

CMS State Spending Plan Partial Approval Letter

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. The state's spending plan indicates that the General Assembly has included appropriations in the State Fiscal Year 2022 budget for standardizing the Division of Developmental Disability (DD) residential habilitation rates to the Mercer State Fiscal Year 2020 lower bound rates. Please confirm that the rate standardization will not reduce provider rates, compared to those in place as of April 1, 2021, before the date indicated in the state's corrective action plan.

State Response: The rate standardization for State Fiscal Year (SFY) 2022 will not reduce provider rates before the date indicated in the state's corrective action plan. The state's corrective action plan begins reducing rates July 1, 2022 (SFY 2023).

2. Missouri's plan indicates that additional provider payments could be leveraged to increase recruitment and retention of in-home workers and Direct Support Professionals, as well as workforce and performance incentives for attendance and quality. Clarify whether the providers that will be receiving the additional payments are delivering 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). If this activity is not directly related to the services listed in Appendix B or services that could be listed in Appendix B, please explain how the activity expands, enhances, or strengthens HCBS under Medicaid.

State Response: The providers that will be receiving the additional payments are delivering services under those listed in Appendix B of the SMDL.

3. Missouri indicates that the state is interested in developing career paths to support education and training of Direct Support Professionals. Clarify whether the career paths, education, and training benefits are targeting providers that are delivering 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 this activity is not directly related to the services listed in Appendix B or services that could be listed in Appendix B, please explain how the activity expands, enhances, or strengthens HCBS under Medicaid.

State Response: The career paths, education, and training benefits being developed target providers delivering services under those listed in Appendix B of the SMDL.

4. The state's spending plan describes the use of a new level of care (LOC) assessment tool and the intent to implement the LOC criteria on October 31, 2021. The state's spending plan indicates that the state will assess individuals using the "old/standard" LOC criteria and the "new" LOC criteria. Please explain how postponing the implementation of the new LOC tool to October demonstrates compliance with ARP section 9817. Please confirm that the old/standard and new assessment tools and criteria will both be used for all individuals through March 31, 2024, and assure that this change will not reduce or restrict eligibility beyond what was in place as of April 1, 2021.

State Response: The state filed regulation and waiver amendments to transform the eligibility criteria used to determine Level of Care in early 2021 prior to the release of the ARP section 9817 guidance. The state has been working closely with the CMS waiver team to continue this transformation utilizing a dual criteria approach. The state has requested a new implementation date of October 31, 2021. This new implementation date will allow the state adequate time to accommodate any needed adjustments to both the waiver and regulation amendments. Utilizing both sets of criteria (“old/standard” and “new”) allows the state to stay in compliance with ARP section 9817 guidance while also moving forward with the transformation. LOC is determined as met if the individual meets the criteria of at least one of the two sets of criteria. This will allow all existing and newly referred participants to continue to be assessed using the old/standard eligibility criteria, while also allowing those that would newly become eligible with the new transformed LOC criteria to receive services.

5. Missouri is exploring a medical day care model for medically fragile children to attend school or daycare. Facilities would have a medical wing or room staffed with the necessary nursing and therapy personnel. Clarify the facility type(s), and confirm that the settings are in compliance with the home and community-based settings criteria. Additionally, clarify that the providers are delivering services that are listed in Appendix B or that could be listed in Appendix B. If this activity is not directly related to the services listed in Appendix B or services that could be listed in Appendix B, please explain how the activity expands, enhances, or strengthens HCBS in Medicaid.

State Response: This activity is currently under exploration. Providers would be delivering services listed in Appendix B. The facility type has not yet been determined. All applicable settings requirements would be met.

6. Missouri’s spending plan describes the implementation of the MO Health Risk Screen Tool (HRST), and indicates that ARP funding might support the upfront one-time training costs of raters and other team members for the MO HRST implementation process. Please indicate the implementation date of the new tool and confirm the training costs are being occurred after April 1, 2021.

State Response: The MO HRST statewide implementation process is anticipated to be initiated November 2022. Training costs will occur after April 1, 2021.

7. Missouri expressed interest in pursuing additional provider review services to enhance quality. Clarify whether this activity is targeting providers that are delivering 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 this activity is not directly related to the services listed in Appendix B or services that could be listed in Appendix B, please explain how the activity expands, enhances, or strengthens HCBS under Medicaid.

State Response: The additional provider review services to enhance quality will target providers delivering services under those listed in Appendix B of the SMDL.

8. Missouri indicated that ARP section 9817 funds could be used for research and planning for a value-based purchasing (VBP) model. Clarify whether this activity is targeting providers that are delivering 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 this activity is not directly related to the services listed in Appendix B or services that could be listed in Appendix B, please explain how the activity expands, enhances, or strengthens HCBS under Medicaid.

State Response: The research and planning for a VBP model will target providers delivering services under those listed in Appendix B of the SMDL.

CMS will need additional information before it can determine whether those 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.

State Response: The state agrees.

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.

State Response: The state requests additional clarification on the first sentence above as there has been no change in the current approved rate methodology based on the utilization of enhanced FMAP to fund those increases.

Based on the state's understanding, and as referenced in the second sentence above, a waiver amendment is only required for a change in rate methodology. The rate standardization utilizing the 10 percent temporary increased FMAP for State Fiscal Year (SFY) 2022 passed by the General Assembly is in accordance with the current approved waiver rate methodology as well as the approved corrective action plan for the Comprehensive Waiver. The 5.29% temporary rate increases for the SFY 2022

passed by the General Assembly are also in accordance with the rate methodology in current approved waiver agreements. These rate increases were appropriated to become effective July 1, 2021 for the benefit of our providers and the individuals they serve.

- 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.

State Response: The state agrees.

- 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.

State Response: The state does not operate HCBS through a managed care delivery system.

- 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.

State Response: The state will continue to engage stakeholders in the spending plan, narratives, and any resulting waiver or state plan amendment.

Additional Information Related to the Quarterly Spending Plan and Narrative

CMS is clarifying that Missouri's next quarterly spending plan and narrative is due 75 days before the quarter beginning January 1, 2022. However, at Missouri'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 information on the amount or percentage of 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 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;
- 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 federal financial participation (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.

State Response: The state agrees.