DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
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Disabled and Elderly Health Programs Group

August 1, 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 4 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 SMDL # 22-002. The District can begin implementing all of the activities in the spending plan and narrative and 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 state's FMAP for certain Medicaid HCBS listed in Appendix B of SMDL # 21-003. The increased FMAP is available for qualifying expenditures between April 1, 2021, and March 31, 2022.

Full approval of the spending plan and narrative is conditioned upon the state's continued compliance with program requirements as stated in SMDL # 21-003 and SMDL # 22-002. These requirements are in effect as of April 1, 2021, and continue until March 31, 2025, or until the state has fully expended the funds attributable to the increased FMAP, whichever comes first.

It is important to note that CMS 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 and SMDL # 22-002. 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.

General Considerations

As part of this 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.
- Please note that, if your state is reducing or eliminating a waiting list for a section 1915(c) waiver program as part of the state's activities to enhance, expand, or strengthen HCBS under ARP section 9817, the state cannot use the funds attributable to the increased FMAP to pay for approved capacity as of April 1, 2021. The state must increase the Factor C to establish additional waiver slots and can only use the funds attributable to the increased FMAP to pay for services for individuals who are newly enrolled in the waiver program directly as a result of the increase in Factor C.

  CMS is also clarifying that, if your state increases the number of section 1915(c) waiver slots and enrolls additional individuals who are not already Medicaid eligible into the waiver program as a result, the state will have an increase in non-HCBS Medicaid expenditures as a result of the increase in waiver program enrollment. In this situation, the state can use the funds attributable to the increased FMAP to pay for community-based Medicaid expenditures, including community-based state plan services not listed in Appendix B, for individuals who become Medicaid eligible because of the state increase in the number of waiver slots as part of a state's activities to expand, enhance, or strengthen HCBS under ARP section 9817. However, your state cannot use the funds attributable to the increased FMAP to pay for institutional services for those individuals, as this would be inconsistent with the intent of ARP section 9817. Your state should clearly indicate in the spending plan and narrative if the state is using the funds attributable to the increased FMAP to pay for community-based state plan services not listed in Appendix B for individuals who become Medicaid eligible because of the increase in the number of waiver slots.

Other Information Related to the District's Spending Plan and Narrative Submissions

Effective June 3, 2022, states are only required to submit an HCBS spending narrative semi-annually (every other quarter), rather than quarterly; HCBS spending narratives are due 75 days before the start of every other federal fiscal quarter until the state's funds in an amount

equivalent to the enhanced FMAP received by the state have been expended. The next HCBS spending narrative is due 75 days before the quarter beginning October 1, 2022 (federal fiscal year 2023 quarter 1). Please note the frequency for submitting the HCBS spending plan is not changing. States must continue to submit an HCBS spending plan 75 days prior to the beginning of each federal fiscal quarter until the state's funds in an amount equivalent to the enhanced FMAP received by the state have been expended.

The District submitted the federal fiscal year 2023 quarter 1 spending plan and narrative on August 1, 2022. The District's next spending plan is due October 18, 2022. Please refer to SMDL # 21-003 and SMDL # 22-002 for information on the reporting process.

The District's spending narrative submissions 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, if applicable;
- 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;
- 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 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.

Your state's spending plan submissions should:

- Provide projected and actual spending amounts for each of the state's planned activities to enhance, expand, or strengthen HCBS. In those projections, clearly identify if the state intends to draw down FFP for any activities, as well as the amount of state and federal share for any activities for which the state plans to claim FFP and whether those activities will be eligible for the HCBS increased FMAP under ARP section 9817. In particular, in your next spending narrative, clearly indicate whether the District intends to draw down FFP for the following new activity included in the federal fiscal year 2022 quarter 4 spending plan and the authority under which the state intends to claim FFP:

  - "Innovative Programs, Pilots, or Studies" to improve integration of medical, behavioral, and LTSS care of HCBS recipients and reducing acute care costs or demonstrating value-based purchasing arrangements between health plans and LTSS providers;
- Update 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; and
- Update anticipated and/or actual expenditures for the state's activities to enhance, expand, or strengthen HCBS under the state Medicaid program between April 1, 2021, and March 31, 2025.

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

Sincerely,

Jennifer Bowdoin
Director, Division of Community Systems Transformation

cc: Eugene Simms