State Medicaid Director (SMD # 21-003) Letter on 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

Executive Summary

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 in federal matching funds for certain Medicaid expenditures for home and community-based services. On May 13, 2021, the Centers for Medicare & Medicaid Services issued a State Medicaid Director Letter (SMD# 21-003) to provide guidance to states on the implementation of Section 9817 of the ARP and to identify additional funding opportunities for states to enhance and increase access and support for services delivered in home and community-based settings. Below we summarize the most recent CMS guidance issued through SMD# 21-003.

Definitions:

HCBS: Home and Community-Based Services
State HCBS Spending: The state's expenditures on Medicaid HCBS as of April 1, 2021.
State HCBS Spending Pool: Additional state funds available resulting from the enhanced FMAP for HCBS between April 1, 2021, and March 31, 2022.
HCBS Reinvestment: Funds from the State HCBS Spending Pool used for additional allowable HCBS to garner additional Enhanced ARP HCBS federal match.

Section by Section

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

Section 9817 of ARP increases the federal medical assistance percentage (FMAP) by 10 percentage points for eligible Medicaid HCBS expenditures between April 1, 2021, and March 31, 2022. Total FMAP, taking into account other enhancements such as the 6.2 percent enhanced FMAP under the Families First Coronavirus Response Act (FFCRA), cannot exceed 95 percent.

Eligible Services

CMS provides a list of eligible HCBS for which states may claim enhanced FMAP under Section 9817 of the ARP. Administrative activities, such as claiming related to No Wrong Door systems, are not eligible. The list of eligible HCBS that qualify for enhanced ARP funding includes:

- Home health services, including home health nursing, home health aide services, medical supplies, durable medical equipment, as well as physical, occupational, and speech therapy, if covered by the state
- Personal care services and self-directed personal care services
- Case management and targeted case management
- Rehabilitative services, including mental health rehabilitation and SUD services
- Private duty nursing, when provided in the home
- Services authorized under a 1915(c) waiver, including self-directed waiver services
- Services authorized under the 1915(i) state plan option
- Community First Choice services (the ARP enhanced FMAP is additive to the increased FMAP for CFC)
- Program for All-Inclusive Care of the Elderly (PACE) services
- School-based services, to the extent that they include one or more of the services identified in

bullets one through eight above
- Any of the above services, when authorized under an Alternative Benefit Plan
- Any of the above services, when authorized under an 1115 Waiver
- Any of the above services, when delivered through managed care

Program Requirements

To receive the enhanced ARP HCBS FMAP, states must use funds to supplement, not supplant, existing HCBS spending. This means that states may not reduce their state share of HCBS spending and allow the enhanced FMAP to make up the difference. Rather, states are expected to maintain spending levels as of April 1, 2021, so that the enhanced ARP HCBS FMAP generates additional state funding (State HCBS Spending Pool) for states.

As a condition of receiving the enhanced ARP HCBS FMAP, and until funds obtained through the enhanced ARP HCBS FMAP are fully expended, states must not:

- Impose more restrictive eligibility standards, methodologies and procedures for HCBS programs and services than those in place on April 1, 2021;
- Reduce the amount, duration, or scope of HCBS covered as of April 1, 2021; and
- Reduce payment rates for HCBS providers lower than they were on April 1, 2021.

These maintenance of effort requirements do not supersede existing waiver requirements. States are required to maintain temporary changes to HCBS eligibility, services, and payments authorized under Appendix K and other authorities for as long as allowable under those authorities; however, when they expire, CMS will not consider any resulting reduction in eligibility standards, covered services, or payment rates to have violated the maintenance of effort requirement.

States must use the funds they receive to "implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS." If the state uses the funds, they receive to implement new HCBS or expand existing HCBS (HCBS Reinvestment), the state may also claim the enhanced FMAP on those additional services. CMS will allow states to claim the enhanced FMAP one time, meaning the HCBS Reinvestment cannot be used to claim a third round of enhanced FMAP, though the new or expanded HCBS will still be eligible for the regular FMAP along with all other Medicaid spend. Other state spending, such as spending on administrative activities, is not eligible for claiming enhanced FMAP and reinvestment.

CMS is allowing states to use the State HCBS Spending Pool generated as a result of the enhanced FMAP for eligible HCBS claims through March 31, 2024.

Activities to Enhance, Expand, or Strengthen HCBS

To qualify for the enhanced FMAP under section 9817, states must use the State HCBS Spending Pool on activities that enhance, expand or strengthen HCBS. Generally, states may use their state HCBS Spending Pool to fund activities that address COVID-related concerns, promote HCBS capacity building and infrastructure development activities, and pursue innovative LTSS rebalancing strategies. States may implement these activities in the short-term or as part of a longer-term strategy (through March 31, 2024). All activities must comply with the waiver authority the state uses for their HCBS programs, especially if they are using the enhanced ARP HCBS FMAP to pay for the state share of the activity. For example, any increased service expenditures (e.g., related to caps and limitations or reimbursement

rates) must not exceed the spending cap under a state's 1915(b) waiver authority. CMS recommends that states consider applying for a waiver amendment, so the new spending is reflected under the state's cost effectiveness projections.

CMS has provided a list of authorized activities within the letter and will use the reporting requirements outlined below as the means to approve or deny activities that are not already on this list. Authorized activities include:

- New or additional services
- Increased rates
- New or enhanced paid leave benefits for direct service professionals
- New or enhanced specialized payments (e.g., hazard pay, overtime pay, shift differential pay) for direct service professionals
- PPE and testing supplies
- Workforce recruitment and training, including both direct service professionals and behavioral health providers for members receiving HCBS during the COVID-19 PHE
- Supports for family caregivers
- Purchase and implementation of assistive technologies for individuals with disabilities
- One-time community transition costs to facilitate a move from an institution or other congregate living arrangement to the community, including transition coordination
- Skill rehabilitation for those with mental health and SUD needs
- Materials in several language, including American Sign language, to educate individuals receiving HCBS on COVID-19 prevention, treatment, and recovery
- Vaccine support for individuals with HCBS needs and their caregivers

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

States must report their spending activities at the outset of their spending plan and quarterly thereafter through the end of the spending period (March 31, 2024).

Initial HCBS Spending Plan

States must submit their initial HCBS spending plan projection and accompanying narrative within 30 days of the release of SMD# 21-003 (June 13, 2021). The Initial Spending Plan Projection is an estimate of the total State HCBS Spending Pool and HCBS Reinvestment funds attributable to the increase in FMAP that the state anticipates claiming between April 1, 2021, and March 31, 2022, and the state's anticipated expenditures on allowable activities as outlined previously in the letter. The accompanying narrative is meant to prove all spending listed in the projection will enhance, expand, or strengthen HCBS under the state Medicaid program. Further, the state must explain how they intend to sustain such activities beyond the spending period and reference any additional federal funds the state expects to receive through reinvestment of the initial enhanced FMAP dollars.

The State Medicaid Director must also submit a letter, due alongside the initial spending plan. The letter must designate a state point of contact for the quarterly submissions and provide assurances that the state will supplement, not supplant funding; not restrict eligibility and access to HCBS, including their amount, duration, and scope; and maintain HCBS provider rates equal to those in place on April 1, 2021.

Going forward, states must submit quarterly HCBS spending plans and an accompanying narrative for CMS approval.

Quarterly HCBS Spending Plan

The quarterly submissions are substantially similar to the initial submission. States must submit their quarterly projected spending plan 75 days prior to the start of each fiscal quarter, beginning with Q4 2021, and until the state has expended their enhanced FMAP funding.

Reporting associated with the enhanced FMAP under Section 9817 of ARP does not supersede or replace any authorization requirements under the state's current waiver authorities.

Claiming Federal Financial Participation (FFP) at the Increased FMAP on the Form CMS-37 and Form CMS-64

Once states have completed initial HCBS spending plans, FFP at the increased FMAP is available for the HCBS on a quarterly basis through state submission of Form CMS-37 and Form CMS-64 in the automated Medicaid Budget and Expenditure System (MBES). State quarterly budget estimates are submitted through Form CMS-37 and allowable state quarterly expenditures are submitted through Form CMS-64. Increased FMAP is available for HCBS expenditures incurred on or after April 1, 2021, through March 31, 2022.

Under the ARP, the increased FMAP is additive to enhanced FMAP available to states under:

- Families First Coronavirus Response Act (Section 6008(a);
- Adult group expenditures matched at "newly eligible" FMAP;
- Adult group expenditures matched at "expansion state" FMAP;
- Expenditures matched at "disaster-recovery" FMAP;
- Expenditures subject to temporary increase in FMAP for medical assistance under state Medicaid plans;
- HCBS expenditures matched at increased FMAP.

The FMAP increase does not apply to the following Medicaid expenditures:

- Medicaid administrative expenditures
- Expenditures for family planning services eligible for 90 percent match
- Expenditures for services "received through" an Indian Health Service facility
- Expenditures matched at 100 percent for individuals in Qualifying Individuals programs
- Health home services under section 1945 of the Act
- Any other expenditures not matched at the FMAP determined for each state.

CMS is working to modify MBES/CBES to reflect each state's increased FMAP. If expenditure reporting for the third quarter of FY 2021 is delayed, states should report expenditures through prior period adjustments in following FY quarters.

States should follow existing federal requirements regarding match rates available for a given quarter and CMS will conduct oversight to ensure all expenditures are accurate. The FMAP is based on date of payment, not date of service, for quarter expenditures. All states should use Form CMS-64 to report Medicaid collections and overpayments at the same match rate the expenditures were originally

claimed, including the 10-percentage point FMAP increase. Recoveries must also be returned at the same match rate they were claimed.

For HCBS in managed care, states should report spending qualified for the FMAP increase on the Form CMS-64. States should use the portion of the capitation rates developed for eligible HCBS as the basis upon which an increased match can be claimed. This claiming method should only be used for FFP purposes, and states may be required to submit managed care claiming methodologies for CMS review.

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

Due to the duration of the COVID-19 public health emergency, CMS is giving states the option to offer up to three additional 30-day retainer payment periods in calendar year 2021. Additional days of retainer payments may be retroactively effective to January 1, 2021. States wanting additional days of retainer payments are encouraged to submit an Appendix K, 1115 demonstration Attachment K, 1115 demonstration amendment, or a disaster relief state plan amendment to implement these additional retainer payment periods.

To require managed care plans to make retainer payments, states must seek approval for state directed payments. These retainer payments must be part of a 1915(c) HCBS waiver, section 1115(a) demonstration for section 1915(c) HCBS, or other Medicaid authority.

Enhanced Federal Match Flowchart

The chart below illustrates states' initial opportunity for an enhanced ARP HCBS federal match and the option to reinvest into HCBS for a second round of enhanced ARP HCBS federal match. In total, states may have two funding pools from which to spend on activities that enhance, expand, or strengthen HCBS under the Medicaid program.