

Centers for Medicare & Medicaid Services  
Questions and Answers  
Long Term Services and Support Listening Session  
Tuesday, July 30, 2024

1. Question: Under this first question, “what additional information or clarification is needed?” We really need CMS to provide additional clarification around the definition of the services that are involved. I know that the plan is that you guys plan to have out additional guidance sometime next year, but I think we need that information soon, within the next couple of months. The reason I say that is because many states are working on their budgets. I know in Ohio, we have a biennial budget, so we only do every two years. We’ve got to have a better understanding and clarification, and we're getting a lot of confusing interpretations of what's included, what's not included.

Let me give you a couple examples. So one, for habilitation, right? How do you define habilitation? You guys just decided not to use the taxonomy codes that the state utilizes in their waiver applications. So, we need to really know how that is defined. There's many services that fall under habilitation that might have a personal care component or a homemaker component to them, but the purpose of the service is to serve people with intellectual and developmental disabilities and to work as more of a habilitation service. So, getting a clear definition within the next couple of months of what is habilitation versus what is homemaker services, versus what is personal care, is really going to be very important.

The other example is what CMS expects when you have services that are bundled together and most of that has to do around concerns. Will you be requiring those to be broken out? Many of those providers, they are doing one service even though it may bundle up different services together. And we know that many states do things differently. So, whereas one state might say, “hey, I've got this service and it's three units of homemaker and two units of personal care, and it's five units of something else.” They may have that broken out and other states don't, and it's just one service that might have many different components that may look like or smell like homemaker or personal care. So, we really need to get some clarification on what services are in and out of both the reporting and the performance standards as the providers try to determine are there services and what do they need to do? And then look towards budget processes within the state to say, do our current rates support the 80/20 requirement? And do we have to change how our rates are done? Or do we have to do additional work? We may have to hire consultants to come in and do rate studies. There’s a lot of things that need to be done, and even though I know these requirements are four and six years out, I think that the work has to be done within the next year or two, to get people prepared to be able to do this on time.

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- a. Answer: The good news is that these questions come up really in just about every conversation we have on payment adequacy, so they're very much on our radar screen, and we know they have to be addressed in full clarity in some regulatory guidance, so thank you for that. The bad news is that we are not busting out today with the answers to those questions, but they're on our shortlist for sure to make sure we address in our summary guidance. And you know, quick nod to that upcoming guidance. As you can imagine, there's going to be a series of guidances issued. This is not the implementation of the HCBS provisions does not lend itself to a single letter to the Medicaid directors, and so I would look for a real series of guidance documents coming out. And we're coming a lot of internal conversations around the pace of those documents, the sequencing of them. Feasibly, how quickly we'll be able to get guidance on the street, understanding that there's a real hunger for information and practical realities like budgeting, you know, which sometimes are looking a couple of years down the road. So, there would need to, you know, our balancing act will be the need to get information on the street as quickly as possible with the need to make sure our own implementation approach is fully sound internally. But that is taking up an awful lot of conversation at CMS now, and so as guidance starts coming out, we will be having additional conversations with this broad stakeholder group.
  - a. Comment from participant: I know there's plenty of people who want to comment, but the guidance also needs to be very clear on how your expectations are for the financial reporting. As you know, providers typically have a year to be able to submit claims and claims are paid after the dates of service, and so there's a lot of questions and clarification that's needed around the timing, is this basically a cash accounting or accrual basis? How do those things work out, and what are the expectations?
- 2. Question: I have 130 clients total, of which 50 is Medicaid. And I have looked at our budget. I'm an accountant as well, trying to figure out how to get these numbers to be 80/20. I will be pulling out of Medicaid because it doesn't even make sense if you don't include insurance and training and travel, because that is required things by the government. That is required, the rest overhead. I can decide if I'm going to have a crappy office or not, there's not a lot of expenses you get to decide. I just wrote a \$10,000 check just for liability insurance that I've never used in the 17 years I've been in business. So, I don't know how the other Medicaid-only offices are going to be able to even come up with this. Why is not training that is required by Medicaid to be included? That is their hours. That is their pay. We have to take them off of a client in order not to go to overtime to get training. I don't understand why training and insurance to cover your workers are not included. It's all for the benefit of the worker.
  - a. Answer: We took out of the calculation, personal protective equipment, training, and travel so they wouldn't unnecessarily skew the calculations. But direct

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support workers' time spent on those things is certainly part of the calculation of compensation. It's the time spent, mileage, expenses, for example, the cost of paying for PPE, the cost of hiring someone to come in and facilitate a training, the cost of the training itself. Those are the things that are totally out of the calculation, but the direct support worker's time is certainly accounted for. The time that they're accounted, the time that they are in training, the time that they are, in travel, those things are accounted. But again, the time that the direct worker, spends in training should already be accounted for, that the training costs are excluded. For example, those associated with the training itself. Getting a qualified trainer to come in, developing materials for the training. Those are distinct from the compensation to the direct care worker while participating in the training. And so, the exclusion of those three things, PPE, travel, training, was meant to, you know, indicate that those three things are very important for a provider organization to be doing, and should not count against the provider in calculating the percentage of the Medicaid rates spent on compensation.

- i. Comment and question from participant: I appreciate that because when they talk about training is not included, everybody is assuming that includes the training wages paid. So, thank you for that clarification because it's not clear. The word training means everything. The other thing, as an accountant in Dunn, Texas, for a gajillion people over the many years, we are one of the lowest type of businesses with our ratios. We are a 2.0 multiplier, which means if I pay my caregiver \$15, that means I have to charge \$30. In order to offer benefits, any business has to be a 2.7 multiplier to cover even a partial amount of those benefits, and which means if I paid a worker \$20, I'd have to charge \$54, which means I'd have no clients and then they'd have no work. How do you think we're going to do an 80/20, when we're already the lowest kind of business in our ratios at a 50%?

1. Answer from CMS: So, I would say a couple of things when you're looking at your numbers, I think it's also important to be having a conversation with your state Medicaid agency and the other agencies that are going to be implementing this regulation. By those, I mean the agencies that fund programs for older adults, fund programs for individuals with intellectual developmental disabilities, fund programs for individuals with mental health. All of those state agencies should be coming together and having a statewide approach to implement this access regulation and we're having conversations with all of those agencies, starting with, but not limited to, our state Medicaid agency partners. And so, they know that even though this is a federal regulatory requirement, there's a lot of state shaping of how they're going to meet the 80%, including whether or not they're going to take advantage of the

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small provider threshold, the hardship exemption opportunity. And so, they will want to be hearing from their provider community with the very detailed concerns, that you're laying out. Our goal, obviously, is not through this provision to make it harder for a provider to participate in Medicaid. Our goal is to say that we have got to take actions, the actions that we can in recognition of the national crisis that is jeopardizing the stability of the direct service workforce, and in a very short line from that, is jeopardizing the ability of Medicaid beneficiaries to receive their services. But you know, those exemptions in the reg are there for a reason because we heard similar concerns to yours loud and clear in the public comments. And so, I would suggest that you start having conversations with your state contacts, be they in the Medicaid agency or one of the other operating agencies. Make sure they're aware of your concerns. They're going to be needing to hear from their provider communities in determining whether to make use of the small provider threshold, make use of the hardship exemption. And so that kind of feedback would be really critical in shaping their implementation approach.

a. Question: What is the definition of small?

i. Answer: It's a state-developed criteria. So, there's no federal definition in the reg about what constitutes a small provider. The state will need to tell us and when I say "us," I mean it's going to be part of the state's reporting requirement to CMS. It's also going to be part of the requirement for them to put on their website and for us to reflect on our public website. They will need to tell us what that small provider threshold is. Is it providers with, you know, X number or less of employees, X percentage of, you know, their client base in Medicaid? All of those things, and other determining factors are at the state's discretion to develop. So, they'll need to tell us what comprises their small provider threshold, how many providers meet it, and then what is the state's plan to move those providers over time into compliance with the 80%. but that compliance date or that applicability date for providers meeting the state small provider threshold would not be 2030. It would be something separate.

1. Comment from participant: Well, because this is coming all at the same time where our

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office employees now have to make a minimum of \$21.50 to and then starting in January, it's like \$28.29 an hour to be salaried still. Although has anybody who sat down with the budget and came up with the 80/20 was doable versus 70/30 or some other number? How what did the budget look like? Do you have an example budget that you think people should, strive for? Because I'm an accountant and I can't come up with one to get to there. And I'm damn frugal. So, we're the best provider in our area, and we take everybody and anybody they send us, and I don't know what they're going to do because I can't get there. I don't know what these other providers do. Because the Medicaid folks, they call more, you need an extra office person just to have Medicaid to handle the phone calls compared to when we only took private pay. So, I'm just trying to figure this out like everybody else.

- a. Answer: So, I would refer you to both the notice of proposed rulemaking and the response to comments in the final rule for our articulation of how we got to the 80%. All of our data sources and all of our kind of laying out of our arguments is in the notice of proposed rulemaking. And then you can track, you know, all of the public comments that we got in response to that information in the final rule.
3. Question: We have attendant care in Kentucky, and I didn't know if that was part of one of the positions that would be considered with the 80/20, because it is a different service code than personal care.
- a. Answer: And I imagine so many other people are going to have that exact same question based on how the various states title their services and whether or not there's a really clear linkage between a particular service and what we are titling personal care, homemaker, home health aide, so I hear that question. Rather than give you a yes or no answer today, because I don't know the specifics of

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Kentucky, I think what I'll do is confirm for you that these are the types of operational issues that we know we're going to need to address in our summary guidance. Maybe not in such a way that every single iteration of service is going to be immediately clear, but at least our guidance, our firm intent is to have our guidance spell out some of the principles of how we're thinking of those buckets of services, so it will be easier for states, providers to do a crosswalk from that information to however their services are titled. So, we know that a top tier question in order to make this work, and so look for guidance, look for more information in our summary guidance about how to do that.

4. Question: We operate about 65 group homes. Sixteen of those are ICFs (Intermediate Care Facilities). Our understanding is ICFs are carved out of this requirement at this point in time. Is that accurate?
  - a. Answer: Great question. So, in the access regulation itself, these requirements apply to Home and Community-Based Services found under the various HCBS authorities, the 1915(c) waivers and the 1915(i), (j), and (k) state plans. Those authorities do not include Intermediate Care Facilities. In a separate regulation that was published, I'm losing the exact date, but it was in the same regulation that published the minimum staffing standards for nursing homes. There was a reporting requirement only that applies to nursing facilities and ICFs that will require states to provide information transparency on the percentage of Medicaid payments for ICF services that are spent on compensation to either the direct care workforce or the support staff and that support staff category is new and associated with just the nursing facility and ICF reporting because that support staff doesn't have as much of a presence in HCBS. So, it's just direct care staff under the HCBS reporting requirements, direct support staff—direct care staff and support staff on the institutional reporting. But NIF and ICF reporting is not found in the access reg. It's found in a component of the regulation for the minimum staffing standards, and Jen just shared the link to that regulation, and it will—that reporting requirement I believe is also four years after the effective date of the regulation, which was this summer. So, it's good to keep in mind really the menu of regulations, that are new, and it's a good linkage to the fact that there's this other reporting requirement in that separate reg but again, there's no 80%. There's no federally mandated threshold associated with the NIF and ICF reporting. It is a transparency measure.
5. Question: First of all, I feel like the approach that you used in the companion guide for the quote unquote “fee-for-service provisions” are the payment transparency stuff to bundled services was a good one and should probably be carried over to this arena. Where it was looking at—the guidance was looking at, is this a service where the individual components or the things that are bundled together are in themselves defined services that have a defined fee schedule, and then they're just bundled together to create a different service. And that seems to be a good distinction between a service that doesn't

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have those components but may in fact include some subservices or pieces of that service that are that might be personal care or homemaker. That's the first thing.

The second thing is, one of the things that I think is really unfortunate about the way that the rule turned out is that in the discussion of the payment adequacy, there was no clear expectation as to how states should go about meeting it. And by that, I mean and it kind of goes back to what Melissa Moran was saying earlier about, OK, I'm not in a position to only spend 20% on "administrative things" because a lot of those are regulatory compliance, things of that nature that you don't really have a choice in doing or not doing. So the guidance to states it seems to me, even though the rule doesn't mandate this, it seems to me that the state, the guidance of the states should encourage strongly encourage the states to meet that standard by increasing the component of the rate that is for the direct care compensation so that the direct care compensation 80% requirement can be met without requiring providers to reduce the kind of the mandated administrative costs that they need to expend to stay in business. So that's definitely something that I'd like to see CMS emphasize.

- a. Answer: As for the lack of directive to states on an implementation approach in the regulation, that's absolutely true. You won't find any statement to states saying you must raise your reimbursement rates for personal care, home health aide, homemaker, to account for meeting this 80%. We availed ourselves of the levers available to us as we, you know, implemented based on our statutory authority, you know, what we could do in regulation. We said really ad nauseam throughout the regulation, based on this statutory authority, we can do this. We don't have the authority to say to states, you have to raise your rates in order to comply with anything in the Medicaid statute. I understand that that's the elephant in the room. And in the conversations that all providers should be having with their states and parcel is understanding how a state is going to implement these provisions. It could be that they are having conversations around opportunities to enhance payment rates. It might be that they need to hear from their provider community loud and clear, here's what we're getting paid now, here's what I need in order to be able to meet this federal requirement, whether that helps and carries the day or not, not clear. But information like that I think is going to be very helpful to states in their implementation approach as they figure out what they have the authority to do, and what they need to go forward with, you know, in terms of requesting additional funding. But it doesn't—it's not a foregone conclusion that states will need to raise rates, all states. Some states won't be able to. Some states will say, here's how I'm going to be implementing this regulation, and I don't think we'll require a payment rate increase. States included in that calculation is going to be how they're going to utilize the small provider threshold, how they're going to utilize the hardship exemption. What does that mean in terms of the amount of providers who are left, who have to meet the 80%? All of those are varying by provider type, by state. But we understand that a lot of these conversations are

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going to be necessary, and we encourage you to have those conversations with your state. And so that's what I can tell you now. Understanding that the federal government won't be privy to those discussions, but we recognize the importance of them. And I know we're about at time.

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