Centers for Medicare & Medicaid Services
Listening Session: American Rescue Plan Act's Home
and Community-Based Services Provisions, the FMAP Increase
Moderator: Jill Darling
March 25, 2021
2:00 pm ET

Coordinator: Welcome and thank you all for standing by. All participants will be in a listen-only mode until the question-and-answer portion of the presentation. During that time, if you would like to ask a question, please press star 1 and record your name when prompted. As a reminder, this call is being recorded. If you have any objections, you may disconnect at this time. Now I will turn the call over to your host, Jill Darling. You may begin. Thank you.

Jill Darling: Great. Thank you, (Jeff), Good morning and good afternoon, everyone. I'm Jill Darling in the CMS Office of Communications here at CMS. Welcome to today's listening session on the American Rescue (Plan) Act's Home and Community-based Services Provisions, the FMAP increase.

Before we begin, I have one brief announcement. This listening session is open to everyone. But if you are a member of the press, you may listen in but please refrain from asking questions during the comment and question portions of the call. If you do have any inquiries, please contact CMS at press@cms.hhs.gov.

And I will now hand the call off to Anne Marie Costello, Acting Director for the Center for Medicaid and CHIP Services.

Anne Marie Costello: Thank you, Jill. And hello to everyone. I want to welcome you today to today's listening session. I also want to sincerely thank you for joining us today and especially for all that you have done during the COVID-19 public

health emergency to ensure critical supports for some of our nation's most -- oh, I'm so sorry -- some of our nation's most vulnerable populations as said.

As you all know well, Medicaid and CHIPS cover nearly 78 million Americans and this number has increased by 6 million over the last year.

Your ideas and feedback, oftentimes in the front lines of the pandemic, have been a tremendous resource to us at CMS as we develop policy and guidance for our state partners.

Recently on March 11, 2021 our nation received an unprecedented boost in an effort to change the course of the pandemic when President Biden signed the American Rescue Plan Act of 2021 or ARPA as we now refer to it as.

ARPA represents the largest expansion of health coverage to the American people since the Affordable Care Act and among other things has a significant and immediate impact on state Medicaid and CHIP programs and beneficiaries.

In particular on the topic of this first session, ARPA supports states in enhancing home and community-based services, which have been critically important to Medicaid beneficiaries impacted by COVID-19.

Again, we appreciate and value your feedback and we look forward to hearing from you today.

I will now turn the call over to Alissa Deboy, the Director of CMCS's Disabled and Elderly Health Programs Group, who will provide more details on the law and the purpose of today's call. Alissa?

Alissa Deboy: Thank you very much, Anne Marie, and good afternoon, everyone. As Anne Marie noted, I am Alissa Deboy. And I am the Director of the Disabled and Elderly Health Programs Group within CMCS.

We're delighted to be able to meet with you today and we really appreciate you taking the time to participate.

As you are aware, Section 9817 of the American Rescue Plan Act of 2021 provides for an increase in federal reimbursement of Medicaid home and community-based services, or HCBS, by 10 percentage points from April 1, 2021, through March 31, 2022.

This increase is for states to supplement, not supplant, existing state funds expended for HCBS. The law specifies the states must implement or supplement the implementation of one or more activities to enhance, expand or strengthen Medicaid HCBS.

The purpose of this listening session is to hear from a broad range of stakeholders to help inform our development of guidance for state Medicaid agencies related to this very important provision.

Please note that we are not able to engage in in-depth discussion about our interpretation of the provision or to answer specific questions on this call. Rather, based on several stakeholder groups that have reached out to us wanting to speak with us, we wanted to provide an opportunity for you to provide input for consideration.

We want to thank those of you who have already sent in letters with your thoughts and questions as they have been very helpful resources to us. I would like to note that we have staff across the Center for Medicaid and CHIP

services and multiple staff from DHPG, my group, on the call in listening mode. And we are anxious to hear your feedback on the provision, particularly the opportunities and any potential challenges you see in implementation.

In addition we have several questions I would like to share quickly to give everyone a sense of some of the areas in which we would particularly like to hear your feedback.

We will return to these questions as prompts over the course of this call.

The first question is what information do think states need to identify expenditures that qualify for the increased FMAP?

The second question, are there additional Medicaid services not listed in statute that should be considered for the enhanced FMAP?

The third question, what activities related to expanding, enhancing or strengthening the HCBS should states be allowed to use in the enhanced FMAP score?

The fourth question, what activities or infrastructure have worked in increasing HCBS capacity either generally or during the public health emergency?

And finally the fifth question is what is a reasonable amount of time for states to spend the funding attributable to the increased FMAP on activities to expand, enhance or strengthen HCBS?

Jen Bowdoin, who is the Director of our Division of Community Assistance Transformation, will help guide us through this call. And she'll be joined by

Melissa Harris, Deputy Director of DHPT and Ralph Lollar, who is the Director of Division of Long-Term Services and Support with myself to keep us on point during this call.

Again, we look forward to your feedback. And with that, (Jeff), who is our operator, we are ready to open the phone queue line.

Coordinator: Absolutely. If you would like to ask a question, please press star 1 and record your name when prompted. If you elect to withdraw your question, please press star 2.

Our first question comes from (Damon Tzersaki). Your line is open.

(Damon Tzersaki): Hi. Good afternoon and first of all thank you so much for hosting this call. We think it's really important for you to hear from the community and just really appreciate you taking the time to listen to the stakeholder feedback.

I know we did send a letter already on this and are very excited about this provision as the states are really looking to bolster their HCBS infrastructure and services throughout this pandemic and utilizing this funding.

I think from our perspective something that we really did want to emphasize is that there are a number of infrastructure investments and opportunities that can really improve HCBS delivery systems.

We just encourage you to look at this funding in a holistic manner that looks at both service delivery as well as the infrastructure that supports it. And I'll just give one tangible example, which is we've seen that the information technology systems that states have developed over the years, particularly those states with very robust information technology infrastructure, have been

extremely useful in identifying individuals that are at risk of COVID infection and severe complications and getting the services to them, getting different types of in-home services as well as vaccinations to those individuals.

So that's one example of where this technology could be really, really useful if the funding is available to build out that infrastructure.

So I'll leave it at that. Thanks so much for holding this call.

Alissa Deboy: Thanks, (Damon). We appreciate that comment and the feedback that you've provided in writing. So we will take all of that back and we will consider it as we develop the guidance.

(Jeff), the next question please.

Coordinator: The next question comes from Mark Davis. Your line is open.

Mark Davis: Hello. This is Mark Davis with PAR in Pennsylvania and also an active member of ANCOR, a national association for providers who work with intellectual disabilities or autism. And, again, thank you for the time today.

I just wanted to respond to your questions. One is I think we have seen almost a doubling of turnover among direct support professionals during the pandemic.

And we have seen significant vacancy open position rate of about 20% leading to a significant impact on the individuals we serve being left in very, very difficult situations in terms of caregiving and providing the necessary supports.

And we also have seen an increased cost from overtime and other costs associated with keeping our DSP safe and keeping them well, you know, in the job.

And so I would say anything we can do for the workforce is just really, really critical right now. We can't provide our supports and services without the workforce.

And secondly I wanted to respond to the question about what kind of time. I would say that we want to do it through June 30 of 2022.

We want to give states and providers enough time so, you know, another three months or so, a couple of months, May and June, at least to file claims so that states will know what the 10% percent will be so they can allocate it out but also do it as quickly as possible so that we can address the urgent and emergent needs associated with the pandemic.

So again I appreciate your time and that's all I've got. Thanks.

Alissa Deboy: Thank you, Mark. We appreciate that feedback as well. (Jeff), we're ready for the next question. (Jeff), are you there?

Coordinator: The next question comes from Peter Van Runkle. Your line is open.

Peter Van Runkle: Hey there. Thank you for allowing us the opportunity. It's a great thing and certainly this provision is a great thing. I'm Pete Van Runkle. I'm with the Ohio Health Care Association. We represent providers of home and community-based services, both on the aging and also on the DV side.

My question is kind of a technical one that I think really needs to be addressed clearly in the guidance that CMS is going to produce. And it has to do with the non-supplanting language and specifically trying to think that through in terms of how FMAP works that it is a contribution to an expenditure that the state makes for Medicaid services.

And so if you think about it in terms of a - let's say it's a 60/40 split of 60 federal, 40 state prior to this additional 10%. Then how does the state generate the additional 10% by (spending) the same amount of state dollars?

In other words to do that they would have to, I think, increase their spending by that 10% on the home and community-based service involved in order to keep - in order to not supplant any state's funding but also make use of or obtain the additional federal funding.

Is it like that or is it that the state could leave their spending on the home and community-based service itself the same, take the extra 10% and then use it for some other purpose, presumably and hopefully related to home and community-based services but not necessarily?

I think that's a really important distinction and that technical clarification is really going to be helpful in terms of crafting what states can do with this money.

Thank you.

Alissa Deboy: Thanks, Pete. We appreciate that feedback. And we will take that into consideration as we develop the guidance. (Jeff), we're ready for the next comment.

Coordinator: Our next question comes from (Leah). Your line is open.

(Leah): Hi. This is (Leah) in Colorado. And my questions are first can the state use funding on expenses that would typically be considered administrative costs?

And just for example could we hire, you know, state staff within the Medicaid agency to be devoted in some way to HCBS programs?

And secondly can we use the funding on new innovations that aren't currently part of waiver agreements or existing programs?

So, for example, could we use money to pilot a new type of service? And I think that's all I had. Thank you.

Alissa Deboy: Thanks much. We appreciate those questions and we will take them into consideration as we develop the guidance. (Jeff), we're ready for the next comment.

Coordinator: The next question or comment comes from (Sarah Hurley). Your line is open.

(Sarah Hurley): Hi, yes. This is (Sarah Hurley) actually also from Colorado. One of our main questions is just wanting to confirm that the state is able to utilize the money from the 10% FMAP for services and then also be able to receive the traditional FMAP 6.2 increase that we get through the Families First Act.

So any, I guess, additional information on that in the guidance would be great.

Alissa Deboy: Okay. Thank you very much. We will take that into consideration as well. (Jeff), we're ready for the next comment.

Coordinator: Our next question/comment comes from Kelly Buckland. Your line is open.

Kelly Buckland: Yes. Thanks. This is Kelly Buckland from the National Council on Independent Living. We're a membership organization for the Centers for Independent Living.

And as you probably know, Centers for Independent Living are charged with transitioning people out of nursing homes and other congregate settings and also diverting them from those same places.

So what we've seen in the last - well, since COVID hit, is that there are a lot of people being moved out of hospitals directly into nursing facilities that really don't need to go there because the hospitals are so busy it's the path of least resistance.

So it would be really good if this money could have some guidance language around it that would really help focus on diverting people from these facilities in the first place versus having them work to get them out once they're put there.

Alissa Deboy: Thank you for that feedback. We will take that back as well and consider it as we develop the guidance. (Jeff), we're ready for the next comment.

Coordinator: Our next comment comes from Brendan Flinn. Your line is open.

Brendan Flinn: Hi, there. Thank you for hosting this call. I'm Brendan Flinn calling with Leading Age.

And I just wanted to raise a couple of points. So first of all on workforce, obviously workforce is central to the home and community-based service

system. And these dollars represent a really great opportunity to allow states to really bolster their HCBS workforce.

And this could include things like writing into the guidance, permission for states to develop or expand programs, to recruit and train HCBS workers or to directly connect workers who are looking for employment to specific HCBS providers and/or beneficiaries depending on the setup of services or to allow states to establish, expand or supplement essential worker (K) programs.

You know, particularly with some of the other money that's coming in to the state and local governments, there could be some opportunity to blend the different pools of money from the American Rescue Plan to put essential workers particularly in the HCBS space. And so anything in the guidance that could advance that would be super helpful.

Separately on technology, while we're definitely encouraged by the rate of vaccination among older adults. Not all community-based providers are back up and running in person and are still operating remotely.

At the same time, however, not all medicated HCSB beneficiaries have access to the necessary technology or even just Internet to participate in those remote services.

And we think that states should be allowed to leverage this FMAP increase to fill the gaps in access, both to support participants through the current pandemic as well as to make sure that they are able to access that type of support moving forward.

Just a few quick things on payment. So just like I said, not all providers are fully operational at this point. And those that are have not necessarily seen all participants come back for in-person services.

Some states might want to offer retainer payments using the FMAP dollars. And if they do, these specific retainer payments should not be time limited or if they are, they should not be put on the same time limit track as the Appendix K retainer payments.

Similarly some states might be more inclined to issue one-time payments to HCBS providers rather than commit to a rate increase. And the guidance should reflect that and allow states that flexibility to issue some sort of, like, one-time or time limited payment that would allow states to reimburse providers without creating a downstream shock at this time next year due to rate cuts with FMAP only lasting one year.

And then finally many HCBS providers borrowed, you know, SBA loans or received other non-Medicaid support from their state to the state CARES Act funds and other COVID-19 relief.

And to get these to most effectively use these, particularly FMAP, there should not be any further limited burdens placed on states that involve other participants in the HCBS system to not, you know, condition any support they receive on whether or not they receive funds through those programs.

And then I actually cited just one other quick item. We know that states have made great progress in the Medicaid space with connecting beneficiaries to palliative care. And we would encourage CMS to leverage those dollars - to leverage these dollars to move those efforts forward.

So I know that's a lot I just put in, but thank you again for the opportunity to share.

Alissa Deboy: Thanks, Brendan. We appreciate that feedback. (Jeff), we're ready for the next comment.

Coordinator: Our next question comes from (Ryan Lubitz). Your line is open.

(Ryan Lubitz): Thank you so much. Hi. This (Ryan Lubitz), also with Colorado. So we would encourage some information in regards being able to utilize some of this funding for our case management and related to perhaps enhanced payments to case management agencies for COVID-related work, non-COVID related enhancements to case management, IT infrastructure, looking to make sure that we can do some case management innovation and enhancement.

Thank you.

Alissa Deboy: Thank you for that feedback. (Jeff), we're ready for the next comment.

Coordinator: Our next comes from (Bea Richter). Your line is open.

(Bea Richter): Good morning, Alissa. Thank you for the opportunity to provide comments. One of the questions you asked at the top of the meeting was the types of activities or investments that have been helpful to increase HCBS capacity and improvements.

And a couple of ideas there. It's really important that states are given the flexibility to use this money not only through rate enhancements or increases to services but also to be able to hire staff and contractors to do things like gap analyses, resource provider service development, policy work.

In the past it's been very helpful if we could use general funds that's freed up from FMAP to make capital investments. There's some capital investments needed in our assisted living facilities in terms of ventilation systems to prepare for future kind of infectious disease outbreaks.

In addition, there are some gaps in the system around specialty providers. And we would like to be able to make one-time investments in capital to help providers build Medicaid capacity for some of these provider networks.

We would also like to be able to make some investments that strengthen the HCBS system in such a way that it actually diverts or delays entry into the more formal Medicaid LTS systems. And we hope that would be an appropriate use of the money.

Also our in-home clients have experienced a lot of increases in basic necessities, things like food, things like purchasing technology, broadband, Internet access, et cetera, to be able to participate in remote services. And we would like to use some of the money to increase the personal needs allowance for client's services in their own home.

One of the barriers to this funding is the short-term nature of the funding and the one-time nature of the funding. So the more flexibility and time you can give states to be able to pilot things, to evaluate the impact, the better we will be able to work with our legislatures and then our appropriation environments to find long-term sustainable funding to continue the investments over the long-term.

Thank you again for the opportunity.

Alissa Deboy: Thank you for that feedback, (Bea). (Jeff), we're ready for the next comment.

Coordinator: Our next comment comes from Stan Soby. Your line is open.

Stan Soby: Thank you for taking my comment. Stan Soby with Oak Hill in Connecticut and ANCOR member.

My question is will there be some measures in the guidance to ensure that the funding that is provided through this enhancement is used to supplement and not supplant state funds when the state generally accepts funding into the general fund and then makes an allocation to budgetary expenditures from that?

Thank you.

Alissa Deboy: Thank you for that comment. (Jeff), we're ready for the next comment.

Coordinator: Our next comment comes from Shannon McCracken. Your line is open.

Shannon McCracken: I'm Shannon McCracken from ANCOR. They're a national nonprofit trade association. And on behalf of our over 1,600 community-based providers of services to people with ADD, we appreciate the opportunity to be heard today.

We have sent a letter to you and, of course, urge you to create a simple process with clear guidance for states to ensure that the funds are disbursed quickly and spent in a manner that reflects Congressional intent.

I'll summarize just briefly three of the specific recommendations in our letter. First is one that others have commented on defining supplement versus supplant.

Any state investment in HCBS hearings, the single year funding should grow by the percentage of FMAP increase 10% to reflect the new federal investment.

State reporting should be required to ensure that the new funding is being spent in that manner. Some state legislatures are currently negotiating their FY22 budgets and beyond.

ANCOR members are concerned that some states may reduced their upcoming HCBS expenses along with provider reimbursement rates on paper to save the general revenue and use the FMAP increase of 10% to fund the savings "realized in their general revenues."

The second point is securing state authority to administer a new temporary benefit. If a state chooses to administer a new temporary benefit, for example respite or other support with these funds, CMS approval should be done through Appendix K to ensure expedited approval.

And the third is in regard to the allowable uses. States should be urged to closely work with stakeholders, including consumers, providers and workforce members on the investment of funds and a reasonably expedited approach to address the specific needs in their state.

States should be encouraged to fund measures that include but are not limited to bolstering the direct care workforce, increasing access to and use of technology and remote supports and promoting the safe provision of services and continuing that with social distancing and appropriate PPE.

CMS should specifically note that funding may be used for important investments in the service infrastructure to support the administration quality and availability of HCBS.

PRF guidance on allowable expenditures is ever changing and subject to confusing interpretation for providers. So relative to this, with HCBS financing, HHS has a new opportunity to help community-based providers in the field by communicating clearly and consistently and that will lead to confidence that it will happen.

Thank you so much. And we look forward to working with you to rollout this much needed funding quickly and in a targeted manner. Thank you.

Alissa Deboy: Thank you, Shannon, for that feedback today and for your feedback in writing. We will take that back as we consider and develop the guidance. (Jeff), we're ready for the next comment.

Coordinator: Our next comment comes from (David Boland). Your line is open.

(David Boland): Thank you. (David Boland). I'm in Colorado. One of the things I wanted to talk about was if we're going to do - the states choose to do something a little more innovative to expand their HCBS program. They need to be able to have more time than just one year to spend the money.

So if they could get - while the money is limited to match for a year, if they could be able to spend that money all the way up until June 30, 2023 so they could try to get some innovative projects off the ground and then create the funding within their state's budgets, that would be very helpful to be able to have a little bit more time.

And then I think that there is a real need to be able to help the workforce out while it's kind of like a hero type pay or bonuses for those people who have helped us keep people out of nursing homes or transitioned people out of nursing homes, which we need to continue to do. Obviously no one should go to congregate living because we've got more pandemics coming.

So something that can be used for workforce pay and then also for technology for clients. Remember many of our clients are on SSI. They don't have much money to buy technology.

So the state being able to provide some technology for those people who are in dire need would be really helpful for audiovisual supervisors, for case managers to do assessments and check in with people and actually see them.

So those are my comments. Thank you.

Alissa Deboy: Thank you, (David). We appreciate those comments. (Jeff), we're ready for the next comment.

Coordinator: Our next comment comes from (Linda Rambler). Your line is open.

(Linda Rambler): Thank you. I just really have a quick suggestion to make in that you have already partnered with the Administration for Community Living on the National Center for Advancing Person Centered Practices and Systems.

And I think this would be an excellent opportunity to look really at the outcomes of person-centered planning and practices and making sure that we're not just funding services and systems that people think we need to be funding, but we're actually giving people what they need and then coming up with outcome measures like, you know, not just satisfaction surveys but do the

quality of their lives actually increase because they are connecting with community or they are accessing assistive technology to be more independent or being able to have more people in their lives who care about them?

So I'm thinking that outcome measures are very, very important and need to be looked at. And I'm hoping that some of these funds could be directed solely for that purpose.

Thank you.

Alissa Deboy: Thank you, (Linda), for that suggestion. (Jeff), we're ready for the next comment.

Coordinator: Our next comment comes from (Charles Dew). Your line is open.

(Charles Dew): Hi. I'm with (1199) New England in Connecticut. One piece on the workforce training, we would love to see some guidance, just making clear that the increased match can be used for things like (unintelligible) management training funds.

And then just a second comment is about, you know, we would also like to see if it's possible states being able to spread out this extra funding over a number of years to fund something like permanent wage increases for home care workers.

Thank you.

Alissa Deboy: Thank you for that comment. (Jeff), we're ready for the next comment.

Coordinator: The next comment comes from Barbara Palmer. Your line is open.

Barbara Palmer: Thank you very much. And I certainly appreciate you all hosting this. And most of the things that I have to say have been said but I would like to say them again.

In Florida, just like everywhere I'm sure, our direct care workers are really suffering. And the providers that hire them are suffering them as well.

And I just want to underscore the clarification that we need about doing bonuses. And I'm a little confused. If we want to do bonuses without increasing the services needed, that needs to be clarified because I'm not sure if all of this has to be tied somehow to service increase. I don't think so but I need to have that clarified.

The second thing is on the technology equipment that someone just mentioned because we've got people that need computers. They need phones. They need generators. We need monitoring equipment for people that are in supported living that are in their own places.

And also for training, we need a lot of training for individuals as well as their families and providers.

And then one thing in particular is the contract - with a pilot, can we - I think I heard something about that but I got on a little late. Can it be used for example for something to design a facility that we would use for dual diagnosis and treatment? Of course, ongoing services could not be used with this money, but building it and designing it, I hope, could.

And that's basically it. But I agree with everybody that said something about we need more time to spend this money. And in that regard, I don't think we're

asking for the 10% for three years. I think we're asking to spend the 10% over three years. But, I don't know - let's get (some) on.

Okay. Thank you so much again for what you do.

Alissa Deboy: Thank you for that, Barbara, for that feedback. (Jeff), we're ready for the next comment.

Coordinator: The next comment comes from Amanda Dillon. Your line is open.

Amanda Dillon: Hi. Thank you. I'm in Texas. And I think just to the extent you're able to, it would be helpful for the guidance to include instructions for states about how these additional funds will impact the calculation of waiver cost effectiveness or waiver budget neutrality.

Thanks.

Alissa Deboy: Thank you for that feedback. We will take it into consideration as we develop the guidance. (Jeff), we're ready for the next comment.

Coordinator: Our next comment comes from Serena Lowe. Your line is open.

Dr. Lowe: Good afternoon and thank you for hosting this call. Just a few comments coming from someone who is currently working for organizations that represent consumers of HCBS, their families and progressive providers who are 100% dedicated to providing individualized tailored supports in the community, one person at a time.

I fully support what (Bea) from Washington State and the Colorado team said about allowing for flexibility. I am really encouraging and even pushing states

towards investing some of the funding into innovation and into helping providers who want to transform into more integrated individualized options to have the option to do as opposed to going backwards and fulfilling models that we know from a congregate standpoint are unsafe at this point and also not contributing to the outcomes that individuals have said they want.

We're also concerned about the person-centered planning strategies that states are deploying. Many states were very much behind the curve, as you know, prior to the pandemic.

We're very worried that PCP is becoming kind of a checklist in many states because of the pressures and demands they have to replace people and that individuals are not getting a lot of say in terms of options and really what they see for their life and the services that they need.

And that part we really hope that the guidance will not only provide stronger clarity and detail around what expectations CMS has related to PCP but also related to self-direction.

We're seeing several states actually tighten restrictions around the use of self-direction at a time when consumers and families need as many options and vehicles and flexibility that they can to use HCBS funds in the best way for that individual.

In terms of progressive providers, I just want to provide an alternative perspective.

Our providers that we represent through (CASH) are actually seeing an uptick in demand not a downturn. And they also have not had issues during the pandemic in maintaining DFPs because they were already and always

committed to paying DFPs their full wage regardless of reimbursement levels, which has created very long-term commitment of these individuals and high quality individualized services, which again increased demand and produced cost savings over time.

In terms of DFP innovations, however, there's a lot of great work going on at a provider level and at a state level. I would encourage you to look at Maryland and some of the work that they're doing.

And also ACL currently has a blazing the trail competition specifically around DFP workforce development issues that we would encourage you to take a look when you're looking for promising practices and models.

We do really encourage, and I totally echo the woman who said the (NCAPS) is a great place to really reference, but also utilizing your federally funded grantees like the Centers for Independent Living and the AC coalitions, many of whom have relationships with Medicaid and can help pay for some of these technological gaps.

And just finally, we really think in addition to guidance it's going to be really important for CMS to constantly and consistently provide additional examples of promising practices if not in the guidance than elsewhere as well as ongoing to TA to states and providers who, you know, really do want to get the money out as soon as possible.

But we do just caution that we want the funding to be used in a thoughtful manner to help states transform their HCBS system and avoid going backwards in the future.

Thank you so much.

Melissa Harris: Thanks, Serena. This is Melissa Harris. (Jeff), if I could ask you before we go to the next question, if you could issue a reminder to folks on how to raise their hand to ask a question that would be great. And now we are ready for the next question.

Coordinator: Sure, absolutely. If you would like to ask a question or comment, please press star 1 and record your name when prompted. And if you would like to withdraw your question, please press star 2.

Our next comment comes from Beth Swedeen. Your line is open.

Beth Swedeen: Thank you. And I really appreciate this opportunity to give input on how to systemically improve home and community-based services so people can live the lives that they want in the community.

I'm with the Developmental Disabilities Council in Wisconsin and wanted to focus on a few things that we think would improve overall HCBS and give states some guidance, one of them being some sort of guidance on a pilot for community living, whether it's using housing navigators or other strategies to really promote true community living.

Another would be a one-time transformation fund to help providers that want to move more aggressively and to community-integrated employment.

Another would be -- this was mentioned several times -- technology and the fact that during the pandemic we saw so many people who were disconnected in their communities and the congregate living situations they were living in did not have technology so they could not participate.

So it's not just the purchase of the actual technology, but maybe a one-time allowance for broadband to get people connected. I think once they are connected there would be much less likelihood that that would be cut off.

And some work around participant rights and really engaging people who use home and community based services to know their rights and to speak up. We, in Wisconsin, have a living well grant from ACL.

And we're doing a lot with participants' rights and are finding that is one of the most under-focused on and yet most important health and safety features of community-based programs.

And finally some work around values-based purchasing and really encouraging providers to do some self-assessment, maybe using it as a template like the personal outcomes measure or something like that so that maybe they will be eligible for enhanced payment based on the kinds of services that they're providing much like is being done in primary and acute care.

And I just also wanted to really echo the importance of stakeholder engagement at the state level for each of these plans and to bring participants of the programs in for part of the planning.

And then the need for a longer implementation period to really get some innovation work off the ground and gather some evaluation on its efficacy.

So, again, thank you very much.

Alissa Deboy: Thank you, Beth. We appreciate that feedback. (Jeff), we're ready for the next comment.

Coordinator: Our next comment comes from (Debbie Jenkins). Your line is open.

(Debbie Jenkins): Good afternoon. Thank you for the opportunity for being able to share today. I agree with many of the recommendations shared so far, especially the needs for states to engage stakeholders in the process in determining how these funds will be used.

But one thing I think we'll have to remember is that there are a variety of programs that fall under home and community-based services.

I believe CMS should provide guidance to states that ensures that all programs and populations served through home and community-based services benefit from the increased funding.

The previous 6.2% increased FMAP that states were given, much of that did not go to Medicaid services in many states. Over the past year many of these programs have been challenged through the pandemic, and these funds are in dire need in order for services to be continued and for people to get the supports that they need.

So I just encourage you to ensure that the guidance does include something around making sure that all populations that currently receive services through home and community-based service programs receive some of the benefit of these funds.

Thank you.

Alissa Deboy: Thank you, (Debbie), for that feedback. (Jeff), we're ready for the next comment.

Coordinator: Our next comment comes from (Mary Brogan). Your line is open.

(Mary Brogan): Thank you and good morning. It's morning here in the Pacific. I really agree with so many of the points that have been made and many of the aspirational innovation of kinds of goals that we would like to use for HCBS services and use these fundings for.

What strikes me is that not only do we as administrators of HCBS programs need guidance, so do states in terms of procurement processes. And if we could - if guidance could be considered to be able to use these monies in an expeditious way along the lines of how other public health emergency fundings are able to be spent because this will get bogged down in our state procurement processes, at least where I live and so guidance to government about any kind of flexibilities that should be considered for states to spend.

The other point I would make is that we don't want to - we want clarity to our state governments that these funds won't be lapsed and used for something else because what happens if we have an excess of funding at the end of any given year, those funds lapse into general funds.

So those kinds of considerations as well as an expedited approval process from CMS if there are any kinds of changes that we need to have approved. Thank you.

Alissa Deboy: Thank you, (Mary) for that feedback. (Jeff), we're ready for the next comment.

Coordinator: Our next comment comes from Shyla Patera. Your line is open.

Shyla Patera: Hello. My name is Shyla Patera. And I have enjoyed this conversation. But I represent North Central Independent Living in rural North Central Montana.

And many of the comments that people have mentioned have impacted our Center for Independent Living. But a few of the issues that I work with as an advocate and also as a Medicaid member, I would like to see some flexibility with non-emergency medical transportation, especially for rural areas and utilizing, like, certain designations, like frontier designation or different kinds of things to make sure that our rural residents don't get left out in the cold as far as getting to major needed medical care when they need it and also making sure that people with disabilities such as myself aren't discriminated when seeking both COVID and non-COVID medical care.

And I would also like to ask if one of the innovative programs that CMS would consider states utilizing is a program for dual Medicaid and Medicare eligible so that they could get access to Community First Choice programs.

As an advocate at a Center for Independent Living, I have had a lot of people who are on Medicare want home and community-based services. And I really do believe that this would be a great opportunity to pilot some programs throughout the country as well as some of the comments that we've talked about regarding nursing home diversion and housing and transportation as well.

So thank you for your time.

Alissa Deboy: Thank you for that feedback. (Jeff), we're ready for the next comment.

Coordinator: Our next comment comes from Patti Killingsworth.

Patti Killingsworth: Thank you so much, Alissa, and team. We really appreciate you taking the time to hear from states and other stakeholders and especially for the forthcoming federal guidance around these funds.

In general I support the recommendations that were submitted jointly by advancing states and HCSBs. I just want to hit a few particular points and add to that a little bit.

With regard to the process for disbursing funds, I really encourage CMS to follow a process that's similar to that used for distribution or other FMAP and the other enhanced FMAP that was related to COVID without additional application or administratively burdensome processes.

I certainly support the designation of these funds for the statutory purposes thinking of that sort of like an MSP or balancing fund that would carry over across federal and state fiscal years.

And then the report of how those funds are expenses, not of the prior approval process that was done with MFP rebalancing because I think that would place an undue burden on CMS and potentially result in delays in states being able to use the funds, but really as an accountability mechanism so that CMS can ensure the funds have been spent to strengthen HCBS programs.

I think in that regard making clear in the guidance that states are accountable for demonstrating that funds were spent for the statutory purpose will help to prevent efforts by other interests to divert these funds for other purposes as has been stated by other individuals on the call.

We do request that those reporting processes be implemented in a manner that's not unduly burdensome for states in terms of either the frequency or complexity of those reporting processes.

I do think the recommendations in the joint letter around definition of enforcement and enforcement of supplement not planned or reasonable and practical. I didn't really have anything to add there but wanted to support those.

With respect to allowable use that many folks have talked about, I really urge CMS to construct broadly those activities that will expand and strengthen home activity based services.

And rather than trying to prescribe an exhaustive list just to establish reasonable parameters that allow sites maximum flexibility to innovate regarding those approaches.

There are all kinds of ideas we have as we are moving forward with an IDB integration initiative that we think will improve both provider and health plan capacity to deliver valued outcomes for people supported for piloting unique technologies and approaches that we think will increase people's independence.

And so we would just like to see flexibility for states to really think and not be confined within pre-prescribed lists.

I would add that streamline processes for any state planner waiver authority that states might need to implement those kinds of innovations would be greatly appreciated so we can move forward to use these funds in an effective way.

I do support and reiterate the critical importance of not establishing arbitrary timelines by which the funding has to be spent. I think that will result - and that's not really being able to be as thoughtful and deliberate as we might like to be or to be able to make adjustments as we learn so that we can really use these funds in the ways that will most benefit the people that we serve.

And then finally I just would like some recognition that these are non-recurring funds and that if states implement short-term innovations that we recognize that they are non-recurring funds and that at some point some of those short-term innovations may not have funding to continue and that there be processes in place to ensure that states won't then be held accountable for that.

Again, I thank you for the opportunity to provide comment.

Alissa Deboy: Thank you for that feedback, Patti. We really appreciate it. (Jeff), we're ready for the next comment.

Coordinator: Our next comment comes from Josh Evans. Your line is open.

Josh Evans: Hi. I hope you can hear me. This is Josh Evans. I'm with an organization called IARF based out of Illinois representing developmental disability and behavioral health service providers across the state.

I joined the long list of individuals that have mentioned being a part of ANCOR, which is an exceptional federal organization representing my organization and others across the country.

We tend to support and agree with the comments made by them as well as Shannon McCracken.

I think it is evident by the exhaustive list of recommendations that have come forward on Items 3, 4 and 5 that the nature of Medicaid being a partnership between the state and federal government, the guidance that should be issued should respect that and states should have broad authority, with some limits, to invest these funds going forward. And the hope is that the guidance would come out quickly.

Some things I wanted to speak to specifically. I wholly accept and understand where groups are talking about being very broad-based and applicability of these funds.

But I believe some emphasis should come on the need to invest in direct services, whether that is from an organization such as a division or office but also through contract with direct support staff and other service providers.

I think that the language of the ARPA was intentionally ambiguous to ensure that the state and federal partnership can go forward in ways that - varied approaches can be taken for states to implement use of these funds.

I do take issue with the previous speaker in a couple of respects, one being that I think that given that this was part of the American Rescue Plan there should be recognition that these funds should be able to go out in a somewhat expedited manner to address the needs that organizations and individuals are facing in the HCBS space.

Secondly I would not want to see CMS make a clear statement that these are one-time funds and should be invested accordingly. I think states are in different places. Organizations are in different places.

And I don't know that it is prudent and I don't see that it was outlined in statutes that CMS should issue a statement that these funds should be time limited and for one-time purposes.

I think if states are able to utilize these funds to bake and to strengthen a long-term and ongoing investment in the HCBS service array, they should have the ability to do so.

But I do want to say thank you to everybody that has contributed to this point. Thank you to CMS for the work that you're doing now and going to be doing in the future. And thank you for the opportunity to weigh-in today.

Alissa Deboy: Thank you, Josh, for your comments. (Jeff), we're ready for the next comment.

Coordinator: Our next comment comes from (Liz Perry). Your line is open.

(Liz Perry): Great. Thanks. Hi. I hope everyone can hear me. This is (Liz) with the National PACE Association. Thank you for this call today and the opportunity to provide comments.

We are appreciative of the provision and the fact that PACE is specifically mentioned and included in the provision.

I did just want to ask per the PACE federal regulation, PACE organizations must accept the habitation payment as payment in full and may not bill, charge or collect any other form of payment from the state agency.

And we would like for CMS to just clarify that given the HCBS provision and that PACE was included in it that PACE organizations would be able to receive some sort of supplemental payment either to offset unexpected costs incurred during the public health emergency, support the workforce, enhance telehealth services or any other expense that PACE organizations and states kind of come to an agreement with.

I just wanted to flag that for CMS. Thanks again for the time today.

Alissa Deboy: Thank you for that comment. We will take that back and consider it as we develop the guidance. (Jeff), we're ready for the next comment.

Coordinator: Our next comment comes from Charles Carr. Your lines is open.

Charles Carr: Yes. Good afternoon and thank you for this opportunity. My name is Charles Carr. I'm with the National Council of Independent Living.

My question is will the HCBS funds will be considered an allowable expense to cover penalties for states that are not in compliance with EVV. There are probably about 30 states that aren't included, including my home state of Massachusetts. We're looking at a penalty for non-compliance.

And secondly I'm hoping that CMS will revisit guidance around EVV and look at the provision, especially one that does not allow for dual verification, that essentially requires the use of GPS in locating people. That is invasive and present huge workforce problems.

So a short-term fix using HCBS money in the American Recovery Plan to pay penalties, a longer term fix eliminating that guidance in the CMS area that prohibits the use of dual verification. Thank you very much.

Alissa Deboy: Thank you for that comment. (Jeff), we're ready for the next comment.

Coordinator: Our next comment comes from (Christina Metzler). Your line is open.

(Christina Metzler): Hello. This is (Christina Metzler). I'm both concerned and heartened by some of the comments. And I just want to make a few points to CMS.

I think it's critical that you provide guidance to states and even direction at this point to begin doing what you're doing today, which is opening the discussion for both the provider community and the consumer community.

And that you might also think about extending involvement with existing councils, such as independent living, mental health, developmental disabilities and states because these funds are significant in many ways. But as we also know the needs are much greater.

We have waiting lists and we have lack of outcomes and we have a lack of attention to the principles of Olmsted. I think Ms. Buckland earlier talked about community, true community services.

So bottom line, I think that CMS should encourage states to be doing outreach. That they should in their application inform CMS about how they did outreach and what was found.

And that perhaps CMS should consider looking at outcomes more carefully as was mentioned earlier in distributing these funds and not just use them to offset costs, which I recognize are there because of COVID, but to strengthen the system and expand the availability of true home and community-based services to citizens. Thank you.

Alissa Deboy: Thank you for that comment. We will take that back. (Jeff), we're ready for the next comment.

Coordinator: Our next comment comes from Maureen Castano. Your line is open.

Maureen Castano: Thank you very much. I'm here with the Florida Healthcare, Agency for Health Care Administration.

And we would just request that CMS provide clear guidance on measures or benchmarks of reporting tied to the requirement that states prove that funds are used to supplement and not supplant and request that the guidance be provided immediately as the funds become available so that we can have that opportunity to build the necessary reporting and/or audit tools to carry out this.

And again I thank you and appreciate the time you've taken to hear us.

Alissa Deboy: Thank you for that feedback. We will get the guidance out as quickly as possible. (Jeff), we're ready for the next comment.

Coordinator: Our next comment comes from (Joe Havig). Your line is open.

(Joe Havig): Thank you. And thanks again for taking the time to listen to our questions and thoughts. I have two thoughts relative to the guidance.

First I would ask that the guidance be very clear regarding the mechanics for claiming and spending. Since this is an increased FMAP, our general understanding is that the federal share is spent on the base services.

So if a state has $1 billion in HCBS spending and the CMS, you know, federal investment was $600 million, it will now be $700 million, but that additional $100 million in federal share will be spent, earned and reported on the CMS 64, all in the year that those base payments actually occurred.

It's the freed up state funds that remain that would need to be reinvested. And so that's what we would want clarified and that also that those freed-up state funds would therefore still be eligible for federal match on any new expenses.

The second comment relates to states where their HCBS services are a component of the global NCO capitation but CMS clarifies how those states can earn the additional FMAP and what the process is for doing so. Thank you.

Alissa Deboy: Thank you for that feedback. We will take that into consideration as we develop the guidance. (Jeff), we're ready for the next comment.

Coordinator: Our next comment comes from Stacy Smith. Your line is open.

Stacy Smith: Yes. Good afternoon. I want to thank everyone on the call for your commitment to this program.

I just want to echo the previous caller's comments around the guidance. I think it would be extremely helpful if CMS, you were able to get the guidance out in stages.

You know, as you all solely know, the Congress' intent is to get the money out the door as quickly as possible by setting that April 1st deadline and addressing some of the needs under the public health emergency.

I think there was also the realization that HCBS had been getting less out from some of the funding either through, you know, provider relief funds or other mechanisms such as the 6.2% FMAP increase under the Families for Coronavirus Funds Act.

So if there was any way you could stage the guidance, you know, where you could focus on some of those easier items to address, many of which were discussed on today's call, I think that would be very, very helpful especially because the states, they're in session.

Some of the state's budgets, in the budget cycle, are beginning April 1. So I think there's some critical decisions that need to be made around the use of funds around investment.

The second area, and, you know, the partnership with Medicaid and base care were provided in a letter to you all yesterday. But I think it's critical, and the questions we've had from providers in the states, from state association executives, the conversations they've had with their state Medicaid Departments is really around Subsection B, you know, the state requirements, Items Number 1 and 2, and specific to the correlation between investment at HCBS and the additional 10 percentage point increase in the federal match.

And, you know, specifically, would the percentage increase be dependent on the cost or size of the investment? You know, if you look at some of the

investments that could be made, if you figure it over the period of time, it could end up being less than 10%.

So is the additional 10% funding, is it a cap so that the states can ensure their currently level of funding based on the April 1 line items. And I believe it's in sub-bullet (b) as well. Thank you very much.

Alissa Deboy: Thank you for that comment. (Jeff), we're ready for the next comment.

Coordinator: Our next comment comes from (Erica Johnson). Your line is open.

(Erica Johnson): I just wanted to ask that there be clarification that HCBS increase in FMAP doesn't only apply to LTSS populations but also to other populations which may not quite qualify for LTSS but the programs they are under will have some of those, like, home health or personal care services under SET.

Just clarifying that if it's in the state plan as an HCBS service, whether it's under an LTSS population or under an acute population, that all populations are eligible for these HCBS investments, like strengthening those services.

Alissa Deboy: Thank you for that comment. We will take that back. (Jeff), we're ready for the next comment.

Coordinator: Our next comment comes from Joseph Russell. Your line is open.

Joseph Russell: Thank you so much. I'm Joe Russell from the Ohio Council for Home Care and Hospice. I have a couple of comments. They sort of have already been made but I wanted to make them again.

First is we believe that there needs to be some additional clarity and guidance to the states around proving, I guess, is a good word, proving that investments have been made.

Our concern is in the State of Ohio, very little investments have been made in the last two decades in home care. And with the increase being tied to the FMAP, it's not abundantly clear if the state needs to make investments via an FMAP in order to get that additional 10%.

Since no investments have been made, there is no additional dollars to be able to potentially draw down that additional 10%. And we're a little afraid that some states, including Ohio, would make a calculation that they might forego the 10% increase simply because the spending potentially tied to those investments would take them beyond the year of the investment.

The other piece, we think it's important that the reporting of these investments is also clear. We've got concerns in Ohio that the dollars may not flow the way - to these investments the way they should.

For example, if the state decided to "invest" in HCBS and then gave leeway for those dollars to the managed care plans, that those investments may not ever actually be made.

So I think that kinds of surmises what our point is. I think there needs to be clarity around proving that the investments are being made in the way that the state is saying and also reporting so that the state can feel safe that they are going to actually be able to make investments without future budget considerations.

Thank you so much.

Alissa Deboy: Thank you for that comment. (Jeff), do we have any other callers in the queue?

Coordinator: I'm showing no other questions or comments at this time.

Melissa: Thank you, (Jeff). This is Melissa Harris from the Disabled and Elderly Health Programs Group. And I want to thank everyone for their participation today.

We are quite excited at the potential in this piece of legislation. We hear you. Well, of course, my phone is ringing. Apologies for that.

We hear you on the themes of the comments. Today we've been taking good notes. We understand the need for expeditious issuance of guidance. We hear the request for clarification on the scope of services the enhanced FMAP can be used for, administrative and/or service provision. And we heard the need for continued stakeholder engagement.

And so we thank you for your time today. This call came together relatively quickly and so we appreciate you making time for us today. And we look forward to continuing conversations with you after our guidance is released and we can provide some additional clarification as we walk through the language.

So with that, I think we'll wrap-up for today. Look for our guidance coming out and being posted on the medicaid.gov Web site as soon as possible. And we encourage conversations to be happening at the state levels as well.

You've heard a lot of state representatives on the phone today. And so we encourage our non-state stakeholders to reach out to their states, make their recommendations known as well and we look forward to continuing the conversation with you.

So with that, we will wrap it up for today and wish you a good rest of your day. Thank you.

Coordinator: Participants, this concludes today's conference. You may disconnect at this time. Thank you. Speakers, stand by.

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