DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

SMD# 21-003
RE: Implementation of American Rescue Plan Act of 2021 Section 9817: Additional Support for Medicaid Home and Community-Based Services during the COVID-19 Emergency

May 13, 2021

Dear State Medicaid Director:

On March 11, 2021, President Biden signed the American Rescue Plan Act of 2021 (ARP) (Pub. L. 117-2). Section 9817 of the ARP provides qualifying states with a temporary 10 percentage point increase to the federal medical assistance percentage (FMAP) for certain Medicaid expenditures for home and community-based services (HCBS). States must use the federal funds attributable to the increased FMAP to supplement, not supplant, existing state funds expended for Medicaid HCBS in effect as of April 1, 2021, and states must use state funds equivalent to the amount of federal funds attributable to the increased FMAP to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program.

The purpose of this letter is to provide guidance to states on the implementation of section 9817 of the ARP, as well as to describe opportunities for states to strengthen the HCBS system in response to the COVID-19 Public Health Emergency (PHE), increase access to HCBS for Medicaid beneficiaries, adequately protect the HCBS workforce, safeguard financial stability for HCBS providers, and accelerate long-term services and supports (LTSS) reform under section 9817 of the ARP. This increased federal funding can help states increase community living options for people with disabilities, in accordance with Title II of the Americans with Disabilities Act, 42 U.S.C. §§ 12131–12134, as interpreted by the Supreme Court in *Olmstead v. L.C.*, 527 U.S. 581 (1999), which requires public entities to administer services to individuals with disabilities in the most integrated setting appropriate to their needs. In addition, this letter updates Medicaid retainer payment policy for HCBS providers during the COVID-19 PHE.

Section 1: Increased Federal Medical Assistance Percentage (FMAP) under Section 9817 of the ARP

Section 9817 of the ARP temporarily increases the FMAP by 10 percentage points for certain Medicaid[1] HCBS expenditures beginning April 1, 2021, and ending March 31, 2022 (see **Appendix A**). To receive the increased FMAP, states and territories must meet certain

[1] The increased FMAP under section 9817 of the ARP is not applicable to HCBS expenditures under the Children's Health Insurance Program.

requirements, referred to as "Program Requirements" below. It is important to note that the increased FMAP for HCBS for any state or territory cannot exceed 95 percent. Additionally, any payment made to Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa for expenditures on medical assistance subject to the FMAP increase must not be taken into account for purposes of applying payment limits under subsections (f) and (g) of section 1108 of the Social Security Act (the Act).

A. Eligible Services

As required by section 9817 of the ARP, the increased FMAP is only available for expenditures for certain services provided under title XIX of the Act. **Appendix B** provides a brief description of eligible services under section 9817 of the ARP and includes the corresponding Form CMS-64 claiming line for these services. Later in this letter is a further discussion of Form CMS-64 and the increased FMAP claiming process. States can contact HCBSincreasedFMAP@cms.hhs.gov if they have questions about the services for which they can claim the increased FMAP.

A state may not claim the increased FMAP for any HCBS expenditures other than those listed in **Appendix B**. For example, Medicaid administrative claiming for HCBS activities performed by state No Wrong Door systems and state long-term care ombudsman programs are not eligible for the increased FMAP.[2] These HCBS activities are administrative in nature and are not considered HCBS services as defined under section 9817(a)(2)(B) of the ARP and as described in **Appendix B** of this letter.

B. Program Requirements

In accordance with section 9817(b) of the ARP, states must comply with two program requirements to receive the increased FMAP for HCBS expenditures: (1) federal funds attributable to the increased FMAP must be used to supplement existing state funds expended for Medicaid HCBS in effect as of April 1, 2021; and (2) states must use the state funds equivalent to the amount of federal funds attributable to the increased FMAP to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program. Requirements are effective retroactively to April 1, 2021. In other words, states cannot use the state funds equivalent to the amount of federal funds made available by the increased FMAP to pay for HCBS that is available under the Medicaid program as of April 1, 2021. These state funds must be used to enhance, expand, or strengthen HCBS beyond what is available under the Medicaid program as of April 1, 2021. Additional information is provided later in this subsection related to the requirements for states that have implemented temporary changes to their HCBS programs in response to the COVID-19 PHE.

States will be permitted to use the state funds equivalent to the amount of federal funds attributable to the increased FMAP through March 31, 2024, on activities aligned with the goals of section 9817 of the ARP. This time period to expend funds attributable to the increased

[2] As indicated in Appendix D, states could consider using the state funds equivalent to the amount of federal funds attributable to the increased FMAP to support these programs as part of their efforts to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program.

FMAP will provide states with sufficient time to design and implement short-term activities to strengthen the HCBS system in response to the COVID-19 PHE, as well as longer term strategies to enhance and expand the HCBS system and to sustain promising and effective programs and services. It also aligns with the two-year time period during which states may file claims for federal financial participation (FFP) for Medicaid expenditures. This time period will ensure that states have sufficient time to demonstrate that they fully expended the state funds equivalent to the amount of federal funds attributable to the increased FMAP for claims paid through March 31, 2022.

CMS expects states to demonstrate compliance with section 9817 of the ARP, beginning April 1, 2021, and until the state funds equivalent to the amount of federal funds attributable to the increased FMAP are fully expended. To demonstrate compliance with the requirement not to supplant existing state funds expended for Medicaid HCBS, states must:

- Not impose stricter eligibility standards, methodologies, or procedures for HCBS programs and services than were in place on April 1, 2021;
- Preserve covered HCBS, including the services themselves and the amount, duration, and scope of those services, in effect as of April 1, 2021; and
- Maintain HCBS provider payments at a rate no less than those in place as of April 1, 2021.

Please note that these requirements do not supersede other statutory or regulatory requirements that apply to section 1915(c) waivers, or other requirements under other provisions authorizing HCBS, including requirements set forth in Special Terms and Conditions under section 1115 demonstrations and managed care authorities under which states are delivering HCBS. For example, if states have implemented temporary changes to HCBS eligibility, covered services, and/or payment rates through the Appendix K template for section 1915(c) waivers, a disaster relief state plan amendment for section 1915(i) or (k) programs, or an Attachment K for HCBS services under a section 1115 demonstration, states are expected to retain those changes for as long as allowable under those authorities (e.g., according to the end date approved under an Appendix K but no later than 6 months post PHE). However, CMS will not apply penalties or non-compliance restrictions on the receipt of the increased FMAP once the authority for those temporary changes has expired or if the state needs to implement changes to comply with other federal statutory or regulatory requirements.

States should contact CMS about anticipated eligibility or other changes to their HCBS programs that could take effect before the state funds equivalent to the federal funds attributable to the increased FMAP are fully expended to ensure that the changes will not result in non-compliance with these requirements.

To demonstrate compliance with the requirement to use state funds equivalent to the amount of federal funds attributable to the increased FMAP to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program, states must spend the state funds on HCBS-related services and infrastructure, as discussed further in this letter. States may use these funds to pay for additional Medicaid-covered services listed in **Appendix B** and, in turn, may be eligible for the increased

FMAP on those expenditures one additional time. However, once the state has reinvested state funds equivalent to the amount of federal funds attributable to the increased FMAP for additional Medicaid-covered services listed in **Appendix B**, the state should not claim the increased FMAP for subsequent expenditures occurring between April 1, 2021, and March 31, 2022, on Medicaid-covered HCBS. Please see Appendix E for an example of how a state could reinvest the funds attributable to the increased FMAP in additional Medicaid-covered HCBS to receive additional federal match.

CMS understands that states may experience enrollment and utilization fluctuations unrelated to changes in state policies and procedures, especially during the COVID-19 PHE. CMS will not apply penalties or non-compliance restrictions on the receipt of the increased FMAP if states experience reductions in HCBS enrollment, service utilization, or expenditures that are unrelated to changes in state policies or procedures.

C. Activities to Enhance, Expand, or Strengthen HCBS

Under section 9817 of the ARP, states can implement a variety of activities, including enhancements to HCBS services, eligibility, infrastructure, and reimbursement methodologies, to enhance, expand, or strengthen Medicaid HCBS. CMS understands that some states may have an immediate need to address the continued impact of the COVID-19 pandemic while also furthering longstanding state priorities to build HCBS capacity and to pursue innovative rebalancing strategies to reform LTSS systems. The funds attributable to the increased FMAP described in section 9817 of the ARP are available to assist states to engage in simultaneous short-term and longer-term implementation activities.

Examples of activities that states can initiate as part of this opportunity are provided in **Appendices C** and **D**. These appendices include activities to address COVID-related concerns, to promote HCBS capacity building and infrastructure development activities, and to pursue innovative LTSS rebalancing strategies. CMS recognizes that states are in a unique position to identify and tailor activities that align with state goals and priorities, and accordingly, these examples are not exhaustive. CMS will determine whether a state's activities meet the requirements of section 9817 of the ARP through the required reporting discussed under *Required Reporting on Activities to Enhance, Expand, or Strengthen HCBS under the Medicaid Program*.

States should follow the applicable rules and processes for section 1915(c) waivers, other Medicaid HCBS authorities, including section 1115 demonstrations, and other managed care authorities (as applicable), if they are making changes to an HCBS program and intend to use state funds equivalent to the funds attributable to the increased FMAP to pay the state share of the costs associated with those changes. If states make programmatic changes to comply with section 9817 of the ARP, states should monitor section 1915(b) waiver expenditures. For example, states should evaluate if activities to demonstrate compliance with section 9817 of the ARP (e.g., expanding the amount, duration, or scope of existing HCBS services provided in a managed care delivery system or increasing the HCBS provider payment rates) will increase expenditures above the projections approved in a section 1915(b) waiver. If states have concerns about exceeding cost effectiveness projections, states should consider a waiver amendment, as

appropriate, to revise cost effectiveness projections prospectively. CMS notes that increasing FMAP for HCBS services rendered through a section 1915(c) waiver generally will not have any adverse effect on demonstrating cost neutrality under a section 1915(c) waiver, but when states add HCBS to a section 1915(c) waiver, they must calculate the impact on cost neutrality prior to submitting the amendment. Section 1115 demonstrations must be budget neutral, which means that the proposed demonstration cannot cost the federal government more than it would absent the demonstration. CMS will work closely with states to determine the feasibility of their budget neutrality models and suggest changes as necessary.

We note that states are not limited to using state funds equivalent to the amount of the increased FMAP for services that are otherwise covered in Medicaid; however, FFP is only available for covered services. Please also note that, regardless of whether a state intends to claim FFP, the state should follow the reporting requirements described below under *Required Reporting on Activities to Enhance, Expand, or Strengthen HCBS under the Medicaid Program* for approval of the activity under section 9817 of the ARP.

States are encouraged to review guidance and information from CMS to learn more about activities to enhance, expand, and strengthen HCBS under the Medicaid program. Recently released CMS documents include a Long-term Services and Supports Rebalancing Toolkit, a State Health Officials letter regarding Opportunities in Medicaid and CHIP to Address Social Determinants of Health (SDOH), and the Medicaid Long Term Services and Supports Annual Expenditures Report for Federal Fiscal Years 2017 and 2018.

CMS recognizes the importance of effective stakeholder engagement processes that can provide states with varied perspectives on how to expand, enhance, and strengthen HCBS. States may want to consider engaging a broad community of stakeholders—Medicaid and other state agency leadership, participants in HCBS programs, residents in long-term care facilities, HCBS providers, family members and other caregivers, the aging and disability network, health plans, and the direct support workforce—to provide insight, ideas, and feedback to inform the state's approach to developing and implementing activities under section 9817 of the ARP. Further, CMS expects that states will offer, in good faith and in a prudent manner, a public notice process, including tribal consultation as applicable, when implementing changes to their HCBS programs.

D. Required Reporting on Activities to Enhance, Expand, or Strengthen HCBS under the Medicaid Program

CMS requires participating states to submit both an initial and quarterly HCBS spending plan and narrative to CMS on the activities that the state has implemented and/or intends to implement to enhance, expand, or strengthen HCBS under the Medicaid program to demonstrate that the state is supplementing, but not supplanting, existing state funds expended for Medicaid

HCBS.[3,4] Spending plans and narratives may be submitted in a state preferred format. The state must submit the initial HCBS spending plan and narrative within 30 days of the release of this guidance. Please submit all HCBS spending plans and narratives to HCBSincreasedFMAP@cms.hhs.gov. CMS will review and approve the initial state spending plan and narrative within 30 days of a state's submission if the submission adheres to the terms of this SMDL. CMS will provide an electronic approval notification.

- **Initial HCBS Spending Plan Projection**: The initial HCBS spending plan projection should estimate the total amount of funds attributable to the increase in FMAP that the state anticipates claiming between April 1, 2021, and March 31, 2022, as well as the anticipated expenditures for the activities the state intends to implement to enhance, expand, or strengthen HCBS under the state Medicaid program between April 1, 2021, and March 31, 2024. The spending plan projection is the primary place for quantitative information.
- **Initial HCBS Spending Narrative**: The initial HCBS spending narrative is intended to provide information on the state's required ARP section 9817 activities and the connection between the spending plan projection and the scope of the activities. States must provide sufficient detail to demonstrate that the state's activities enhance, expand, or strengthen HCBS under the state Medicaid program. States should explain how they intend to sustain such activities beyond March 31, 2024.

When submitting the initial HCBS spending plan projection and narrative, the state should also submit a letter signed by the State Medicaid Director that provides a designated state point of contact for the quarterly spending plan and narrative submissions and an assurance of the following:

- The state is using the federal funds attributable to the increased FMAP to supplement and not supplant existing state funds expended for Medicaid HCBS in effect as of April 1, 2021;
- The state is using the state funds equivalent to the amount of federal funds attributable to the increased FMAP to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program;
- The state is not imposing stricter eligibility standards, methodologies, or procedures for HCBS programs and services than were in place on April 1, 2021;
- The state is preserving covered HCBS, including the services themselves and the amount, duration, and scope of those services, in effect as of April 1, 2021; and
- The state is maintaining HCBS provider payments at a rate no less than those in place as of April 1, 2021.

[3] The spending plan process described here is different from the budget submission process that states complete quarterly by submitting a form CMS-37 in the Medicaid Budget Expenditure System (MBES) related to quarterly Medicaid grants awards. For the latter process, CMS will send to states instructions regarding how to account for the increase to states' projected federal share expenditures related to the increased HCBS FMAP on future budget submissions.

[4] These requirements do not necessitate that CMS promulgate new regulations because they can be implemented under existing authorities applicable to state reporting requirements set forth in section 1902(a)(6) of the Act and regulations at 42 C.F.R. § 431.16.

States also must submit a quarterly HCBS spending plan and narrative for CMS review and approval. States may update their initial spending plan submissions through the quarterly spending plan submissions. Updates and/or modifications to the quarterly HCBS spending plan and narrative should be highlighted for ease of CMS review. The reporting interval is based on federal fiscal year quarterly reports. States must report on a quarterly basis until funds are expended. As part of the reporting cycle, two documents to be submitted:

- **Quarterly HCBS Spending Plan:** The quarterly HCBS spending plan should estimate, by quarter and in total, the amount of funds attributable to the increase in FMAP that the state has claimed and/or anticipates claiming between April 1, 2021, and March 31, 2022, as well as anticipated and/or actual expenditures for the state's activities to implement, to enhance, expand, or strengthen HCBS under the state Medicaid program between April 1, 2021, and March 31, 2024. States must submit the quarterly projected spending plan 75 days prior to the beginning of each federal fiscal quarter beginning with the quarter that starts on October 1, 2021, and until the state's funds in an amount equivalent to the enhanced FMAP received by the state have been expended.

- **Quarterly HCBS Spending Narrative:** Similar to the narrative that was submitted with the initial HCBS spending plan, a shorter narrative for progress reports serves to provide activity updates. A state may also choose to provide information on activity outcomes, lessons learned, challenges, or any other information that the state deems as relevant and important to advancing HCBS. States should explain how they intend to sustain such activities beyond March 31, 2024. States must submit the HCBS spending narrative 75 days prior to the beginning of each federal fiscal quarter beginning with the quarter that starts on October 1, 2021, and until the state's funds in an amount equivalent to the enhanced FMAP received by the state has been expended.

CMS will publicly post summary information reported by states on their initial and quarterly spending plans and narrative, including the amount of funds attributable to the FMAP increase that the state anticipates claiming or has claimed and the activities the state intends to implement and has implemented to enhance, expand, or strengthen HCBS under the state Medicaid program.

The initial and quarterly spending plans and narrative should be inclusive of any additional federal funds attributable to increased FMAP that the state expects to receive by reinvesting the state funds equivalent to the amount of federal funds attributable to the increased FMAP as state share for additional Medicaid-covered HCBS between April 1, 2021, and March 31, 2022. As noted previously, states may reinvest state funds equivalent to the amount of federal funds attributable to the increased FMAP for additional Medicaid-covered services listed in **Appendix B** once, and states should not claim the increased FMAP for subsequent expenditures occurring between April 1, 2021, and March 31, 2022 on Medicaid-covered HCBS. In the initial and quarterly spending plans and narratives, states should demonstrate that the subsequent expenditures are for activities for which the state does not receive the increased FMAP.

When submitting the quarterly HCBS spending plan and narrative, the designated state point of contact should attest to the following via email:

- The state is using the federal funds attributable to the increased FMAP to supplement and not supplant existing state funds expended for Medicaid HCBS in effect as of April 1, 2021;
- The state is using the state funds equivalent to the amount of federal funds attributable to the increased FMAP to implement or supplement the implementation of one or more activities to enhance, expand, or strengthen HCBS under the Medicaid program;
- The state is not imposing stricter eligibility standards, methodologies, or procedures for HCBS programs and services than were in place on April 1, 2021;
- The state is preserving covered HCBS, including the services themselves and the amount, duration, and scope of those services, in effect as of April 1, 2021; and
- The state is maintaining HCBS provider payments at a rate no less than those in place as of April 1, 2021.

These reporting requirements are based largely on those of the Balancing Incentive Program,[5] which also provided a temporary FMAP increase for Medicaid HCBS. CMS has purposefully developed simplified reporting processes for section 9817 of the ARP to expedite the release of funds and to minimize state administrative burdens. CMS has also aligned time-frames for reporting with state FMAP claiming periods. These operational requirements, combined with using the Form CMS-64 for states to claim the increased FMAP for HCBS expenditures, provide a pathway for states to quickly access funding to implement activities to expand, enhance, and strengthen state HCBS systems. By providing quicker access to the funding, states are in a stronger position to address the impact of the COVID-19 pandemic on Medicaid HCBS beneficiaries and the providers who serve them.

Please note that these initial and quarterly HCBS spending plan and narrative requirements do not supersede any authorization requirements that apply to section 1915(c) waivers, other Medicaid HCBS authorities, including section 1115 demonstrations, and managed care authorities. States should follow the applicable rules and processes of those authorities if they are making changes to an HCBS program that operates under section 1915(c) or another Medicaid authority and intend to use the funds attributable to the increased FMAP to pay the state share of the costs associated with those changes. For example, if a state seeks to expand HCBS services, the state will need to explore whether an amendment to an HCBS authority is needed. Additionally, if the HCBS services will be provided in a managed care delivery system, a Medicaid managed care authority is needed to authorize those approved service(s), and changes to the state's contracts with its managed care plans to operationalize any programmatic changes may be needed. States and their actuaries will also need to determine if the actuarially sound capitation rates need to be revised and if a corresponding rate amendment is necessary (i.e., to address any expansion of these services or the amount, duration, or scope of these services or increasing the HCBS provider payments). Additionally, states that seek to contractually require their managed care plans to increase HCBS provider payments must adhere to federal

[5] The Balancing Incentive Program (BIP), authorized by the Affordable Care Act, offered states temporary enhanced FFP for Medicaid HCBS. For an evaluation of the program see: https://aspe.hhs.gov/basic-report/final-outcome-evaluation-balancing-incentive-program.

requirements for state directed payments in accordance with 42 C.F.R. § 438.6(c), including prior approval as required.

States should reach out to their CMS contact if they have any questions about how to request approval under Medicaid authorities. In order to facilitate the review process, it is highly recommended that states submit amendments solely focused on the activity required to meet the needs in the CMS approved initial and/or quarterly HCBS spending plan and narrative. Depending on the nature of proposed actions, and the timeframes for their implementation, Disaster Relief state plan amendments, Appendix K updates, or an Attachment K for HCBS services under a section 1115 demonstration, may be submitted, and/or traditional state plan amendments, waiver amendments, or section 1115 demonstration amendments. To the extent feasible, CMS will prioritize review and approval of these requests.

E. Claiming FFP at the Increased FMAP on the Form CMS-37 and Form CMS-64

FFP associated with the increased FMAP is available for qualifying expenditures for the HCBS services listed in **Appendix B** on a quarterly basis through Form CMS-37 and Form CMS-64 submissions in the automated Medicaid Budget and Expenditure System (MBES). The increased FMAP is available for qualifying HCBS expenditures incurred on or after April 1, 2021, through March 31, 2022.[6] Failure to follow the required steps could result in CMS initiating action to defer or disallow certain expenditures.

- **Obtaining FFP associated with the increased FMAP through the Form CMS-37:** Once the state completes the initial HCBS spending plan and narrative and, in subsequent quarters, the quarterly HCBS spending plan and narrative described in section D of this letter, CMS will provide FFP associated with the increased FMAP to states through the process described in 42 CFR § 430.30(b) for state quarterly budget estimates submitted through the Form CMS-37.

- **Obtaining FFP associated with the increased FMAP through the Form CMS-64:** Once the state completes the initial HCBS spending plan and narrative and, in subsequent quarters, the quarterly HCBS spending plan and narrative described in section D of this letter, CMS will provide FFP associated with the increased FMAP to states through the process described in 42 CFR § 430.30(c) for allowable state quarterly expenditures submitted through the CMS-64. By claiming FFP at the increased FMAP, the state agrees to use an equivalent amount of state funds, attributable to the increase from section 9817 of the ARP, only for purposes of providing new or expanded offerings of HCBS and related supports and infrastructure described but not limited to **Appendices C** and **D**. Funding must be used to supplement not supplant existing services.

[6] The claiming process is available to states to participate in from April 1, 2021 through March 31, 2022. States that are approved to use their initial reinvestment funds for Medicaid-covered services listed in **Appendix B** may be eligible for the increased FMAP on those initial expenditures. However, once states have reinvested state funds equivalent to the amount of federal funds attributable to the increased FMAP in additional Medicaid-covered HCBS, states should not claim the increased FMAP for subsequent expenditures between April 1, 2021 and March 31, 2022 on Medicaid-covered HCBS.

- **MBES Modifications:** We are working to modify MBES/CBES as soon as possible to reflect each state's increased FMAP.[7] Once MBES/CBES is reprogrammed to utilize the increased FMAP, the system will enable state entry of expenditures at the increased FMAP, and apply such FMAP for the actual claimed expenditures that are incurred. Expenditure reporting associated with the increased FMAP for the third quarter of fiscal year (FY) 2021 may be delayed. In those cases, states may need to report expenditures associated with the increased FMAP through prior period adjustments in subsequent quarters of the FY.

- **Other Expenditure Reporting Information:** States should follow existing federal requirements regarding the applicability of a particular match rate available for a given quarter (see **Appendix A**). The applicable FMAP is based on date of payment, not date of service for current quarter original expenditures. The FMAP applicable to expenditures for prior period adjustments should be the FMAP at which the original expenditure was claimed, for both private and governmental providers. All states are responsible for reporting Medicaid collections and overpayments on the CMS-64. States must report overpayments and collections at the same match rate at which the expenditures were originally claimed, including when the original rate incorporated the 10 percentage point FMAP increase. Recoveries of FFP must be returned at the same match rate at which they were originally claimed. Therefore, if a Medicaid expenditure was claimed using the increased FMAP, the federal share of any recoveries associated with that expenditure would have to be returned using the same increased FMAP. Consistent with existing requirements, states must document expenditures to ensure a clear audit trail, including by isolating expenditures that are matched at increased FFP rates. CMS will conduct oversight to ensure that the state expenditures are allowable and accurate, including with respect to the matching rate claimed.

- **Claiming the Increased FMAP for Managed Care Expenditures:** States should report expenditures eligible for the 10 percentage point increase on the Form CMS-64. The portion of the capitation rate that is attributable to only services in **Appendix B** and upon which an increased match may be claimed should be determined with the data utilized to develop the applicable capitation rates. The use of this claiming methodology is solely for FFP claiming purposes and does not negate the requirements that Medicaid capitation rates be actuarially sound and must be developed in compliance with federal requirements under 42 C.F.R. part 438. States have used similar claiming methodologies for FFP for services and populations such as family planning, section 1915(k) benefits, and the new adult group. States may be required to submit their managed care claiming methodologies for the increased FMAP under ARP section 9817 to CMS for review and approval.

[7] Some FFP related to ARP may be issued as separate grant awards. As such, CMS may also update the Form CMS-37 for the applicable quarters to identify budget estimates associated with the increased FMAP.

Section 2: Medicaid Coverage of HCBS Retainer Payments during the COVID-19 PHE

Retainer payments allow certain providers to continue to bill for individuals who are enrolled in an HCBS program or who otherwise receive personal care services authorized under sections 1915(c), 1915(i), 1915(k), or 1115, as specified in their person-centered service plan, when circumstances prevent the individual from receiving the service. Previously, CMS had indicated that states may authorize up to three 30-day episodes of retainer payments for an individual during the period of the COVID-19 PHE using the Appendix K template for section 1915(c) waivers, a disaster relief state plan amendment for section 1915(i) or (k) programs, or an Attachment K for HCBS services under a section 1115 demonstration. Due to the duration of the COVID-19 PHE, which has spanned two calendar years, CMS is authorizing states to choose to offer up to three additional 30-day periods in calendar year 2021. CMS notes that these additional episodes may assist states and providers in reopening services while limiting access to buildings to allow for proper social distancing.

These additional days of retainer payments may be retroactively effective to January 1, 2021. States are encouraged to submit an Appendix K, section 1115 demonstration Attachment K, a disaster relief state plan amendment, or section 1115 demonstration amendment to implement any additional days of retainer payments. Guardrails contained in the retainer payment guidance reflected in Frequently Asked Questions issued on June 30, 2020,[8] continue to apply to retainer payments authorized in 2021; this additional flexibility is additive to that guidance.

For states that are seeking to contractually require managed care plans to make retainer payments to providers where the authorized service is covered under the managed care plan contracts, states must seek approval under 42 C.F.R. § 438.6(c) for state directed payments. In order for states to seek approval under 42 C.F.R. § 438.6(c), the retainer payments must be authorized as part of the section 1915(c) HCBS waiver, section 1115(a) demonstration for section 1915(c) HCBS services, or other Medicaid authority. Once the retainer payments are authorized under one of these authorities, a state directed payment preprint must also be submitted to effectuate the state directed retainer payments under a state's contract(s) with its managed care plans. For technical assistance on state directed payments, please contact us at statedirectedpayment@cms.hhs.gov.

Closing

CMS remains committed to supporting states with strengthening and enhancing their HCBS systems and helping to ensure that Medicaid beneficiaries receive high quality, cost-effective, person-centered services in the setting of their choice. Section 9817 of the ARP provides states with additional federal funding for Medicaid HCBS that states can use to enhance, expand, or strengthen HCBS in response to the COVID-19 PHE, accelerate LTSS reform, and address other state-specific HCBS needs and priorities, such as *Olmstead* planning. As detailed below, CMS is available to provide continued technical assistance to states when implementing this provision.

[8] COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies, https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf

Programmatic and financial questions and state HCBS spending plans and narratives for section 9817 of the ARP can be submitted to HCBSincreasedFMAP@cms.hhs.gov.

For specific information about using section 1115(a) demonstration authority to support state efforts related to section 9817 of the ARP, contact Teresa DeCaro, Acting Group Director, State Demonstrations Group, at Teresa.DeCaro@cms.hhs.gov.

For questions about retainer payments during the COVID-19 PHE, contact Ralph Lollar at Ralph.Lollar@cms.hhs.gov.

Sincerely,

Anne Marie Costello
Acting Deputy Administrator and Director

Enclosure

Appendix A: Applicability of the Increased Federal Medical Assistance Percentage (FMAP) to Other FMAPs Specified in the Social Security Act

Section 9817 of the ARP temporarily increases the FMAP by 10 percentage points, up to 95 percent, for allowable medical assistance expenditures for certain HCBS expenditures under the Medicaid program beginning April 1, 2021, and ending March 31, 2022. In general, the increased FMAP is available for allowable Medicaid HCBS medical assistance expenditures for which federal matching is paid ordinarily at the state-specific FMAP rate defined in the first sentence of section 1905(b) or 1905(ff) of the Act. In no case may the FMAP determined for a state be more than 95 percent with respect to such HCBS expenditures.

To the extent applicable, the increased FMAP under section 9817 of the ARP is additive to:

- Section 6008(a) of the Families First Coronavirus Response Act;
- Adult group expenditures matched at the "newly eligible" FMAP specified in section 1905(y) of the Act;
- Adult group expenditures matched at the "expansion state" FMAP specified in section 1905(z) of the Act;
- Expenditures matched at the "disaster-recovery" FMAP specified in section 1905(aa) of the Act;
- Expenditures subject to the temporary increase in FMAP specified in section 1905(ii) of the Act for medical assistance under state Medicaid plans that begin to expend amounts for all individuals described in 1902(a)(10)(A)(i)(VIII); and
- HCBS expenditures matched at the increased FMAP specified in section 1915(k) of the Act.

The increase does not apply with respect to the following Medicaid expenditures:

- Medicaid administrative expenditures, for which the matching rate is not defined in section 1905(b) or 1905(ff);
- Expenditures for family planning services eligible for 90 percent match as specified in section 1903(a)(5);
- Expenditures for services "received through" an Indian Health Service (IHS) facility (including an IHS facility operated by an Indian tribe or tribal organization), as the 100 percent match rate for these services is not the same as the state-specific FMAP defined in the first sentence of section 1905(b) to which the 6.2 percentage point FMAP increase applies;
- Expenditures matched at 100 percent for individuals in Qualifying Individuals programs;
- Health home services under section 1945 of the Act; and
- Any other expenditures not matched at the FMAP determined for each state that is defined in the first sentence of section 1905(b) or 1905(ff).

Appendix B: Home and Community-Based Services Eligible for the ARP Section 9817 Temporary Increased FMAP

HCBS Medicaid Authority	Benefit Description	Corresponding Form 64 Claiming Line
State Plan Benefits		
Home Health Care	Home health services are mandatory services authorized at section 1905(a)(7) of the Act, and defined in regulations at 42 C.F.R. § 440.70. Home health services include nursing services, home health aide services, medical supplies, equipment, and appliances, and may include therapy services (physical therapy, occupational therapy, speech pathology and audiology).	Line 12-Home Health Services
Personal Care Services	Personal care services (PCS) are optional services authorized at section 1905(a)(24) and defined in regulations at 42 C.F.R. § 440.167. Personal care services can include a range of human assistance provided to persons who need assistance with daily activities. These services are provided to individuals who are not an inpatient or resident of a hospital, nursing facility (NF), intermediate care facility for individuals with intellectual disabilities (ICF/IID), or institution for mental diseases (IMD), and may be provided in the individual's home and, at state option, in other locations.	Line 23A-Personal Care Services-Regular Payment
Self-Directed Personal Care Services	Section 1915(j) of the Act allows self-direction of state plan personal care services. Requirements are set forth in 42 CFR Part 441 Subpart J.	Line 23B-Personal Care Services-SDS 1915(j)
Case Management	Case management services, as defined under sections 1905(a)(19) and 1915(g) of the Act and 42 CFR § 440.169 and 42 CFR § 441.18, assist Medicaid-eligible individuals in gaining access to needed medical, social, educational, and other services.	Line 24A-Targeted Case Management Services-Community Case Management Line 24B-Case Management State Wide

HCBS Medicaid Authority	Benefit Description	Corresponding Form 64 Claiming Line
School Based Services	These services include medical assistance for covered services under section 1905(a) that are furnished to a child with a disability because such services are included in the child's individualized educational program established pursuant to Part B of the Individuals with Disabilities Education Act or furnished to an infant or toddler with a disability because such services are included in the child's individualized family service plan. Only school based services that meet the definition of one or more of the services listed in this appendix can be claimed at the increased FMAP under section 9817 of the ARP.	[This line is under development; further instructions will be issued.]
Rehabilitative Services	The rehabilitative services benefit is an optional Medicaid state plan benefit authorized at section 1905(a)(13) of the Act and codified in regulation at 42 CFR § 440.130(d) as "medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a beneficiary to his best possible functional level." All rehabilitative services, including mental health and substance use disorder services, authorized under this benefit can be claimed at the increased FMAP under section 9817 of the ARP.	[This line is under development; further instructions will be issued.]

HCBS Medicaid Authority	Benefit Description	Corresponding Form 64 Claiming Line
Private Duty Nursing[9]	Private duty nursing is an optional Medicaid state plan benefit authorized at section 1905(a)(8) of the Act and codified in regulation at 42 CFR § 440.80 as "nursing services for recipients who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or skilled nursing facility. These services are provided: (a) by a registered nurse or a licensed practical nurse; (b) under the direction of the recipient's physician; and (c) to a recipient in one or more of the following locations at the option of the State: **(1) his or her own home;** (2) a hospital; or (3) a skilled nursing facility." The increased FMAP under section 9817 of the ARP is only applicable when the service is provided in a beneficiary's **own home**, and is being included here based on the authority at ARP section 9817(a)(2)(B)(vii) given to the Secretary to specify additional services eligible for enhanced funding.	[This line is under development; further instructions will be issued.]
Alternative Benefit Plans (Section 1937 of the Act)	Any of the Medicaid-covered services described under section 9817 of the ARP are eligible for the enhanced match when authorized under an approved Alternative Benefit Plan.	Follow CMS-64.9 Base Category of Service Definitions
HCBS Authorities		
Section 1915(c)	Waiver authority found at section 1915(c) of the Act gives states the option to offer long-term services and supports (LTSS) in home and community-based settings to individuals who would otherwise require institutional care. States have broad latitude to determine the services to offer under waiver programs, consistent with the benefit package specified in section 1915(c)(4)(B) of the Act. For example, services may include home accessibility modifications (e.g., installing a wheelchair ramp or grab bars in a shower) to improve individuals' ability to remain in their homes and prevent institutional admission.	Line 19A – Home and Community-Based Services – Regular Payment (Waiver)

[9] ARP section 9817(a)(2)(B) identifies certain services that are eligible for the HCBS increased FMAP. While private duty nursing is not explicitly identified as among the eligible services, CMS has determined that expenditures for private duty nursing services delivered in the home qualify under "such other services specified by the Secretary of Health and Human Services" in ARP section 9817(a)(2)(B)(vii) and are eligible for the HCBS increased FMAP.

HCBS Medicaid Authority	Benefit Description	Corresponding Form 64 Claiming Line
Section 1915(i)	Section 1915(i) is an optional state plan benefit that allows states to provide HCBS to individuals who meet state-defined needs-based criteria that are less stringent than institutional criteria (and, if chosen by the state, target group criteria) as set forth in 42 CFR Part 441 Subpart M. States have broad latitude to determine the services to offer under the section 1915(i) state plan benefit option, consistent with the benefit package specified in section 1915(c)(4)(B) of the Act.	Line 19B- Home and Community-Based Services - State Plan 1915(i) Only Payment
Section 1915(j) – Self-directed 1915(c) services.	Section 1915(j) of the Act allows self-direction of HCBS otherwise available under a section 1915(c) waiver program that are provided to an individual who has been determined eligible for the self-directed option. Requirements are set forth in 42 CFR Part 441 Subpart J.	Line 19C- Home and Community-Based Services - State Plan 1915(j) Only Payment
Section 1915(k)	The section 1915(k) Community First Choice (CFC) state plan benefit provides certain individuals, who meet an institutional level of care, the opportunity to receive necessary personal attendant services and supports in a home and community-based setting. States receive an extra six percentage points of federal match for CFC service expenditures. To the extent applicable, the increased FMAP under section 9817 of the ARP is additive to the increased FMAP specified in section 1915(k).	Line 19D- Home and Community Based Services State Plan 1915(k) Community First Choice
Program of All-Inclusive Care for the Elderly (PACE)	PACE provides comprehensive medical and social services to certain frail, elderly individuals, most of whom are dually eligible for Medicare and Medicaid. An interdisciplinary team of health professionals provides PACE participants with coordinated care.	Line 22- Programs Of All-Inclusive Care Elderly

HCBS Medicaid Authority	Benefit Description	Corresponding Form 64 Claiming Line
Managed Long-Term Services and Supports	Managed long term services and supports (MLTSS) refers to the delivery of LTSS through capitated Medicaid managed care programs. Only the state plan and HCBS services defined in this appendix that are provided through a managed care delivery system are eligible for the enhanced FMAP referenced in this guidance. States can implement MLTSS using an array of managed care authorities, including a section 1915(a) voluntary program, a section 1932(a) state plan amendment, a section 1915(b) waiver, or a section 1115 demonstration. Any of those managed care authorities can be "paired" with other Medicaid authorities, such as section 1905(a), 1915(i), 1915(j), or 1915(k) or an HCBS waiver program under section 1915(c) to authorize HCBS benefits to be delivered through a managed care delivery system. See *Claiming the Increased FMAP for Managed Care Expenditures* in section 1.E of this letter for more information.	[This line is under development; further instructions will be issued.]
Demonstrations		
Section 1115	States can utilize section 1115(a) demonstration authority to test new strategies to promote the objectives of the Medicaid program that are not available under other authorities. Section 1115(a)(1) of the Act allows the Secretary to waive compliance with the Medicaid requirements of section 1902 of the Act, including but not limited to statewideness and comparability, to the extent and for the period necessary to carry out the demonstration project. In addition, section 1115(a)(2) of the Act allows the Secretary to provide FFP for demonstration costs that would not otherwise be considered as federally matchable expenditures under section 1903 of the Act, to the extent and for the period prescribed by the Secretary. Any of the Medicaid-covered HCBS services described above are eligible for the enhanced match when authorized under an approved 1115 demonstration.	Follow CMS-64.9 Base Category of Service Definitions

Appendix C: Examples of Section 9817 of the ARP Activities to Support State COVID-Related HCBS Needs

Under section 9817 of the ARP, states can implement a variety of activities to enhance, expand, or strengthen Medicaid HCBS. This appendix provides examples of activities that states can initiate as part of this opportunity to address COVID-related concerns during the period of the public health emergency.

Activity	Activity Description
Increased Access to HCBS	
New and/or Additional HCBS	Provide new or additional Medicaid HCBS services or increase the amount, duration, or scope of HCBS to reduce the risk of institutionalization during the COVID-19 PHE.
HCBS Provider Payment Rate and Benefit Enhancements	
Payment Rates	Increase rates for home health agencies, PACE organizations, and agencies or beneficiaries that employ direct support professionals (including independent providers in a self-directed or consumer-directed model) to provide HCBS under the state Medicaid program. CMS expects that the agency, organization, beneficiary, or other individuals that receive payment under such an increased rate will increase the compensation it pays its home health workers or direct support professionals. An increase to the PACE Medicaid capitation rate can be implemented as part of the state's regular annual rate update or on a temporary basis as an interim rate increase, but must comply with existing submission, review, and approval requirements. States are not permitted to provide supplemental funding to PACE organizations outside of the PACE Medicaid capitation payment due to regulatory requirements.
Leave Benefits	Provide paid sick leave, paid family leave, and paid medical leave for home health workers and direct support professionals that are not already included in the service rate/rate methodology.
Specialized Payments	Provide hazard pay, overtime pay, and shift differential pay for home health workers and direct support professionals that are not already included in the service rate/rate methodology. Provide adult day centers with funding to make physical, operational, or other changes to safely deliver services during the COVID-19 PHE.
Supplies and Equipment	
Purchase Personal Protective Equipment (PPE) and Testing Supplies	Purchase PPE and routine COVID testing for direct service workers and people receiving HCBS, to enhance access to services and to protect the health and well-being of home health workers and direct support professionals.
Work Force Support	
Workforce Recruitment	Conduct activities to recruit and retain home health workers and direct support professionals. Offer incentive payments to recruit and retain home health workers and direct support professionals.

Activity	Activity Description
Workforce Training	Provide training for home health workers and direct support professionals that is specific to the COVID-19 PHE.
Caregiver Support	
Supports for Family Caregivers	Support family care providers of eligible individuals with needed supplies and equipment, which may include items not typically covered under the Medicaid program, such as PPE and payment as a service provider.
Support to Improve Functional Capabilities of Persons with Disabilities	
Assistive Technology and Other Supports for Persons with Disabilities	Provide assistive technologies (including internet activation costs necessary to support use of the assistive technologies), staffing, and other costs incurred during the COVID–19 PHE in order to mitigate isolation and ensure an individual's person-centered service plan continues to be fully implemented.
Transition Support	
One-Time Community Transition Costs	Facilitate individuals transitioning from an institutional or another provider-operated congregate living arrangement (such as a group home or homeless shelter) to a community-based living arrangement in a private residence where the person is directly responsible for his or her own living expenses. One-time community transition costs may include payment of necessary expenses to establish a beneficiary's basic living arrangement, such as security deposits, utility activation fees, and essential household furnishings, for example.[10]
Transition Coordination	Provide transition coordination services to eligible individuals who had to relocate to a nursing facility or institutional setting from their homes during the COVID–19 PHE, or moved into congregate non-institutional settings as a result of the COVID-19 PHE, as well as for temporary relocation of residents from various types of congregate settings to community-based settings to reduce the risk of COVID-19 infection during the COVID-19 PHE.
Mental Health and Substance Use Disorder Services	
Skill rehabilitation	Assist eligible individuals in receiving mental health services, substance use treatment and recovery services, and necessary rehabilitative services to regain skills lost during the COVID–19 PHE.
Expanding Capacity	Recruit additional behavioral health providers, implement new behavioral health services, increase pay rates for behavioral health providers, expand access to telehealth, or make other changes to address increases in overdose rates or other mental health and/or substance use disorder treatment and recovery service needs of Medicaid beneficiaries receiving HCBS during the COVID–19 PHE.

[10] See State Health Office Letter # 21-001, Opportunities in Medicaid and CHIP to Address Social Determinants of Health (SDOH), for more information on one-time community-transition costs.

Activity	Activity Description
Outreach	
Educational Materials	Prepare information and public health and educational materials in accessible formats for individuals receiving HCBS (including formats accessible to people with low literacy or intellectual disabilities) about prevention, treatment, recovery and other aspects of COVID–19 for eligible individuals, their families, and the general community. States could leverage relationships with community partners, such as Area Agencies on Aging, Centers for Independent Living, non-profit home and community-based services providers, and other entities providing HCBS for these activities.
Language Assistance	Pay for American sign language and other language interpreters to assist in providing HCBS to eligible individuals and to inform them about COVID–19.
Access to COVID-19 Vaccines	
Support for Individuals with HCBS Needs and Their Caregivers	Assist with scheduling vaccine appointments. Provide transportation to vaccine sites. Provide direct support services for vaccine appointments. Develop and implement in-home vaccination options. Education and outreach about the COVID-19 vaccine.

Appendix D: Examples of Section 9817 of the ARP Activities to Support State HCBS Capacity Building and LTSS Rebalancing Reform

Under section 9817 of the ARP, states can implement a variety of activities to enhance, expand, or strengthen Medicaid HCBS. This appendix provides examples of activities that states can initiate as part of this opportunity to support state HCBS capacity building and LTSS rebalancing.

Activity Function	Activity Description
New and/or Additional HCBS	Provide new or additional Medicaid HCBS services or increase the amount, duration, or scope of HCBS; funding must be used to supplement not supplant existing services.
Building No Wrong Door Systems (NWD)	Improve access to HCBS through non-administrative NWD activities such as establishing toll free phone lines, developing informational websites and automating screening and assessment tools, and conducting marketing and outreach campaigns.
Strengthening Assessment and Person-Centered Planning Practices	Adopting standardized functional assessments. Enhancing person-centered planning practices. Providing person-centered planning training.
Quality Improvement Activities	Upgrading critical incident management reporting systems. Adopting new HCBS quality measures. Implementing improvements to quality measurement, oversight, and improvement activities. Implementing the HCBS Consumer Assessment of Healthcare Providers and Systems (CAHPS) or another experience of care survey.
Developing Cross-System Partnerships	Creating incentives for managed care plans or providers to develop partnerships with community-based organizations, social service agencies, counties, housing agencies, and public health agencies. Promoting provider collaborations by requiring the formation of and participation in regional/local provider networks. Building Medicaid-housing partnerships. Building social determinants of health (SDOH) network partnerships.
Training and Respite	Providing caregiver training and education. Providing in-person or virtual training to beneficiaries, caregivers, and/or providers to support community integration (e.g., to support beneficiaries with seeking employment, to train providers or caregivers to support individuals with behavioral challenges that can make it difficult to access community resources). Providing respite services to support family caregivers.
Eligibility Systems	Implementing new eligibility policies and/or procedures, such as to implement expedited eligibility for HCBS (subject to CMS approval), or streamline application and enrollment processes
Reducing or Eliminating HCBS Waiting Lists	Increasing the number of HCBS waiver slots in order to reduce or eliminate waiver waiting lists.

Activity Function	Activity Description
Institutional Diversion	Embedding options counselors into hospital discharge programs. Strengthening/improving Preadmission Screening and Resident Review (PASRR) processes to prevent unnecessary institutionalization.
Community Transition	Expanding a community transition program to additional populations or institutional settings. Improving the use and availability of data (e.g., Minimum Data Set, Medicare and Medicaid claims and encounter data) to support community transition programs. Providing additional one-time community transition services or other HCBS that can help to support the transition from institutional settings.
Expanding Provider Capacity	Expanding self-directed programs. Creating financial incentives to expand the number, retention rates, and expertise/skills of the direct care workforce. Providing nursing facilities or other institutional settings with funding to convert to assisted living facilities or to provide adult day services, respite care, or other HCBS.
Addressing Social Determinants of Health and Health Disparities	Assessing health disparities among older adults and people with disabilities. Testing alternative payment methodologies or the delivery of new services that are designed to address SDOH that may include housing-related supports such as one-time transition costs, employment supports, and community integration, among others. Providing more intensive care coordination for individuals with significant socioeconomic needs based on risk-stratification modeling.
Employing Cross-system Data Integration Efforts	Establishing data sharing and governance agreements that enumerate standards and practices for data sharing among state and county agencies, providers, and community-based organizations such as with the National Adult Maltreatment Reporting System. Providing training and technical assistance to build providers' performance measurement and predictive analytics capabilities. Building a stronger health and welfare system by integrating claims and encounter data with the state's incident management system.
Expanding Use of Technology and Telehealth	Making investments in infrastructure to facilitate incorporation of HCBS into interoperable electronic health records (EHRs). Covering individual tele-communications start-up costs (e.g., equipment, internet connectivity activation costs). Testing the impact of assistive technologies on the need for in-person supports. Providing smartphones, computers, and/or internet activation fees to address functional needs, promote independence, and/or support community integration.
Providing Access to Additional Equipment or Devices	Providing eyeglasses, wheelchair transfer boards, and adaptive cooking equipment to address functional needs, promote independence, and/or support community integration.

Activity Function	Activity Description
Adopting Enhanced care Coordination	Implementing health information technology care coordination enhancements such as notification systems and capabilities (e.g., hospital admission, discharge, and transfer notifications) to share information across different health care settings. Integrating Medicare and Medicaid data and/or improving Medicaid managed care plan access to Medicare data to improve care coordination for individuals receiving HCBS who are dually eligible for Medicare and Medicaid. Implementing integrated care models that can more effectively address the needs of complex populations.

Appendix E: State Example

States may use the state funds equivalent to the amount of federal funds attributable to the increased FMAP to cover additional Medicaid-covered HCBS. If a state chooses to cover additional Medicaid-covered HCBS, the state would be able to use the applicable portion of the state funds attributable to the increased FMAP as the state share and receive federal financial participation (FFP) for the additional HCBS expenditures it incurs. States that are approved to use their initial reinvestment funds for Medicaid-covered services may be eligible for the increased FMAP on those initial expenditures once, if the additional expenditures are incurred between April 1, 2021, and March 31, 2022. However, once states have reinvested state funds equivalent to the amount of federal funds attributable to the increased FMAP for additional Medicaid-covered services listed in **Appendix B**, states should not claim the increased FMAP for subsequent expenditures occurring between April 1, 2021, and March 31, 2022, on Medicaid-covered HCBS. This example shows how the state could reinvest the funds in additional Medicaid-covered HCBS to receive additional federal match.

State Example

State A has a regular FMAP rate of 70.00%. With the 6.2 percentage point Families First Coronavirus Response Act (FFCRA) increase,[11] the state has an FMAP rate of 76.2%. The 10 percentage point increase under ARP section 9817 is additive to the state's FMAP rate and results in an enhanced rate of 86.2% for qualified HCBS expenditures between April 1, 2021, and March 31, 2022 for **State A**.[12]

As shown in Table 1, **State A** expends $2.5 billion on services that qualify for the temporary 10 percentage point FMAP increase during the period April 1, 2021, through March 31, 2022, at a quarterly rate of $625 million. At this level of expenditures, the state would be eligible to receive $62.5 million in federal funds attributable to the HCBS increased FMAP each quarter, or a total of $250 million for expenditures between April 1, 2021, and March 31, 2022.

As shown in Table 2, **State A** intends to use the initial reinvestment funds for Medicaid-covered services listed in **Appendix B** and to spend an equal portion of the $250 million of state funds equivalent to the amount of federal funds attributable to the increased FMAP on an annual basis between April 1, 2021, and March 31, 2024; this is equal to $83.33 million for each of these periods: April 1, 2021-March 31, 2022, April 1, 2022-March 31, 2023, and April 1, 2023-March 31, 2024. If the state used 100% of the initial reinvestment funds for Medicaid-covered services listed in **Appendix B** in each of these periods, this would equate to an additional $603.84 million in total computable HCBS expenditures between April 1, 2021, and March 31, 2022 when the state is still eligible for the enhanced HCBS FMAP, $277.77 million in total computable HCBS

[11] Section 6008 of the FFCRA provides for a temporary 6.2 percentage point FMAP increase to each qualifying state and territory's FMAP under section 1905(b) of the Act, effective beginning January 1, 2020 and extending through the last day of the calendar quarter in which the public health emergency declared by the Secretary of HHS for COVID-19, including any extensions, terminates.

[12] For illustrative purposes only, this scenario assumes that the FFCRA 6.2 percentage point FMAP increase would continue to be available through March 31, 2022. If the public health emergency ends on or before December 31, 2021, the state's FMAP rate in this scenario would decrease by 6.2 percentage points beginning on the date in which the FFCRA increase is no longer available to states.

expenditures between April 1, 2022, and March 31, 2023, and $277.77 million in total computable HCBS expenditures between April 1, 2023, and March 31, 2024.

Table 1: State Example Showing State and Federal Share and the Funds Attributable to the HCBS FMAP Increase

	Q3 FY 2021	Q4 FY 2021	Q1 FY 2022	Q2 FY 2022	Total – Q3 FY 2021-Q2 FY 2022
Total computable	$625.00 million	$625.00 million	$625.00 million	$625.00 million	**$2,500.00 million**
State share[13]	$86.25 million	$86.25 million	$86.25 million	$86.25 million	**$345.00 million**
Federal share[14]	$538.75 million	$538.75 million	$538.75 million	$538.75 million	**$2,155.00 million**
Funds attributable to the HCBS FMAP increase	$62.50 million	$62.50 million	$62.50 million	$62.50 million	**$250.00 million**

Table 2: State Example Showing Reinvestment in Additional Medicaid-Covered HCBS

	Q3 FY 2021-Q2 FY 2022	Q3 FY 2022-Q2 FY 2023	Q3 FY 2023-Q2 FY 2024	Total
Total computable[15]	$603.84 million	$277.77 million	$277.77 million	**$1,159.39 million**
State share[16]	$83.33 million	$83.33 million	$83.33 million	**$250.00 million**
Federal share[17]	$520.51 million	$194.44 million	$194.44 million	**$909.39 million**
Funds attributable to the HCBS FMAP increase	$60.38 million	$0.00 million	$0.00 million	**$60.38 million**

[13] Assumes the FFCRA increase is available through 3/31/2022. State share is equal to: 13.8% with the HCBS enhanced FMAP and the FFCRA increase.
[14] Assumes the FFCRA increase is available through 3/31/2022. Federal share is equal to: 86.2% with the HCBS enhanced FMAP and the FFCRA increase.
[15] In order to determine the total computable HCBS expenditures for which a state could claim FFP using, as state share, the state funds equivalent to the amount of federal funds attributable to the increased FMAP, divide the amount of state funds by 1 minus the state's FMAP. In this example, divide $62.5 million by .138 to calculate total computable expenditures of $603.84 million for Q3 FY 2021-Q2 FY 2022 and by .300 to calculate total computable expenditures of $277.77 million for Q3 FY 2022-Q2 FY 2023 and for Q3 FY 2023-Q2 FY 2024. This amount can then be multiplied by the state's FMAP rate for the applicable period to determine the amount of additional federal dollars the state could claim on those additional expenditures.
[16] Assumes the FFCRA increase is no longer available after 3/31/2022. State share is equal to: 13.8% with the HCBS enhanced FMAP and the FFCRA increase; and 30.0% without the HCBS enhanced FMAP and the FFCRA increase.
[17] Assumes the FFCRA increase is no longer available after 3/31/2022. Federal share is equal to: 86.2% with the HCBS enhanced FMAP and the FFCRA increase; 70.0% without the HCBS enhanced FMAP and the FFCRA increase.