerely,

Anne Marie Costello Acting Deputy Administrator and Director

Appendix A: Applicability of the Increased Federal Medical Assistance Percentage (FMAP) to Other FMAPs Specified in the Social Security Act

Appendix B: Home and Community-Based Services Eligible for the ARP Section 9817 Temporary Increased FMAP HCBS Medicaid Authority Benefit Description

Appendix C: Examples of Section 9817 of the ARP Activities to Support State COVIDRelated HCBS Needs

Appendix D: Examples of Section 9817 of the ARP Activities to Support State HCBS Capacity Building and LTSS Rebalancing Reform

Appendix E: State Example

All appendices (and the footnotes to the letter) can be accessed by going to the letter, itself:

https://www.medicaid.gov/federal-policy-guidance/downloads/smd21003.pdf