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Accessing Enhanced Federal Funding for HCBS Under the American Rescue Plan

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On March 11, 2021, President Biden signed the American Rescue Plan (ARP) into law, enacting a sweeping $1.9 trillion COVID-19 relief package. The legislation includes a number of provisions that will significantly impact state and federal health care policies and programs, including Section 9817, which provides enhanced federal funding for state Medicaid spending on home- and community-based services (HCBS). Beginning April 1, 2021 and through March 31, 2022, states are eligible to receive a 10 percentage point increase in their federal medical assistance percentage (FMAP)—the share of state Medicaid spending that is paid for by the federal government—for specified HCBS. On May 13, the Centers for Medicare and Medicaid Services (CMS) released guidance on implementing Section 9817 of ARP. The guidance also addresses many of the outstanding questions not addressed by the legislation. This updated brief describes ARP's HCBS enhanced FMAP provision, CMS's implementation guidance, and considerations and next steps for state policymakers.

The Role of HCBS in Medicaid

HCBS are a diverse set of services that assist people with disabilities or chronic illness and older Americans with their daily activities—such as preparing meals, transportation, and personal care—allowing them to live independently and safely in their homes and communities. Some HCBS also meet an individual's medical needs, such as home health care services. Medicaid is the primary payer for all long-term services and supports (LTSS), including HCBS and services provided in institutional settings, such as a nursing home. States have been spending an increasing proportion of LTSS dollars on HCBS for decades, reflecting an emphasis on providing LTSS in the least restrictive and least intensive care settings. In 2018, HCBS accounted for 56 percent of Medicaid LTSS spending–up from 48 percent in 2010–though the proportion of Medicaid LTSS dollars spent on HCBS in each state varies, ranging from 30 to 83 percent.[1] HCBS are an essential component of the care continuum, as evidenced during the COVID-19 pandemic. As states sought to decompress nursing homes and other institutional LTSS settings during the pandemic, they expanded eligibility for and the scope of available HCBS so that individuals could continue to have their needs met outside of an institutional setting.

[1] http://files.kff.org/attachment/Issue-Brief-Medicaid-Home-and-Community-Based-Services-Enrollment-and-Spending and https://www.medicaid.gov/medicaid/long-term-services-supports/downloads/ltssexpenditures-2017-2018.pdf

Section 9817 of ARP provides states with a one-year, 10 percentage point FMAP increase for state Medicaid expenditures for HCBS. The federal government currently pays for anywhere between 56 and 84 percent of state Medicaid expenditures, depending on the state; this includes increases in federal funding that were made available to states for the duration of the public health emergency through previous COVID-19 legislation.[2]

Under ARP's enhanced HCBS funding provision, a state that currently receives federal payments for 60 percent of its Medicaid expenditures will now receive federal payments for 70 percent of its Medicaid HCBS expenditures. The 10 percentage point increase applies only to HCBS expenditures made between April 1, 2021 and March 31, 2022, and it will be provided on top of any other FMAP increases a state may receive for HCBS, such as the six percentage point increase available to states that take up the Community First Choice 1915(k) state plan option for attendant services and supports, or the enhanced FMAP Congress authorized in previous COVID-related legislation.[3] However, ARP caps the cumulative federal contribution a state may receive for Medicaid HCBS at 95 percent. CMS's implementation guidance provides a definitive list of the types of HCBS that are eligible for the increased FMAP. States may only claim the enhanced FMAP for the HCBS listed in Appendix B of the guidance, which includes mandatory and optional state plan HCBS, such as home health care and personal care services; care management; school-based services, rehabilitative services, and services authorized under sections 1915(c), 1915(i), 1915(j), and 1915(k). Administrative activities are not eligible for the enhanced FMAP. States that deliver HCBS through managed care will need to determine what portion of the managed care capitation rates are attributable to HCBS eligible for the enhanced FMAP.

Importantly, ARP requires that the additional federal funds received by a state through the enhanced FMAP must *supplement, not supplant, the state funds expended for HCBS* as of April 1, 2021. This means that in order to receive the 10 percentage point increase in federal funding, a state must:

- Preserve the amount, duration, and scope of covered HCBS;
- Maintain, and not reduce, HCBS provider payments rates; and,
- Not impose stricter eligibility standards for HCBS programs or services.

This expenditure baseline includes state expenditures for HCBS being provided under COVID-related temporary emergency authorities, such as a 1915(c) waiver Appendix K or a Disaster Relief State Plan Amendment (SPA).[4] States are expected to retain changes authorized under COVID-related emergency

[2] https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[3] The 6.2 percent FMAP increase included in the Families First Coronavirus Response Act will expire at the end of the public health emergency, which will most likely occur while the ARP FMAP increase remains in effect. At that time, states still will be eligible for a 10 percentage point FMAP increase above their prior FMAP rate, including any other FMAP increases the state may receive for HCBS.

[4] States may use a 1915(c) waiver Appendix K during an emergency to modify provisions in an existing 1915(c) waiver, including eligibility, scope of services, and provider qualifications. States may use a Disaster Relief State SPA during an emergency to revise eligibility, enrollment, and benefit requirements in their state plans.

authorities, such as the Appendix K template for section 1915(c) waivers, for as long as allowable under those authorities. However, CMS will not hold states in non-compliance with Section 9817 once the authority for temporary changes expires. It is not clear from the guidance if states are able to modify the expiration date of existing emergency authorities to an earlier date and still comply with Section 9817.

How States May Use Enhanced HCBS Funding

ARP's enhanced federal funding for Medicaid-covered HCBS has the effect of reducing state spending on the HCBS that qualify for the new matching funds; and the legislation requires states, as a condition of accepting the enhanced federal funds, to reinvest the freed up state funds to implement, or supplement implementation of, activities to "enhance, expand, or strengthen" Medicaid HCBS.[5] While the enhanced FMAP is only available for one year, states have until March 2024 to reinvest the state savings in new or enhanced HCBS activities.

Activities that states may undertake to enhance, expand, or strengthen Medicaid HCBS include both activities to support state COVID-related HCBS needs during the public health emergency (e.g., supporting access to vaccines for HCBS recipients and their caregivers, and providing assistive technologies that mitigate isolation and ensure access to needed services) and activities aimed at building capacity in the broader Medicaid HCBS system (e.g., upgrading critical incident management systems, and enhancing behavioral health services). States may also use the investment funds to pay for additional Medicaid-covered HCBS (e.g., personal care services, rehabilitative services, certain school-based services), and may claim the enhanced FMAP for these expenditures if the spending occurs between April 1, 2021 and March 31, 2022. However, states can only claim the enhanced FMAP for additional Medicaid-covered HCBS one time.

Operationalizing Section 9817

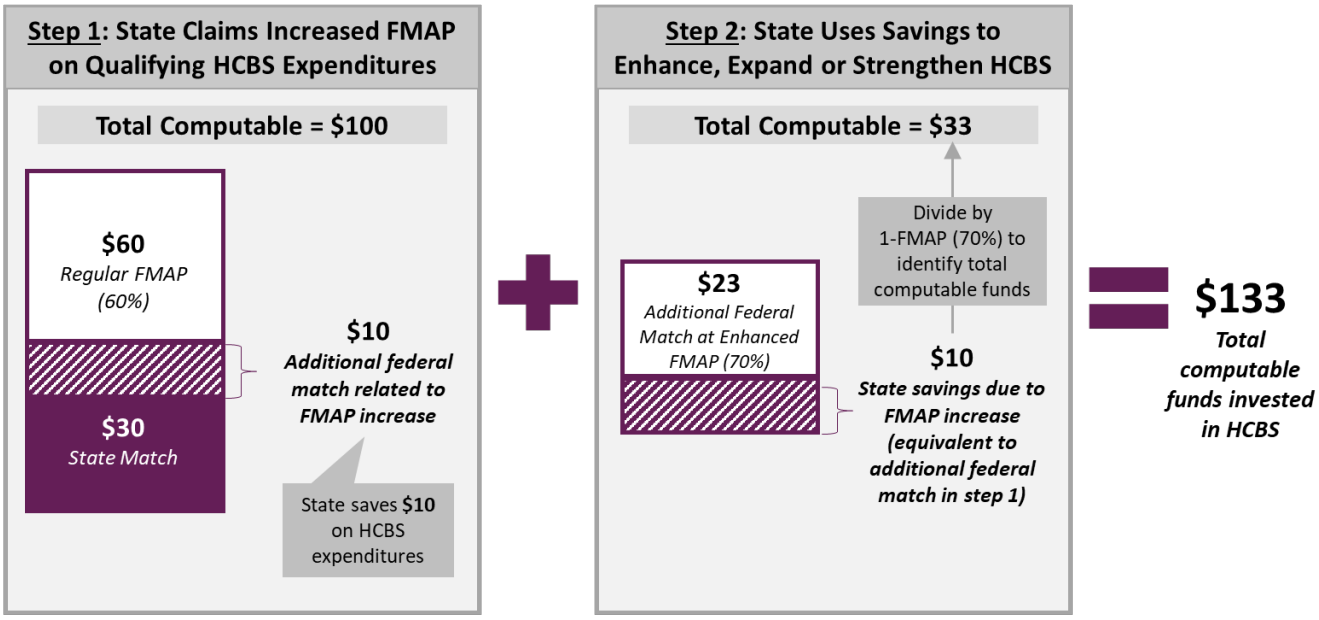
CMS's guidance on Section 9817 of ARP provides examples of the types of allowable uses for the state funds attributable to the enhanced federal funding, and the guidance gives states broad flexibility for HCBS reinvestments, allowing states to develop their own ideas for HCBS investments. Within 30 days of the release of the guidance, states must provide CMS with their initial spending plan and narrative explaining the activities they plan to undertake to enhance, expand, or strengthen Medicaid HCBS, anticipated expenditures for those activities, and how they intend to sustain those activities beyond March 2024. States may reflect ongoing planning in the initial spending plan and narrative (which will be updated quarterly thereafter), as CMS anticipates states may not be able to fully detail the amount of funds they expect to receive through the enhanced FMAP, or how they intent to use all of those funds. Plans may be directional but CMS encourages states to provide as detailed information as possible on their intended investment activities, on how their plans are being developed and when

[5] https://www.congress.gov/117/bills/hr1319/BILLS-117hr1319enr.pdf

additional and complete information is expected to be available. These plans and subsequent reporting should also include information on HCBS investments for which states anticipate needing to obtain federal Medicaid authority, such as a 1915(c) waiver amendment, or amend managed care contracts.

The CMS guidance also provides details on how states should claim federal Medicaid funds associated with the enhanced FMAP, and a state example for reinvesting funds attributable to the enhanced FMAP in additional Medicaid HCBS that are eligible for the enhanced federal match one more time.

Example Scenario: A state with a 60 percent regular FMAP has total HCBS Medicaid expenditures of $100 as of April 1, 2021. The state reinvests funds attributable to the enhanced FMAP in additional Medicaid HCBS provided prior to March 31, 2022 to draw down additional enhanced FMAP.



In this example, savings are invested in **additional HCBS** that qualify for the enhanced FMAP (Appendix B of the guidance) between April 1, 2021 – March 31, 2022. Other activities listed in Appendix C and D of CMS's guidance may qualify for the "enhance, expand or strengthen" requirement, but not at the enhanced FMAP.

Considerations for States

CMS's guidance reaffirms that states may use the additional federal funds to preserve or expand access to HCBS to address ongoing COVID-related challenges during the public health emergency, or to build capacity in the broader Medicaid HCBS system. These activities include:

- Increasing compensation and benefits for direct care professionals by increasing HCBS provider rates, providing hazard and/or overtime pay, and providing paid leave benefits;
- Providing personal protective equipment (PPE) and routine COVID-19 testing to direct service workers and people receiving HCBS;

- Authorizing reimbursement for family caregivers and providing needed supplies and equipment not typically covered under Medicaid (e.g., PPE);
- Creating new HCBS waiver slots to reduce waiver waitlists;
- Modifying existing waiver eligibility criteria or submitting a SPA to expand eligibility for state plan HCBS;
- Providing transition supports, including transition coordination services, to individuals transitioning from an institutional or congregate setting to community-based living; and,
- Adding coverage of new HCBS—including devices and remote technologies—to waivers or state plans.

States will be able to use the enhanced federal funding to support these activities either until the full amount of funds attributable to the increased FMAP have been expended, or March 31, 2024. Beyond that, states will need to consider how to sustain these activities.

The CMS guidance encourages states to consider investments that can enhance HCBS capacity and continue LTSS rebalancing reform beyond March 2024. For example, HCBS workforce shortages, particularly among direct care providers, are one of the most pressing challenges for states and can have an adverse impact on access and quality. The enhanced federal funding for HCBS made available through ARP could be used for supporting and expanding the HCBS workforce through recruitment—including through incentive payments—training and credentialing, which states should consider in tandem with service or eligibility expansion to ensure the workforce can meet the increased demand. States can also explore options for reforming compensation and benefit structures, building career pathways, and establishing directories and referral networks for direct care providers.

Other examples of long-term investment strategies provided by CMS include:

- Creating or improving "No Wrong Door" systems to improve access to HCBS, including outreaching to and engaging targeted communities to facilitate access to HCBS for which they may already be eligible;
- Developing cross-system partnerships among plans, providers, community-based organizations, social service agencies, and other stakeholder groups;
- Improving eligibility processes and policies to streamline the applications and eligibility determinations; and,
- Addressing social determinants of health among older adults and people with disabilities.

As states develop their spending plans, they should also consider:

- Establishing a process to assess and prioritize their COVID-related and longer-term HCBS system priorities across agencies responsible for serving HCBS populations of focus and delivering HCBS services;
- Determining which investments will have a lasting impact on improving HCBS system capacity and achieving LTSS rebalancing goals;

- Engaging stakeholders in the process of identifying investment priorities, including consumer representatives, family advocates, provider groups;
- What changes to implement—or delay—to optimize the amount of enhanced FMAP, including the expiration of disaster-related flexibilities that may impact the total amount of enhanced FMAP a state may draw down;
- What kinds of HCBS investments can be maintained and sustained beyond March 2024 and the sustainability strategy for those investments, when the authorized use of the ARP investment funds expires;
- In states that deliver HCBS via managed care, identifying new requirements and incentives that will leverage the plan role in enhancing, expanding or strengthening Medicaid HCBS; and,
- Engaging state legislators to ensure the HCBS investments authorized under ARP are reflected in state budgets and to identify any other policy or operational changes needed to implement these investments.

Conclusion

States have been working for many years to expand access to HCBS to shift care out of institutional settings and into less intensive and restrictive settings. The COVID-19 pandemic intensified people's preferences for receiving home-based care and reinforced the need for a robust and stable HCBS system to provide high-quality, person-centered care to Medicaid populations. The increased funding provided in ARP will help provide states with significant resources needed to continue state efforts to expand and strengthen HCBS while also signaling to policymakers that investment in HCBS is foundational to broader delivery system reform. State policymakers can prioritize cross-agency collaboration in in identifying their priorities and developing their initial spending plans, engaging key stakeholders and state legislators to ensure this unique opportunity to invest in HCBS is maximized.

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