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National Association of State Directors of Developmental Disabilities Services

NASDDDS

CMS Issues Guidance on Targeted Disregards for Individuals in Need of HCBS



The Centers for Medicare & Medicaid Services (CMS) has issued a State Medicaid Director (SMD) letter providing guidance to states on a "rule of construction" of the Medicaid Act implemented by the Sustaining Excellence in Medicaid Act of 2019. The construction rule provides that states have the option to target and tailor income and resource disregards at individuals who are eligible for, or seeking coverage of, home and community-based services (HCBS), permitting states to adopt higher effective income and resource eligibility standards for people who need HCBS, either for all such individuals or for a particular cohort of such individuals.

The option affords states with broad discretion in selecting the cohorts of individuals needing HCBS for whom the state will apply higher effective income or resource standards. CMS points out that "states could, for example, effectively raise the resource standard for all individuals eligible for HCBS, or for individuals eligible for a particular 1915(i) or 1915(k) benefit approved under a state's plan, or for individuals eligible for one or more of the eligibility groups covered under a state's section 1915(c) waiver."

The construction rule directs that nothing in certain statutory provisions, including section 1902(a)(17) of the Act, "shall be construed as prohibiting a state from applying an income or resource disregard" under the authority of section 1902(r)(2)(A) of the Act "on the basis of an individual's need for home and community-based services authorized under subsection (c), (d), (i), or (k) of section 1915 of such Act or under section 1115 of such Act." While in general

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income and resource disregards adopted by a state must be applied to all individuals seeking coverage under a given eligibility group, CMS interprets the construction rule to create a narrow exception to that rule, such that "states may target income and resource disregards at individuals within an eligibility group based on their need for certain HCBS." For example, "in a state that covers the medically needy, the state could target an income or resource disregard at all prospective medically needy individuals who need the HCBS described in the construction rule, or even more narrowly at medically needy individuals who need HCBS and who are, for example, 65 years old and older, or under the age of 21."

CMS also interprets the construction rule to permit states to target a disregard based on an individual's need for a particular HCBS. For example, "in a state that operates a 1915(c) waiver and also offers coverage for both 1915(i) and (k) services, the state could limit application of the disregard to individuals who need 1915(i) services. Furthermore, if a state operates multiple 1915(i) benefits, it could choose to apply a disregard exclusively for individuals who need one of the 1915(i) benefits."

Generally, CMS would consider it reasonable for a state to define "need" in terms of satisfying the eligibility requirements for these services; i.e., based on an individual meeting the level-of-care and coverage criteria applicable to the relevant HCBS. In the context of 1915(c) services, however, CMS points out that "an individual's eligibility to receive such services is contingent not only on the individual meeting the level of care and coverage eligibility criteria, but also on the availability of a slot in the relevant 1915(c) waiver." However, CMS indicates that "it would be permissible for states to target a disregard at individuals who need 1915(c) services; i.e., individuals who meet the level-of-care and coverage criteria for a 1915(c) waiver, but may not be enrolled in and receiving those services because of a waiting list for available waiver slots." In other words, a state could apply income and resource disregards to individuals who would be eligible for Medicaid if they were actually receiving an HCB service, but because they are on a waiting list are not able to enroll in Medicaid, in order to make them eligible for Medicaid through another pathway.

FMI The SMD letter is available at www.medicaid.gov/Federal-Policy-Guidance/Downloads/smd21004.pdf.

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CMS Issues Guidance on Mobile Crisis Services



The Centers for Medicare & Medicaid Services (CMS) has issued a State Health Official letter offering guidance on the scope of and payments for qualifying community-based mobile crisis intervention services authorized by section 9813 of the American Rescue Plan Act of 2021 (ARP). This provision authorizes a state option to provide qualifying community-based mobile crisis intervention services for a period of up to five years, during the period starting April 1, 2022, and ending March 31, 2027. States that have approved coverage and reimbursement authority through the state plan, section 1915(b) waiver programs with corresponding authority, section 1915(c) home and community-based services waiver programs, or section 1115 demonstration projects may receive an 85 percent federal medical assistance percentage (FMAP) for expenditures on qualifying community-based mobile crisis intervention services for the first 12 fiscal quarters within the five-year period during which they meet the conditions outlined in statute to qualify for the increased match.

Qualifying Services

Qualifying community-based mobile crisis intervention services are defined as items and services for which medical assistance is available under the state plan or a waiver of the plan and that meet the following conditions:

- services must be provided to individuals who are Medicaid eligible, either through the state plan or through a waiver of such plan, and who are experiencing a mental health or SUD crisis.
- states need to ensure that services are provided to individuals outside of a hospital or other facility setting.
- services must be delivered by a multi-disciplinary team that must include at least one behavioral health care professional who is qualified to provide an assessment within their authorized scope of practice under state law, and should also include other professionals or paraprofessionals with expertise in behavioral health or mental health crisis intervention
- states must ensure that all members of the team are trained in trauma-informed care, de-escalation strategies, and harm reduction.
- states must also ensure that community-based mobile crisis intervention services teams are able to respond to crises in a timely manner. CMS is requiring states to establish and ensure training and timeliness standards that take into account additional travel time that may be needed for mobile crisis teams to respond in rural and remote areas.

States should also consider how to meet the needs for language access for people with limited-English proficiency or those who are deaf or hard of hearing and comply with any applicable requirements under the Americans with Disabilities Act, Rehabilitation Act, and Civil Rights Act.

A community-based mobile crisis intervention team may provide beneficiaries experiencing a mental health or SUD crisis in the community with medically necessary transportation to crisis receiving or stabilization settings to facilitate a warm handoff for ongoing care. States must ensure that community-based mobile crisis intervention services teams are maintaining relationships with relevant community partners, including medical and behavioral health providers, primary care providers, community health centers, crisis respite centers, and managed care plans (if applicable). And, states must ensure that community-based mobile crisis intervention services are available 24 hours a day, every day of the year.

Services may be provided through either a fee-for-service (FFS) or managed care delivery system. If providers are being paid through an FFS delivery system, states must comprehensively describe the

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rate-setting methodology used to pay providers of services. The methodology must be "consistent with efficiency, economy, and quality of care" and to be "sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."

Enhanced FMAP

FFP associated with the increased FMAP of 85 percent is available for qualifying expenditures for community-based mobile crisis intervention services, including the costs of services otherwise covered under the state plan or waiver of the plan that are furnished as part of the qualifying services, on a quarterly basis, for the first 12 fiscal quarters in which a state's community-based mobile crisis intervention services program complies with statutory requirements, as long as the expenditures are incurred on or after April 1, 2022, and no later than March 31, 2027. CMS will be implementing changes to the Medicaid Budget and Expenditure/ CHIP Budget and Expenditure System (MBES/ CBES) to ensure that states will be able to accurately report budget estimates and expenditures related to the increased FMAP for qualifying community-based mobile crisis intervention services, consistent with the requirements of section 1947 of the Act. Community-based mobile crisis intervention services. CMS will provide FFP associated with the temporary increased FMAP to states based on budget estimates submitted on the quarterly Form CMS-37. CMS will then reconcile the advance FFP amounts associated with the temporary increased FMAP to states based on actual recorded expenditures submitted through the quarterly Form CMS-64.

In order to receive the increased FMAP for any fiscal quarter, states must demonstrate that additional federal funds for qualifying community-based mobile crisis intervention services that are attributable to the increased FMAP will supplement and not supplant the level of state funds expended for such services in the federal fiscal year prior to April 1, 2022. CMS interprets this to mean that in order to demonstrate compliance with this requirement, states must:

- Not impose stricter standards for receipt of community-based mobile crisis intervention services than those in effect on the last day of the preceding federal fiscal year, September 30, 2021;
- Preserve or exceed the amount, duration, and scope of community-based mobile crisis intervention services in effect on the last day of the preceding federal fiscal year, September 30, 2021; and,
- Maintain community-based mobile crisis intervention services provider payments at a rate no less than those on the last day of the preceding federal fiscal year, September 30, 2021.

CMS points out that "Federal match may be available…for state Medicaid agency costs associated with establishing and supporting delivery of community-based mobile crisis intervention services for people with mental health conditions or SUD as well as call centers and other crisis stabilization services." Allowable administrative activities could include "operating state crisis access lines and dispatching mobile crisis teams as needed to assist Medicaid beneficiaries." States that are interested in claiming FFP for administrative costs associated with the delivery of qualifying community-based mobile crisis intervention services for people with mental health conditions or SUD should submit an amendment to their Public Assistance Cost Allocation Plan (PACAP), which is approved by HHS' Division of Cost Allocation Services (CAS) with CMS concurrence. State Medicaid agency IT system costs may be eligible for enhanced FFP. Approval for enhanced match requires the submission of an Advanced Planning Document (APD). Additionally, a state may submit an APD requesting approval for a 90/10 enhanced match for the design, development, and implementation of their Medicaid Enterprise Systems (MES) initiatives that contribute to the economic and efficient operation of the program, including technology supporting implementation of crisis call centers, community-based mobile crisis intervention services, and crisis stabilization centers, including the maintenance and operations of these services.

FMI Read the SHO letter: www.medicaid.gov/federal-policy-guidance/downloads/sho21008.pdf.

CMS Grants to Increase Medicaid Enrollment Among Children, Address Racial Disparities



The Centers for Medicare & Medicaid Services (CMS) has announced a funding opportunity totaling $49.4 million to fund organizations that can connect more eligible children, parents, and pregnant individuals to health care coverage through Medicaid and the Children's Health Insurance Program (CHIP). Awardees — including state/local governments, tribal organizations, federal health safety net organizations, nonprofits, schools, and others — will receive up to $1.5 million each for a three-year period to reduce the number of uninsured children by advancing Medicaid/ CHIP enrollment and retention. The grants were extended by the Helping Ensure Access for Little Ones, Toddlers, and Hopeful Youth by Keeping Insurance Delivery Stable Act (HEALTHY KIDS ACT) of 2017.

Among other specific initiatives, the grants can support enrollment efforts that target underserved communities, especially those experiencing racial disparities in access. These disparities remain pronounced: American Indian and Alaska Native children experience the highest uninsured rate (11.8%), followed by Hispanic (11.4%) and non-Hispanic Black children (5.9%).

Applicants will be encouraged to consider a range of activities, including:

- Engaging schools and other programs serving young people;
- Bridging racial and demographic health coverage disparities by targeting communities with low coverage rates;
- Establishing and developing application assistance resources to provide high-quality, reliable enrollment and renewal services in local communities;
- Using social media to conduct virtual outreach and enrollment assistance; and
- Using parent mentors and community health workers to assist families with enrolling in Medicaid and CHIP, retaining coverage, and addressing social determinants of health.

FMI Applications will be accepted through March 28, 2022. For more information, visit www.grants.gov/web/grants/view-opportunity.html?oppId=337485.

ABLE Account Contribution Limits Increase

The Internal Revenue Service (IRS) has announced that the cap on contributions to ABLE accounts is growing from $15,000 to $16,000 annually. The increase comes due to changes to the federal gift tax exclusion, which statutorily governs the size of permissible ABLE account contributions.

People with disabilities who are employed can also save some of their earnings in the accounts above and beyond the gift tax amount. For those in the continental U.S., that means up to an additional $12,880 this year. Alaska residents can save $16,090 in compensation and that figure is $14,820 in Hawaii.

FCC Launches the Affordable Connectivity Program



The Federal Communications Commission (FCC) has officially launched the Affordable Connectivity Program (ACP). This program, created by Congress in the Infrastructure and Jobs Act, is a longer-term replacement for the Emergency Broadband Benefit (EBB) program created by ARPA. The FCC also released a toolkit of materials for partners to use to help potential beneficiaries learn about the program. More materials will be added in the coming weeks.

The ACP provides a discount of up to $30 per month toward internet service for eligible households and up to $75 per month for households on qualifying tribal lands. Eligible households can also receive a one-time discount of up to $100 to purchase a laptop, desktop computer, or tablet from participating providers if they contribute more than $10 and less than $50 toward the purchase price.

Enrollment in the ACP is now open for households with at least one member qualifying under any of the following criteria:

Has an income that is at or below 200% of the federal poverty guidelines.

- Participates in certain assistance programs, such as SNAP, Medicaid, Federal Public Housing Assistance, SSI, WIC, or Lifeline.
- Participates in tribal-specific programs, such as Bureau of Indian Affairs General Assistance, Tribal TANF, or Food Distribution Program on Indian Reservations.
- Is approved to receive benefits under the free and reduced-price school lunch program or the school breakfast program, including through the USDA Community Eligibility Provision.
- Received a Federal Pell Grant during the current award year.
- Meets the eligibility criteria for a participating provider's existing low-income program.

The 9 million households fully enrolled in the EBB program as of December 31, 2021, will continue to receive their current monthly benefit until March 1, 2022. More information about steps current EBB recipients must take to continue receiving the ACP benefit after March 1, 2022, will be available in the coming weeks.

FMI The toolkit is available at www.fcc.gov/acp-consumer-outreach-toolkit. Individuals can enroll at acpbenefit.org.

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State Associations Oppose EVV Provisions of Cures 2.0

The National Association of Medicaid Directors (NAMD), ADvancing States, and the National Association of State Directors of Developmental Disabilities Services (NASDDDS) have joined together in a letter to Representatives Diana DeGette (D-CO) and Fred Upton (R-MI) in response to their proposed legislation, the 21st Century Cures 2.0 Act. The letter particularly addresses the Associations' concerns about the proposed electronic visit verification (EVV) policy contained within the language. The proposed legislation includes a provision in Sec. 409 that, "prohibits the use of geographic tracking features and biometrics within EVV systems."

The legislative language would define EVV as a system where services are, "electronically verified (without the use of geographic tracking or biometrics)." The bill intends to ban using global positioning services (GPS) functions within EVV systems. The letter expresses strong opposition to this proposed modification and requests that Congress instead rescind the EVV mandate entirely and leave the decision regarding implementation and system specifications to state agencies.

If GPS is banned, the letter points out, "It would require states to significantly alter their existing systems at great cost in terms of staff time and contracting fees." The policy also does not alter the funding penalties for non-compliant systems, so any state utilizing GPS technology would need to disable their system and would be immediately subject to the statutory funding penalties. Additionally, the letter lays out the challenge of meeting the requirement to electronically verify the place of service without GPS while still allowing free movement around the community.

FMI The letter can be found at www.nasddds.org/wp-content/uploads/2022/01/20211231_Joint_Association_EVV_Letter_FINAL.pdf.

NCD Calls for Health Disparity Population Designation for PWD

The National Council on Disabilities (NCD) has issued a letter calling for the designation of people with disabilities as a "health disparity population" by the National Institute on Minority Health and Health Disparities (NIMHHD), a part of the National Institutes of Health (NIH). NCD argues that the "designation is necessary and appropriate to improve both research and equitable healthcare for people with disabilities," and would also "further the goal of Executive Order 13985, which requires the Federal government to address barriers to equity for underserved and marginalized groups, including people with disabilities."

NCD cites its 2009 report *The Current State of Health Care for People with Disabilities*, which found that, "people with disabilities tended to be in poorer health and used health care at a significantly higher rate than people who did not have disabilities. They also experienced a higher prevalence of secondary conditions and used preventive health services, such as disease screenings, at a lower rate than their non-disabled peers. They were also affected disproportionately by barriers to receiving appropriate healthcare. These barriers included healthcare provider stereotypes about disability, lack of appropriate provider training, lack of accessible medical facilities and accessible examination equipment, such as exam tables and weight scales, and a lack of sign language interpreters and individualized accommodations."

FMI Read the letter: ncd.gov/publications/2021/ncd-letter-nimhd-ahrq-health-disparity-population-designation#_ftn2.

SSA Announces Increase to SSI Payments

The Social Security Administration (SSA) has announced that Supplemental Security Income (SSI) and other Social Security benefits will increase in 2022. The increase is due to an annual automatic cost-of-living adjustment (COLA), which is tied to inflation and is based on the Consumer Price Index from the U.S. Department of Labor's Bureau of Labor Statistics (BLS).

Monthly payments are growing 5.9%, according to SSA. The change applies to SSI payments beginning December 30 and Social Security benefits paid this month. The maximum federal benefit for 2022 will rise to $841 per month for individuals and $1,261 for couples.

FMI Find the SSA announcement at www.ssa.gov/cola/#:~:text=Cost%2Dof%2DLiving%20Adjustment%20(COLA)%20Information%20for%202022,increase%205.9%20percent%20in%202022.

2021 Report to Congress on Autism Services and Research

The *2021 Report to Congress on the Health and Well-Being of Individuals with Autism Spectrum Disorder (ASD)* describes efforts supported by U.S. federal departments and agencies in fiscal years (FY) 2018 to 2021 to address research, health, education, and social services that will improve health and well-being among children, adolescents, and adults on the autism spectrum. This report was completed to meet the requirements of the Autism CARES Act of 2019.

FMI Read the report at iacc.hhs.gov/publications/report-to-congress/2021/report_to_congress_2021.pdf.

CDC Studies Show Rise in Autism Prevalence

A Centers for Disease Control and Prevention (CDC) analysis of 2018 data from 11 communities across the U.S. shows that 1 in 44 (2.3 percent) 8-year-old children have been identified with autism. The CDC also found that children born in 2014 were 50 percent more likely to receive an autism diagnosis by 48 months than those born in 2010. However, the CDC found, "racial and ethnic disparities in diagnosis persist."

FMI Read the study at www.cdc.gov/mmwr/volumes/70/ss/ss7011a1.htm.

Social Security Offices to Reopen

The national network of Social Security customer service offices, which were closed nearly two years ago at the start of the pandemic, is on track to reopen on March 30. The Social Security Administration (SSA) and unions representing the agency's workforce have agreed to reopen more than 1,200 offices, contingent on changes in pandemic conditions and further negotiations. Bargaining is set to conclude by March 1, which would allow 30 days to plan for the office re-entry.