

Disabled and Elderly Health Programs Group

September 2, 2021

Cynthia Beane, LCSW
Commissioner
State of West Virginia
Department of Health and Human Resources
Bureau for Medical Resources
350 Capitol Street, Room 251
Charleston, WV 25301-3709

Dear Ms. Beane:

We are pleased to inform you that West Virginia's initial state spending plan and spending narrative submitted on July 12, 2021 meet the requirements set forth in the May 13, 2021, Centers for Medicare & Medicaid Services (CMS), State Medicaid Director Letter (SMDL) [#21-003](#) and are providing the state with a partial approval of the state's revised plan submitted on August 12, 2021 in response to CMS's request for additional information. West Virginia qualifies for a temporary 10 percentage point increase to the federal medical assistance percentage (FMAP) for certain Medicaid expenditures for home and community-based services (HCBS) under section 9817 of the American Rescue Plan Act of 2021 (ARP). We have approved the temporary 10 percentage point increase to the state's FMAP for certain Medicaid HCBS listed in Appendix B of the SMDL. The increased FMAP is available for qualifying expenditures between April 1, 2021, and March 31, 2022. However, CMS needs additional information, as described beginning on the next page.

Full approval of the state spending plan and spending narrative is conditioned upon resolving the issues described below and upon the state's continued compliance with program requirements as stated in SMDL #21-003. These requirements are in effect as of April 1, 2021, and continue until March 31, 2024, or until the state has fully expended the funds attributable to the increased FMAP, whichever comes first.

It is important to note that CMS partial approval of the initial spending plan and spending narrative solely addresses the state's compliance with the applicable requirements set forth under section 9817 and fulfillment of the requirements as stated in SMDL # 21-003. This spending plan approval does not constitute approval for purposes of claiming federal financial participation (FFP). Approval of any activity in your state's spending plan does not provide approval to claim FFP for any expenditures that are not eligible for FFP. States must continue to comply with all existing federal requirements for allowable claims, including documenting expenditures and draws to ensure a clear audit trail for the use of federal funds reported on the Form CMS-37 Medicaid Program Budget Report and the Form CMS-64, Quarterly Medicaid Statement of Expenditures.

States should follow the applicable rules and processes for section 1915(c) waivers, other Medicaid HCBS authorities, including state plan amendments and section 1115 demonstrations, and other managed care authorities (as applicable), if they are making changes to an HCBS program and intend to use state funds equivalent to the funds attributable to the increased FMAP to pay the state share of the costs associated with those changes. CMS is available to provide continued technical assistance to states when implementing changes to HCBS programs under this provision.

Additional Information Requested

As your state further plans and develops the activities in its spending plan, CMS will need more information on:

Enhancing and Strengthening the HCBS Service Array

- Provide additional information on the services that would be paid for with ARP section 9817 funding under the activity to add slots for the Intellectual and Developmental Disability and the Aged and Disabled waiver programs. In particular, clarify whether the state intends to use ARP section 9817 funding to pay for any services other than those listed in Appendix B or that could be listed in Appendix B for individuals who are Medicaid-eligible prior to HCBS waiver enrollment, or any institutional services for individuals who become newly eligible as a result of the increase in waiver slots.

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

- CMS understands that the state plans to add the TEFRA/Katie Beckett eligibility group to the Children with Serious Emotional Disorder waiver. CMS is confirming that the state can add the TEFRA eligibility group as part of the state's activities to expand, enhance, and strengthen HCBS under Medicaid and that the state can use the state funds equivalent to the funds attributable to the increased FMAP to pay for all Medicaid expenditures for individuals in this eligibility group who become newly eligible for Medicaid. However, the state must either:
 1. Ensure that individuals who become newly eligible for Medicaid through this eligibility group are moved to another Medicaid eligibility group if they have a long-term hospital or other institutional stay of 30 days or longer; or

2. Not pay for long-term hospital or institutional expenditures for individuals in this eligibility group using state funds equivalent to the funds attributable to the increased FMAP if the newly Medicaid eligible individuals remain in the TEFRA group.

Please confirm that your state will meet this requirement and contact CMS if technical assistance is needed related to the implementation of this activity.

CMS will need additional information before it can determine whether these activities or uses of funds are approvable under ARP section 9817.

General Considerations

As part of this partial approval, CMS is noting the following:

- CMS expects your state to notify CMS as soon as possible if your state's activities to expand, enhance, or strengthen HCBS under ARP section 9817:
 - Are focused on services other than those listed in Appendix B or that could be listed in Appendix B (e.g., behavioral health services that are covered under another benefit but could be covered under the rehabilitative services benefit). If any activities are not directly related to the services listed in Appendix B or services that could be listed in Appendix B, please explain how those activities expand, enhance, or strengthen HCBS under Medicaid;
 - Include room and board (which CMS would not find to be a permissible use of funds); and/or
 - Include activities other than those listed in Appendices C and D.

CMS will need additional information before it can determine whether any of those activities or uses of funds are approvable under ARP section 9817.

- HCBS provider pay increases funded through the 10 percent temporary increased FMAP will require an updated rate methodology. For section 1915(c) waiver programs, states are required to submit a waiver amendment for any rate methodology change. If retrospective approval will be required, the state should make the change in the Appendix K application.
- Consistent with regulations at 42 C.F.R. § 447.252(b), the state plan methodology must specify comprehensively the methods and standards used by the agency to set payment rates. The state plan methodology must be comprehensive enough to determine the required level of payment and the FFP to allow interested parties to understand the rate setting process and the items and services that are paid through these rates. Claims for federal matching funds cannot be based upon estimates or projections. The reimbursement methodology must be based upon actual historical utilization and actual trend factors.
- States providing HCBS through a managed care delivery system must comply with applicable federal requirements, including 42 C.F.R. part 438. States must also ensure that appropriate authority is granted for the services and activities to be covered as well as to deliver such services and activities through a managed care delivery system. Additionally, states will need to assess implications for its managed care plan contracts and actuarially sound capitation rates in order to operationalize any programmatic

changes. States that seek to contractually require their managed care plans to increase HCBS provider payments must adhere to federal requirements for state directed payments in accordance with 42 C.F.R. § 438.6(c), including prior approval as required.

- If your state is reducing reliance on a specific type of facility-based or congregate service and increasing beneficiary access to services that are more integrated into the community, your state should be clear with stakeholders in your state’s stakeholder engagement activities, as well as in submissions to CMS of required ARP section 9817 spending plans and narratives and any resulting waiver or state plan amendments, about how these changes enhance the availability of integrated services in the specific waiver or state plan, and offset any reductions in previously covered services, in compliance with the home and community-based settings criteria or other efforts to increase community integration.

Additional Information Related to the Quarterly Spending Plan and Narrative

CMS is clarifying that West Virginia’s next quarterly spending plan and narrative is due 75 days before the quarter beginning January 1, 2022. Please refer to SMDL [#21-003](#) for information on the quarterly reporting process. Your state’s quarterly spending plans and spending narratives should:

- Describe how the state intends to sustain the activities it is implementing to enhance, expand, or strengthen HCBS under the Medicaid program including how the state intends to sustain its planned provider payment increases;
- Provide information on the amount or percentage of any rate increase or additional payment per provider and the specific Medicaid authorities under which the state will be making those rate changes or payments;
- Provide the additional information described above;
- Clearly indicate if your state has or will be requesting approval for a change to an HCBS program and be specific about which HCBS program, which authority it operates under, and when you plan to request the change;
- Provide projected and actual spending amounts for each of the state’s planned activities to expand, enhance, or strengthen HCBS. In those projections, clearly identify if the state intends to draw down additional FFP for any activities, as well as the amount of state and federal share for any activities for which the state plans to claim additional FFP and whether those activities will be eligible for the HCBS increased FMAP under ARP section 9817;
- Clearly indicate whether your state plans to pay for capital investments or ongoing internet connectivity costs as part of any activity to enhance, expand, or strengthen HCBS. Capital investments and ongoing internet connectivity costs are permissible uses of funds to expand, enhance, or strengthen HCBS under section 9817 of the ARP. However, states must demonstrate how capital investments and ongoing internet connectivity costs would expand, enhance, or strengthen HCBS and ensure that capital investments will result in settings that are fully compliant with the home and community-based settings criteria. Further, approval of capital investments and ongoing internet connectivity costs in ARP section 9817 spending plans and narratives does not authorize such activities for FFP;
- Provide updated information (as appropriate) on the status and details of the state’s proposed activities to expand, enhance, or strengthen HCBS; and

- Make other revisions needed to: update the amount of funds attributable to the increase in FMAP that the state has claimed and/or anticipates claiming between April 1, 2021, and March 31, 2022; update 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; update or modify the state's planned activities to expand, enhance, or strengthen HCBS; and report on the state's progress in implementing its planned activities to expand, enhance, or strengthen HCBS.

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

Sincerely,

A handwritten signature in black ink, appearing to read 'Jennifer Bowdoin', with a long horizontal flourish extending to the right.

Jennifer Bowdoin
Director, Division of Community Systems Transformation

cc: Randall Hill