

Disabled and Elderly Health Programs Group


July 23, 2021

Michael K. Smith
Secretary
State of Vermont Agency of Human Services
Office of the Secretary
280 State Drive
Waterbury, VT 05671

Dear Secretary Smith:

We are pleased to inform you that Vermont's initial state spending plan and spending narrative submitted on June 14th, 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 receiving partial approval. Vermont 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 (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 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. Approval of any activity in your state's spending plan does not provide approval to claim federal financial participation for any expenditures that are not eligible for federal financial participation. 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 additional information on the following:

1. Whether the mobile response and stabilization services and the Psychiatric Urgent Care for Kids (PUCK) program are: focused on services other than those listed in Appendix B of the SMDL 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); or targeted to individuals who are not receiving any of the services listed in Appendix B or services that could be listed in Appendix B. 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;
2. The specific services that would be paid for as part of the Permanent Supportive Housing (PSH) activity, whether the state intends to pay for room and board as part of this activity (which CMS would not find to be a permissible use of funds), and who would qualify for the services; and
3. Whether the payments to mental health providers will be made to providers that are not delivering services that are listed in Appendix B or 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 the providers are not delivering services that are listed in Appendix B or could be listed in Appendix B, please explain how those payments expand, enhance, or strengthen HCBS under Medicaid.

CMS will need additional information before it can determine whether any of 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 (e.g., capital investments, for which CMS will need to follow-up with the state to determine whether these are permissible activities or uses of funds).

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 except as permitted in the Appendix K.
- 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 Vermont's next quarterly spending plan and narrative is due 75 days before the quarter beginning January 1, 2022. However, at Vermont's option, the state can submit an updated quarterly spending plan and narrative 75 days before the quarter beginning October 1, 2021. 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 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 federal financial participation (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;
- 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, sweeping horizontal stroke extending to the right.

Jennifer Bowdoin
Director, Division of Community Systems Transformation

cc: Wendy Trafton