March 29, 2021

Elizabeth Richter
Acting Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue S.W.
Washington, DC 20201

Dear Acting Administrator Richter,

The Consortium for Citizens with Disabilities (CCD) is the largest coalition of national organizations working together to advocate for federal public policy that ensures the self-determination, independence, empowerment, integration and inclusion of children and adults with disabilities in all aspects of society.

The undersigned co-chairs of the CCD Long-Term Services and Supports (LTSS) taskforce write to urge CMS to create a simple process and guidance for states to ensure that the funds are sent and spent quickly and appropriately in line with the Congressional intent of the legislation, which was to strengthen the program.

Below, please find recommendations for CMS guidance and clarification in the following areas:

- Services eligible for the increased FMAP bump;
- Methods to ensure that the "supplement, not supplant" language in the legislation is adequately realized;
- Allowable uses of the additional funding; and
- The interplay of the increased FMAP with other statutory FMAP increases.

Services Eligible for the Increased FMAP

We are extremely pleased with the broad definition of "home and community based services" in Section 9817(a)(2)(B) of the American Rescue Plan. While the definition includes many services that are commonly thought of as home and community based services (HCBS), such as HCBS waiver programs and state plan options under Section 1915, home health services, and personal care services, the definition is much broader. CMS guidance should emphasize how broad this definition is, and include specific guidance regarding the availability of the increased funding for both case management services authorized under 1905(a)(19) and rehabilitative services described in 1905(a)(13). Specifically, states and therefore enrollees would benefit from guidance that includes clear examples of services that often fall under these service categories—for both adults and children—including but not limited to:

- Assertive Community Treatment;
- Intensive community-based services;
- Crisis and emergency interventions related to behavioral health, including mobile crisis services;
- Counseling and psychotherapy;
- Somatic treatment and medication management;
- Diagnosis, assessment, and treatment planning;
- Peer support;
- Medication assisted treatment; and
- Care coordination.

CMS should also clarify that the services that are eligible for the increased FMAP bump are in no way limited by the disability category or diagnosis of the individual receiving the service. For example, the above-listed services are often delivered to adults and youth with psychiatric disabilities. Similarly, targeted case management services (1905(a)(19)) are delivered outside of the HCBS waiver context, and can target very specific populations, such as individuals with psychiatric disabilities, individuals with specific diagnoses such as AIDs, foster youth, homeless individuals. CMS should make clear that the increased FMAP is not limited in any way by the diagnosis of the individual receiving the service. Instead, it is dependent upon the service rendered.

We also encourage CMS to exercise its discretionary authority under the ARP to include "private duty nursing" among the HCBS programs eligible for the FMAP increase, Section 9817(a) gives CMS permission to add to the definition of HCBS services "such other services specified by the Secretary." Private duty nursing in the home setting is a key service that allows children and adults with high support needs to avoid institutional placement, which is especially critical during the COVID-19 pandemic.

Definition and Implementation of "Supplement, Not Supplant"

In addition to providing information and guidance on allowable uses for the dedicated funding, it is imperative that CMS clearly defines what "supplement and not supplant" means.

We note that the statutory language states that increased funds should be used to "supplement, and not supplant, the level of State funds expended for *home and community-based services* for programs in effect as of April 1, 2021." (emphasis supplied). Thus, it is state funding for HCBS *services* that must be maintained, not general state expenditures related to HCBS. As noted above, HCBS services are specifically defined in this legislation. It is not sufficient for a state to generally keep their budget for HCBS programs level, inclusive of administrative expenses. The state must specifically keep state expenditures for the statutorily enumerated services level. As an additional guardrail, we recommend that state per capita spending per enrollee receiving the statutorily defined HCBS services should not decrease during this time period. This will help ensure that state funds continue to be directed to enrollees, and not to administrative expenses.

Last, we note that CMS must account for spending via managed care organizations. Particular attention should be paid to states that do not have carved out managed long term services and supports (MLTSS) or where the services defined as HCBS in this statute fall outside of the scope of MLTSS services. Regardless of the scope of the managed care organization, CMS must require mechanisms to show how any additional benefit to the managed care organizations from the FMAP boost is tied to HCBS, is not counted towards the plan's medical loss ratio, not used to supplant services, and is not targeted toward administrative functions. The mechanisms should be more robust than assurances from the plans.

Allowable Uses of the Additional Funding

The original legislation that included the 10 percent increase, The COVID HCBS Relief Act, included a list of allowable uses for the funding. CMS should include this list in its guidance as examples of expenditures that would be permissible. The list includes: increasing rates for agencies that employ home health and direct support professionals (including independent providers in a self-directed or consumer-directed model) to provide Medicaid home and community-based services, increasing direct care worker wages, paying for transportation expenses to and from the homes of those being served, purchasing personal protective equipment for workers and those they are supporting, and providing hazard pay. The extra dollars also can be used to support family care givers, recruit and train additional direct care workers, and for technology to facilitate services. Finally, the funds can help provide services for individuals currently on HCBS waiting lists. These uses should be the starting point for states.

The statutory language regarding the use of additional funding states that the state shall implement or supplement the implementation of "one or more activities to enhance, expand, or strengthen *home and community-based services*…" (emphasis supplied). As noted above, the term "home and community-based services" is defined in the law, and thus the funding needs to either enhance, expand, or strengthen one or more of the *services* identified in the statute. While some investments in infrastructure, rates, and administration can certainly enhance, expand, or strengthen *services*, the burden should be on states to articulate exactly how the investment will do so, and which specific services will be enhanced, expanded, or strengthened. If a state wishes to provide one-time payments to providers or to assist providers financially in other ways, such as debt relief, the state will need to sufficiently demonstrate that it has made a reasonable determination such provider assistance is directly related to enhancing, expanding, or strengthening services. While provider stability and participation is important, broad provider relief payments likely are not sufficiently tied to the Medicaid HCBS services that are the focus of the statute, nor would they clearly align with the intent of the Act. States should also be required to publicly report on outcomes of such expenditures.

Some expenditures are simply too attenuated from enhancing, expanding on strengthening services, and should be prohibited. For example, capital investments are not sufficiently related to services and therefore should be prohibited.

Similarly, CMS should clarify that while the additional funding could be used to improve administration in a way that enhances, expands, or strengthens HCBS services, using these funds to supplant state-level administrative expenses is not a reasonable use. States should be required to maintain state-level funding during the amount of time the state is given to expend the additional funds (which may stretch long beyond March 31, 2022).

Last, we recommend that CMS offer technical assistance for states with allowable ways to invest these funds. This could include technical assistance on how to use this funding to target specific challenges states face, to promote community integration, and to address the needs of specific populations with pressing needs. In particular, many congregate day programs have been forced to close their doors due to the COVID-19 pandemic. Some states may wish to use these funds to transform the services they provide, rather than simply reopening congregate settings when it is safe to do so. CMS should offer detailed guidance and technical assistance to states on how additional funds can be used for provider transformation to transition congregate settings to more individualized services, in furtherance of the goals of the HCBS Settings Rule.

Interplay of Increased HCBS FMAP Funding and Other FMAP Increases

In issuing guidance, it would be helpful if CMS would clarify the interplay of this additional FMAP funding with other enhanced FMAPs. Based on the statutory text, this enhanced FMAP should be added to enhanced FMAPs that currently exist, including the 6.2% FMAP increase in Section 6008 of the Families First Coronavirus Response Act, and the 6% FMAP increase for states implementing the Community First Choice. Additionally, the statutory language states that if the FMAP is already increased pursuant to subsection (y), (z), (aa) or (ii) of Section 1905, the additional 10% is additive. This language means, among other things, that an additional 10% would be added to the increased FMAP already available for newly eligible low-income, uninsured adults.

We appreciate your consideration of these issues and would be happy to provide additional information or discuss any concerns. Please feel free to contact Jennifer Lav at lav@healthlaw.org with any questions.

Sincerely,

Jennifer Lav
National Health Law Program

Julia Bascom
Autistic Self Advocacy Network

Nicole Jorwic
The Arc of the United States

Cc: Alissa Deboy, Director, Disabled and Elderly Health Programs Group
Melissa Harris, Deputy Director, Disabled and Elderly Health Programs Group