

Disabled and Elderly Health Programs Group

February 7, 2022

Melisa Byrd
Senior Deputy Director/Medicaid Director
District of Columbia
Department of Health Care Finance
441 4th Street NW
Washington, DC 20001

Dear Director Byrd:

We are pleased to inform you that the District of Columbia's (the District's) federal fiscal year 2022 quarter 2 spending plan and narrative continue to meet the requirements set forth in the May 13, 2021, Centers for Medicare & Medicaid Services (CMS), State Medicaid Director Letter (SMDL) [#21-003](#) and are receiving partial approval. The District qualifies for a temporary 10 percentage point increase to the federal medical assistance percentage (FMAP) for certain Medicaid expenditures for home and community-based services (HCBS) under section 9817 of the American Rescue Plan Act of 2021 (ARP). We have approved the temporary 10 percentage point increase to the District's FMAP for certain Medicaid HCBS listed in Appendix B of the SMDL. The increased FMAP is available for qualifying expenditures between April 1, 2021, and March 31, 2022. The District can begin to implement any activity included in the revised spending plan if CMS has not identified the activity as not approvable or asked for additional information about the activity, as described beginning on the next page.

Full approval of the spending plan and narrative is conditioned upon the District's resolving the issues described below and upon the District's continued compliance with program requirements as stated in SMDL #21-003. These requirements are in effect as of April 1, 2021, and continue until March 31, 2024, or until the District has fully expended the funds attributable to the increased FMAP, whichever comes first.

It is important to note that CMS partial approval of the spending plan and narrative solely addresses the District's compliance with the applicable requirements set forth under section 9817 and fulfillment of the requirements as stated in SMDL # 21-003. This spending plan approval does not constitute approval for purposes of claiming federal financial participation (FFP). Approval of any activity in the District's spending plan does not provide approval to claim FFP for any expenditures that are not eligible for FFP. The District must continue to comply with all existing federal requirements for allowable claims, including documenting expenditures and draws to ensure a clear audit trail for the use of federal funds reported on the Form CMS-37 Medicaid Program Budget Report and the Form CMS-64, Quarterly Medicaid Statement of Expenditures.

The District should follow the applicable rules and processes for section 1915(c) waivers, other Medicaid HCBS authorities, including state plan amendments and 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. CMS is available to provide continued technical assistance to the District when implementing changes to HCBS programs under this provision. Furthermore, the District should follow the applicable rules and processes for claiming FFP for Medicaid administrative costs, including, if necessary, updating the District's Public Assistance Cost Allocation Plan to reference methodologies, claiming mechanisms, interagency agreements, and other relevant issues that will be used when claiming and appropriately allocating costs.

Additional Information Requested

As the District further plans and develops the activities in its spending plan, CMS will need more information on the following:

- Clearly indicate whether the following activities are targeted at providers delivering services that are listed in Appendix B of the SMDL or that could be listed in Appendix B (e.g., behavioral health services that are covered under another benefit but could be covered under the rehabilitative services benefit):
 - Innovative Programs, Pilots, or Studies; and
 - Adult Substance Abuse Rehabilitation Services (ASARS) Provider Capacity Building.

If these activities are not focused on providers that are delivering services listed in Appendix B or that could be listed in Appendix B, explain how the activities enhance, expand, or strengthen HCBS under Medicaid.

CMS will need additional information before it can determine whether these activities or uses of funds are approvable under ARP section 9817. Please update the District's spending plan and narrative to provide the information requested in this letter.

General Considerations

As part of this partial approval, CMS is noting the following:

- CMS expects the District to notify CMS as soon as possible if the District's activities to enhance, expand, or strengthen HCBS under ARP section 9817:
 - Are focused on services other than those listed in Appendix B or that could be listed in Appendix B (e.g., behavioral health services that are covered under another benefit but could be covered under the rehabilitative services benefit). If any activities are not directly related to the services listed in Appendix B or services that could be listed in Appendix B, please explain how those activities enhance, expand, or strengthen HCBS under Medicaid;
 - Are focused on services delivered in Institutions for Mental Diseases (IMD) or other institutional settings, providers delivering services in IMDs or other institutional settings, or other activities implemented in IMDs or other institutional settings (which

CMS would not find to be a permissible use of funds, unless the District can demonstrate that the activity supports institutional diversion or community transition or otherwise supports the intent of ARP section 9817);

- Include room and board (which CMS would not find to be a permissible use of funds); and/or
- Include activities other than those listed in Appendices C and D.

CMS will need additional information before it can determine whether any of those activities or uses of funds are approvable under ARP section 9817.

- HCBS provider pay increases funded through the 10 percent temporary increased FMAP will require an updated rate methodology. For section 1915(c) waiver programs, states are required to submit a waiver amendment for any rate methodology change. If retrospective approval will be required, the District should make the change in the Appendix K application.
- Consistent with regulations at 42 C.F.R. § 447.252(b), the state plan methodology must specify comprehensively the methods and standards used by the agency to set payment rates. The state plan methodology must be comprehensive enough to determine the required level of payment and the FFP to allow interested parties to understand the rate setting process and the items and services that are paid through these rates. Claims for federal matching funds cannot be based upon estimates or projections. The reimbursement methodology must be based upon actual historical utilization and actual trend factors.
- States providing HCBS through a managed care delivery system must comply with applicable federal requirements, including 42 C.F.R. part 438. States must also ensure that appropriate authority is granted for the services and activities to be covered as well as to deliver such services and activities through a managed care delivery system. Additionally, states will need to assess implications for its managed care plan contracts and actuarially sound capitation rates in order to operationalize any programmatic changes. 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. CMS is available to provide technical assistance to states related to these requirements.
- If the District is reducing reliance on a specific type of facility-based or congregate service and increasing beneficiary access to services that are more integrated into the community, the District should be clear with stakeholders in the District's stakeholder engagement activities, as well as in submissions to CMS of required ARP section 9817 spending plans and narratives and any resulting waiver or state plan amendments, about how these changes enhance the availability of integrated services in the specific waiver or state plan, and offset any reductions in previously covered services, in compliance with the home and community-based settings criteria or other efforts to increase community integration.

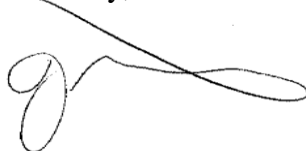
Additional Information Related to the Quarterly Spending Plan and Narrative

The District's second quarterly spending plan and narrative were due February 1, 2022. Please refer to SMDL [#21-003](#) for information on the quarterly reporting process. The District's quarterly spending plans and narratives should:

- Describe how the District intends to sustain the activities it is implementing to enhance, expand, or strengthen HCBS under the Medicaid program including how the District intends to sustain its planned provider payment increases;
- Provide information on the amount or percentage of any rate increase or additional payment per provider and the specific Medicaid authorities under which the District will be making those rate changes or payments;
- Provide the additional information described above;
- Clearly indicate if the District has or will be requesting approval for a change to an HCBS program and be specific about which HCBS program, which authority it operates under, and when you plan to request the change;
- Provide projected and actual spending amounts for each of the District’s planned activities to enhance, expand, or strengthen HCBS. In those projections, clearly identify if the District intends to draw down FFP for any activities, as well as the amount of state and federal share for any activities for which the District plans to claim FFP and whether those activities will be eligible for the HCBS increased FMAP under ARP section 9817;
- Clearly indicate whether the District plans to pay for capital investments or ongoing internet connectivity costs as part of any activity to enhance, expand, or strengthen HCBS. Capital investments and ongoing internet connectivity costs are permissible uses of funds to enhance, expand, or strengthen HCBS under section 9817 of the ARP. However, states must demonstrate how capital investments and ongoing internet connectivity costs would enhance, expand, or strengthen HCBS and ensure that capital investments will result in settings that are fully compliant with the home and community-based settings criteria. Further, approval of capital investments and ongoing internet connectivity costs in ARP section 9817 spending plans and narratives does not authorize such activities for FFP;
- Provide updated information (as appropriate) on the status and details of the District’s proposed activities to enhance, expand, or strengthen HCBS; and
- Make other revisions needed to: update the amount of funds attributable to the increase in FMAP that the District has claimed and/or anticipates claiming between April 1, 2021, and March 31, 2022; update anticipated and/or actual expenditures for the District’s activities to implement, to enhance, expand, or strengthen HCBS under the state Medicaid program between April 1, 2021, and March 31, 2024; update or modify the District’s planned activities to enhance, expand, or strengthen HCBS; and report on the District’s progress in implementing its planned activities to enhance, expand, or strengthen HCBS.

We extend our congratulations on this partial approval and look forward to working with you further throughout the implementation of ARP section 9817. Programmatic and financial questions and quarterly spending plan and narrative questions for section 9817 of the ARP can be submitted to HCBSincreasedFMAP@cms.hhs.gov.

Sincerely,

A handwritten signature in black ink, appearing to be the name 'Melisa Byrd', written in a cursive style.

Jennifer Bowdoin
Director, Division of Community Systems Transformation

cc: Eugene Simms