

Transcript: Overview & Discussion on CMS Guidance for Additional Support for Medicaid Home and Community Based Services (HCBS) - Children's Services Advocates

May 25, 2021

Okay, I think the exponentially increasing list of attendees has leveled off, so I'm going to kick things off because we only have 45 minutes today and this is a critically important discussion. Good morning everyone, my name is Brett Friedman. I'm the Director of Strategic Initiatives here within the Medicaid program, and I'll be coordinating today's discussion, which is intended to achieve three things.

The first is to discuss the Department of Health's interpretation of the recently issued guidance that implements a provision of the American Relief Plan Act (ARPA) that provides 10% enhanced federal medical assistance percentage (FMAP) to categories of home and community-based services. The enhancement, pursuant to the terms of ARPA is to assist the HCBS industry in making reforms that will help promote care delivery and further sustaining support for these services and so in light of the guidance that was issued by CMS on May 13th, we'll discuss it and how we've read it and how we're viewing it for purposes of applying to CMS, which is a requirement under the guidance for permitted uses.

We'll discuss some guiding principles as to how the Department with our partner agencies, including OMH, OASAS, OCFS, and OPWDD will assess the uses for selection as we submit our plan to CMS.

And then most importantly, we want to hear from you. We've received many written submissions, but consistent with CMS guidance to do a truncated stakeholder listening session, we do want you to, as time permits to provide anything that would help and guide us as we apply to CMS for permitted uses and there's a number of ways to do it. The first is feel free to put any suggestions in the chat. And if you see it on the bottom, right you can see chat, you can type it in and we'll record that as a suggested use. You can also see the bottom right hand screen there's an icon that looks like a hand, or it's supposed to look like a hand. And if you click that, that will give us an indication in the bar that you want to make a comment and we will be able to then call on you, and the moderator will unmute you and we can listen to your comment that way. We'll get through as many as we can in the next 40 to 45 minutes and that will help us understand and supplement how these uses could help support the children's HCBS field.

At the outset we do want to note that we have been coordinating with OMH and OCFS on uses. While DOH, as the single Medicaid State Agency, will be the submitter of the plan to CMS, the feedback process is collaborative and so if you submitted previous feedback and suggestions to OMH, we've received those, if you submit them to us, we will also receive those and so we are coordinating strongly internally to make sure we

make one state submission that reflects all of the feedback that you're providing as an industry.

But to jump in and to provide 5 to 10 minutes of just the critical aspects of the CMS guidance. The first is that the way that CMS has interpreted the statutory provisions of ARPA is that we are going to generate 10% on defined categories of HCBS spend over, it's really fiscal year '22 from April 1st, 2021 to March 31st, 2022. So any amount that we spend or are projected to spend in those years, we get 10% on the gross amounts of the spend. And so that has, you know, we will identify those categories, whether spent through managed care or, as part of our state plan on something called the CMS-64, we will submit that amount based on a calculation on our submission, which will go either on June 12th or I think it will actually be June 14th because June 12th is a Saturday, but we will submit that fiscal estimate to CMS. We're still working on finalizing the fiscal estimate. The Kaiser Family Foundation indicated that our spend would be about \$1.3 billion in enhanced FMAP. We think it's going to be a little bit more than that. We're still determining how much of the total universe that will be based on our historical and projected HCBS expenditures across all of the programs, which includes state plan and waiver spending. And so, the first component of our exercise, which we are doing internally is determining the universe of dollars that we will have, that we'll generate under this new federal funding opportunity.

What CMS has said in terms of the ability to reinvest those funds is that we will take the money that we generate by virtue of this 10% enhanced FMAP, and we can apply it to a certain number of permitted uses.

The permitted uses come really in two forms. The first are those that are what we call matchable under the Medicaid program, so these are funds that we would otherwise spend Medicaid funds on and we would generate in normal times 50% of the amount of spend. So, if we put a dollar in the Feds match it with a dollar, that's how the Medicaid program has historically worked. And so CMS says we can reinvest this enhanced FMAP into purposes that are matchable and so we would turn every dollar of enhanced FMAP and turn it into again, assuming no other enhancements apply, two dollars, which is a very important piece, because it could double the amount of money that we have available for these HCBS investments.

The second critical piece of it is that we get to spend this money over a period of three years. That was unclear to us when ARPA was written, that we thought if we generate this money we'd have to spend it maybe within the year in which it was generated. CMS has indicated that we will generate the money in fiscal year '22, through March 31st, 2022 but we can spend it through March 31st, 2024. But after March 31st, 2024, we can no longer spend the money. If we don't spend it, presumably we'll lose it.

So, those to us are the critical elements. 1) we can use this enhanced FMAP to fund additional federal match and, 2) we have now a three-year period, which has already started lapsing, it was lapsing before the guidance even came out, to spend the money. And the way that we'll be permitted to spend the money is we have to submit a plan to

CMS within 30 days from release of the guidance. We think that's going to be June 14th and it has to delineate what our calculation is of the amount we're going to generate as well as the permitted uses that we will apply the money to and whether those uses are matchable uses or non-matchable uses.

Critically, CMS has imposed what we call a maintenance of effort requirement, or an MOE. You've probably heard the term, maintenance of effort requirement means that we have to lock in certain components of our HCBS delivery system. We can't change them for the duration of time in which we have to spend this money. So, if it takes us all the way to March 31st, 2024 to spend the funds, we can't make certain changes to our HCBS programs through that period of time.

And these changes come in three forms. The first is we can't change eligibility requirements, so we can't reduce eligibility requirements. So, if someone's eligible for HCBS today, they're going to have to be eligible for the duration of our time to spend the enhanced FMAP.

The second component of maintenance of effort is that we cannot change the quote unquote, amount, duration, or scope, or we can't reduce the amount duration or scope of HCBS benefits. So, we can't impose cuts on services for example, during this period of time and it's a blanket term. And we have lots of questions for CMS as to what it means that not reducing the amount, duration, or scope but we need to essentially have locked in the program as it existed as of April 1st, 2021. So, as long as we get to spend this money, the amount, duration, and scope of HCBS benefits need to remain as good as it was on April 1st, 2021.

And then the last piece is we can't cut rates and so we have to leave the rates applicable. We can increase the rates, but we cannot decrease the rates as compared to April 1st, 2021. Again, if we do any of those things, even a little bit, we risk losing all of the enhanced FMAP, which will be in the billions of dollars. So, there are these requirements that will dictate not just how we spend the money, but what we can do to our program over this three-year period.

And then what the CMS guidance does is it defines a set of permitted uses. And again, as I mentioned earlier, these permitted uses really come in two forms. The first, are those things that are otherwise matchable under the state plan, under the waiver that applies to these services whether 1115 or 1915(c). So if we apply the enhanced funds to matchable things, we can double the money but we can also take the money and invest it in things that are not matchable so long as they enhance the delivery of HCBS services. These can be in things like social determinants or grant programs. So we'd essentially be directly spending the dollars, not running it through a waiver or the state plan that would in many ways leave money on the table, because we're not utilizing it for matchable things but CMS does delineate that we can, you know, in various ways apply the funds to permitted uses that are not matchable.

So, there's both, you know, what we think are very positive elements of the CMS guidance, right? The longer duration to spend the money, the ability to use the money as state share for purposes of additional federal spending, and the broad permitted categories.

Then, there's a lot of uncertainty around the maintenance of effort requirements and what they mean, how it applies to existing MRT II reforms for example, and other anticipated or planned changes that would apply to the HCBS space. And so, we're trying to figure out those various pieces. We've asked a number of questions to CMS already, as have other states. Probably the number one question that states have been asking in our coordination efforts is can we have longer than June 12 to submit the plan given how important it is and it does have a potential to lock us in. There's an all-state call today with CMS and we hope to learn more about the flexibility in that regard as well as other aspects of the guidance. But at this point, we're left with our own interpretation of what was written on May 13th.

With that background, we've established in collaboration with our partner agencies some of the guiding principles, we call them, in terms of what will help us indicate what should be permitted uses and how we would want to spend the funds as part of our submitted plan to CMS. We have seven guiding principles that we'll look at for purposes of assessing proposals that we receive for use of the funds.

The first, and this is consistent with the appropriations language and this year's state budget, was that we expect, and I can't say with a degree of precision, but that the programs that have generated the HCBS will get to reinvest it. So, for purposes of the children's HCBS programs, we'll look at the spending that will generate the funds and again, maybe not reconciled to every single dollar but, you know, that that delivery system will get to reinvest its own proceeds. It's important for bigger picture right, the OPWDD waiver investments will reinvest the OPWDD dollars and the same for personal care and long-term care and children's services. So that way there'll be some degree of equitable allocation of dollars across the delivery system. Right? And trying to prevent the fact that the money doesn't have to be necessarily fungible across all of the potential state uses. So that's number one, which is we anticipate that the programs that have generated the HCBS will get to spend their allocation.

The second is that we will give priority to permitted uses that are eligible for match. So as not to leave potential additional federal money on the table we will want to prioritize the uses that can pull down additional federal dollars because they're permissible spend under a waiver or a state plan. That then makes common, fiscal sense.

Similarly, we'll prioritize uses that spend the money quickly. You know, because the enhanced match applies through March 31st, 2021, if we start spending the money in - or sorry, March 31st, 2022 - if we spend the money before, then we're actually generating the 10% match on that new spending. So, the quicker we spend the money, the more federal match we'll receive. So, that goes with this principle of maximization of

reinvestment of the funds to generate additional federal match to ensure we have the greatest number of dollars to support the delivery system.

Limited duration proposals - we do lose the ability, as I mentioned to spend the money after March 31st, 2024. As a result, we're going to look to uses that are startup in nature, immediate capacity building in nature, but aren't sort of hardcoded, indefinite spending proposals. And so, I know we've received a lot of proposals that are appropriately limited for the one-time nature of this investment, even over a longer period of time. And so those will, of course, be given preference.

Sustainability is the fourth principle, so we will prioritize proposals that, in our view and the view of our subject matter experts, have the greatest impact on creating sustainable change within the delivery system, capacity building, workforce investments and the like, that's something, and that's part of the narrative, that we have to submit to CMS and so the more money we can invest in certain areas that create meaningful and sustainable change will be given priority.

We want to address known risks and challenges. That is something that, you know, to the extent that we're aware of ongoing issues within a specific area, we're looking to address those issues, capacity being a big one.

We want to ensure principal number six, that the proposal's align with past and present year budget actions, right? You know MRT II was a large systemic reform in terms of transferring the aspects of the delivery system and to create a sustainable Medicaid program. And so, we're going to try and keep aligned with the MRT II recommendations to the extent possible.

And then the last principle, all else being equal, we're going to look at COVID-19, and the challenges created by COVID-19, and try to address those needs. Whether it be PPE, hazard pay and the like, but those types of uses will also be prioritized.

So we're really sticking to the agenda slide just to ensure that we're not speaking at you, but we want to hear from you and with that overview and with those guiding principles in mind, I'd like to open up to this group and hear what you have to say understanding, we have received a number of written submissions already, but I think it would be helpful to really hear from you as to where you think the challenges are, with regards to children's HCBS, so that we can keep that in mind as we prepare the state plan.

So, with that, I'll open the floor and, you know, either let people raise their hand or put questions in the comment box that we can read and discuss. So, with that, please, please, please raise your hand and we can call on you.

We have a very shy crowd. Okay.

Andrea, okay, I was hoping you would help out here, so yes, I think you're unmuted, Andrea. Thank you.

Can you hear me?

Yes, we can.

Okay, so I just want to clarify for the purposes of this discussion that HCBS actually means any services, and you alluded to this Brett, but I just want to make clear, because a lot of people think it's seriously just the home and community based program, which is one of the children's programs. But it actually means the services provided to individuals in the least restrictive environment possible by providing services and support, and for my purposes, children and families at home and in the community. So, for that clarification, the eligible services to draw down the match actually include children's rehabilitative services like CFTSS and the health homes serving children's services. Is that correct?

CFTSS definitely counts. Health home is one of our actually open questions as to whether those types of care management services - So there's two definitions of that are important here. Right? There's the HCBS services as defined by the guidance that generates the match. And then there are the HCBS that we can invest in with the federal match that we generate. And so I think there's an open question based on the - and to your point how CMS defines the eligible and HCBS under both categories is broader than what I think you and I, and others would think about us as sort of the traditional HCBS. Right, it includes things like personal care services and targeted case management that wouldn't traditionally be deemed HCBS but are for purposes of this guidance. So, to your question, a lot of the rehabilitative services are both money that can generate HCBS and money and ways in which we can invest increases in the HCBS. But it's dictated by appendices in the CMS guidance because it is broader than the traditional categories.

Thank you. I can continue if no one else raises their hand.

Yeah. Please, yeah.

We are very concerned about the workforce in the children's field and I think others as well. So, it probably isn't unique, but it is hard to determine, if that's a priority, it's hard to figure out how we support the workforce unless it's through grants because if we do rate increases and the rate increases have to end at the end of the three year period, there would be a question of sustainability. So, I just wanted to hear your thoughts about how you envision the workforce enhancements being drawn down in the most effective way.

So yes, and, you know, we're struggling with that question under a number of different HCBS programs because not all of them have a clear tie into state plan services or waiver services. For the, you know, I think to the extent that we can build in a new category in the 1915(c) waiver that looks at workforce sustainability, that's one way to do it. So, can we look for a time limited three-year investment in areas of the workforce that CMS will permit draw down under the waiver? That's one potential pathway. And

so, what is that - what does that workforce development, workforce retention/recruitment program look like under the context of the waiver? And critically, what's going to happen here is - and I think workforce will be a huge component of anything we do here - we would say we're going to use this for children's HCBS workforce and with some degree of specificity, quite high level in our submission to CMS in mid-June and then we would have to go and submit a 1915(c) Appendix K waiver or disaster emergency waiver and then ultimately a long term waiver that would help us invest the money and match it through the 1915(c) process. The approval periods on the 1915(c) waivers are relatively quick so we would expect the ability to generate the amendment, take it to a public comment as required, and then submit it to CMS and get approval retroactive to the start of the waiver. And that would allow for those investments to flow through the kid's waiver, so this is consistent with how they're paid through managed care. So that's the process by - So I would think about what it would look like as a waiver amendment. And if we can't think of a way to do it as part of a waiver amendment, then we should look at it as a way to do it through what's called a directed payment template which direct plans - which exists in the children's HCBS industry - to pay for services in a certain way so we can achieve match that way. And if those two things are not possible, but we really think it's an important use, then we'll do a direct grant program.

Okay, thank you.

Yeah, so I think any proposals that we receive, we really want to be sure that we've thought through, and we'll work with CMS to get this technical assistance because I'm sure every other state is going to ask for it as well, that it runs through the existing channels that permit federal match. We, as a general matter, want to shy away from grant programs, for a few reasons. One is, it's not matchable. But two, and this is I think the bigger reason, if we're doing the grant program, we have to administer it typically through a competitive procurement. And if we have to procure and award the grants through procurement, that could be a very long process. Right? And again, consistent with one of the overarching principles we want to be able to get this money out as quickly as humanly possible.

Agreed. So, we did submit a fairly extensive list of recommendations and tried to track with the eligible purposes, but just as a couple of highlights for - and in regard to what we didn't put in the memo is our thoughts on sustainability, which we can go back and add in but, you know once you get past three pages of written word, no one's reading it anymore anyway - but one of the things that we feel relatively strongly about, which not only expands access, helps us with workforce and is sustainable, is to bring up more evidence based practices for kids. It can expand access because it's a predictable course of treatment so you can move children and families through the course of treatment and see what the effectiveness is and then move on to another group of children and families quite possibly. We think that because it's evidence based there is more anticipated permanent outcomes. And we also think that it could help with the workforce, because if we find workers who are willing to enter evidence based training, but we have the ability to have an increased rate paid for the fees and the reporting

requirements, we might be able to pass on bonuses to staff who are willing to enter into the training. So, we really like the idea of funding evidence-based practices. We also feel very strongly about expanding the eligible workforce and the eligible purposes to address a couple of the priorities that CMS identified. The addiction and substance use statistics for young people as a result of pandemic are really stark and we think that as a pandemic response it really is appropriate to expand the opportunities for rehab providers to bring kids back to their skill level prior to the pandemic, and we similarly feel that for youth with autism and other behavioral issues. If we can push in and expand access to services for those kids, we'll be able to bring more kids around to recovery quicker as a result of the isolation and loss of school, and other things that have impacted them.

I mean, yeah, that's a great proposal. Thank you. One question and, you know, Andrea, I'm happy to have you sort of weigh in on this, I think one of the big challenges we're going to have here, is that yes, I think this is transformational money, but it doesn't go – it never goes as far as we want it to whether because of the limited time duration or because it's like there's unlimited need. Right? But is there industry consensus around a lot of little uses for the money or more bigger buckets, bigger expenditures, in terms of really funding aspects of the delivery system, as opposed to little need, sort of throughout the delivery system and that's one question I want to ask for each of these outreach sessions we're having, which is we have 20 different things that we fund or we can have two. And whether we think that there's really, you know, that the delivery system here would benefit from two substantial investments, as opposed to 20 smaller ones. If that question makes sense.

I think it makes sense. But I think the problems for the 1915(c) program and the CFTSS program are different and so I'm not sure that I know of one response that would serve both, but I can work on that. Can I give you an optimistic answer? Congressman Tonko has proposed that State match for all mental health services go to 90%. So, maybe that would be the answer to sustainability and addressing all the problems.

That would be great, from his mouth to God's ears, right?

Yeah, I'll end there. I mean, I think that I'd have to give that one a little more thought.

Okay, yeah, just, you know, it's like, how many - how dispersed do we - and I completely acknowledge the point about the difference between the 1915(c) services, 1115 services, and the CFTSS services, all is serving their own unique component, and each probably needing a level of investment and that's helpful context as we look into this.

Okay, I see a question from Diane asking will there be more documentation as to what will be covered in the near future? And so, you know, in terms of documentation that we expect to generate if we're having these work group or listening sessions, if you will, you know, we're going to take that back. We have to very quickly - it was a 30-day timeframe provided by CMS from release of the guidance. And so, that really gave us till

June 12th, which is an incredibly short amount of time to figure out how to spend this type of money and the guidance was so different than the initial authorizing statute that some of the planning we did wasn't necessarily helpful to the end results, but we have to submit our plan to CMS. That plan will be public. And so, folks will see what we ask CMS for across our HCBS programs. Kid's services, being just one of them. And then once CMS approves the plan, which they've agreed to do within 30 days if we submit it timely, then we actually have to go about and implement the approved funding. And the way that we implement the approved funding will be through either state plan amendments, waiver amendments, or grant awards. If it's a sort of non-matchable service and each of those carries with it an ability for public comment and public engagement. So this is not the only bite at the apple, I would say this is a high level bite at the apple, and there will be documentation where folks see what our permitted uses are as we further develop these processes in collaboration with our partner agencies. Hope that answers the question.

Someone asked where can we find the permitted uses? Where do we submit a proposal for specific trainings to benefit staff? So, the permitted uses are - and we can, I'll actually post the link into the Q & A field right now so folks can see it - the permitted uses consistent with CMS policy are set forth in what was called the State Medicaid Director 21-003, this is what came out on May 13th. This is the CMS guidance that directs us in terms of how we can use the money. There's an appendix in that document, which is I'll call it modestly helpful actually, probably more helpful than a lot of other things to come out of the federal government in recent years. But they provide examples of activities that support HCBS needs. It's appendix C in that document, which, you know, sort of helps dictate what CMS thinks states should be spending the money on. Although they're much more open ended and then they also make reference to the LTSS rebalancing tool kit and other existing public guidance around social determinants that we could also seek federal match on and those are incorporated by reference. So, this federal letter is the source of guidance that we are using, and that all states have to use on what the permitted uses are and that's where we're getting our guidance. And in terms of looking at that and a lot of a lot of folks have already done that, but just sending us what you think are worthy places of spending the money given that you face the challenges every day in the delivery system, and understand where additional needs are there and where they should be funded. One thing that's clear is that these funds need to be on new purposes. Right? So, these need to be new or supplemental programs. This is incremental spending to what already exists today.

I hope that answers that question, anyone else with comments or questions?

You know, again, this is - I know we're doing this very quickly and I apologize for that. This is not by State choice. We would love to have a more robust and fulsome stakeholder process, and I know OMH has done them already, which we are building on, but we want to be able to, at least on a high level basis, have reached out and gotten any feedback we can as we have to very quickly pivot and submit this plan to CMS.

So, with that, I mean, not seeing any other questions or comments, I don't know April or Collette or anyone else, if there's anything that you want to mention in terms of what you're seeing and what you've received - If not, we can certainly end this call early, but please from a point of contact standpoint either - Oh, we just received another question.

One challenge faced by families is additional availability of onsite respite. Could this funding be used to develop this as a resource? To the extent that respite is funded under the existing HCBS children's waiver, yes, we could expand access to respite, but as the permitted uses.

But, you know, so just to complete the thought earlier and thank you for keep sending the questions and comments in, is I don't know April or Colette, if there's anything else in terms of the engagement that we want to mention for purposes of this feedback, but you can send your comments to April or Colette who have been collecting them, we are also tracking them here and you know and then we'll go from there.

Thank you, I was just going to say what Brett already said, which is, you know, feel free to reach out to Collette or me with your thoughts and ideas, we'll make sure that those get to Brett and his team, or if you have any questions. And I just want to call out that there was another comment in the chat box about transportation for staff being reimbursable, especially in areas that need cars to travel to children's homes which is then a huge challenge, a big challenge - so whether, I think the question is whether funding can be used to cover the cost of transportation for staff to families' homes, particularly in rural areas.

We can certainly explore that as one of the permitted uses under the guidance as an enhancement. CMS did make a lot of reference to utilization of technology, physical site improvements, and other things that will help with keeping individuals in their home, in least restrictive setting and so, you know, to the extent that transportation is a problem in certain areas of the state, that's something that we can consider in light of the principles as we look through the appropriate channels to seek federal funding.

Thanks Brett! Colette were you going to jump in?

I just want to share that we have received some feedback folks, so appreciate that and we are making sure your information all goes to the centralized place of tracking. And I, I would also agree with when that is where you bring from a lot of providers that the biggest issue for them is just the workforce. Right? So, workforce investment seems to be one of the key points that folks are pointing out. So again, appreciate all the feedback people have been sharing.

We thank you for attending today and I think the sooner you can get any recommendations to the extent they haven't been sent already the better. We are, as I mentioned earlier, and I can't emphasize this enough, we have been put on a very short timeframe by CMS and that way we can consider them again. I think any

recommendations can be sent either through your association leads or directly to April and Colette and we can incorporate those into our existing response.

Brett, I did notice that Maria Cristalli has her hand raised, if we could unmute her line.

Thank you very much, April. Thank you Brett I think, just to underscore its workforce, workforce, workforce from a provider point of view. So, it's an investment I second with Andrea raised about investments for clinicians and incentives for us to stand up evidence base programming. But also, for our bachelor prepared workers, this is really interfering with us, the ability to recruit and retain our workforce and delivering these services. So, any opportunity to help fund some adjustments of getting these folks in the door, like employee referral programs, like, loan forgiveness, we just need to get more people in to deliver these services. It's critical going forward.

Yeah, workforce has been a constant refrain I think across all HCBS settings and that's one thing that I expect will be a substantial piece of anything we do. And the more we can do and identify bringing the barriers to - sort of identifying the specific barriers, whether it is things like loan forgiveness or other recruitment incentives that we can do very specifically as it applies to serving children, then we are happy to consider and incorporate those into our submission.

I'll ask the moderator; do we see any other questions in the chat or anything else from a Q & A perspective? I want to make sure at least in the last few minutes, if there's another comment or two, we can hear them. If not, I can give back a few minutes on this Tuesday morning.

Okay, well, with that we'll wrap it up and I just want to thank everyone for joining this morning and for their ability to provide helpful feedback as we're guided on this process. It's a very exciting opportunity but given the timeframes and the open-endedness in the way it's been structured, also a challenging one and so we want to make sure we invest this money correctly. So thank you for your time and for feedback you provided in advance, or you will provide hopefully this week, and we will do our best to incorporate it as we submit our plan to CMS in the next few weeks. Thank you. And please do not hesitate to reach out with anything else.

Take care. Bye everyone.

Thank you.

Thank you.