

Centers for Medicare & Medicaid Services
Long-Term Services and Support Listening Session
Tuesday, July 30, 2024
2:00 – 3:00 p.m. ET

Webinar recording: https://cms.zoomgov.com/rec/share/dtrkQ1JMf6IOajQ8E7JW1jeqpWfIC2-0hbBSgZajRE7CQr8gflv2GpiTdTqr_hlT.qBrrHOMrxTrKICKh
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Jill Darling: *[not recorded]* Good morning and good afternoon, everyone. We're going to give it a moment to get more folks in the room. Thank you for your patience.

Jill Darling: Good morning and good afternoon, everyone. My name is Jill Darling, and I'm in the CMS Office of Communications, and welcome to today's Long-Term Services and Supports (LTSS) Listening Session. Before we begin with our presentation, I have a few announcements. For those who need closed captioning, a link will be provided in the chat function of the webinar. This webinar is being recorded. The recording and transcript will be available on the CMS Open Door Forum podcast and transcript web page. That link was on the agenda. If you are a member of the press, please refrain from asking questions during the webinar. If you have any questions, please email press@cms.hhs.gov. All participants are muted upon entry. For today's webinar, we will be sharing a presentation, and at the end of those slides, we will share a number of listening session questions we would like to get your feedback on. During this portion of the call, you may use the raise hand feature at the bottom of your screen, and we will call on you to share your feedback and the questions you choose to respond to. Please introduce yourself and what organization or business you are calling from. When the moderator says your name, please unmute yourself on your end. And I will turn the call over to Alissa Deboy, the Director of the Medicaid Benefits and Health Programs Group in the Center for Medicaid and CHIP (Children's Health Insurance Program) Services.

Alissa Deboy: Thank you very much. Good afternoon, everyone, or good morning, depending on where you live in the country. Thank you for joining us for this very important Open Door Forum discussion. Again, I'm Alissa Deboy, and I'm the Director of the Medicaid Benefits Health Programs Group at CMS. Joining me today as the main presenter is Melissa Harris, the Deputy Director of the Medicaid Benefits Health Programs Group. But also on our panel to help answer questions, I want to acknowledge that we have Curtis Cunningham, the Director of the Division of Long-Term Services and Supports; our Senior Policy Advisor in my group, Jodie Sumeracki; and I also want to note that our Lead Subject Matter Expert, Jen Bowdoin, who is the Director of our Division of Community Systems Transformation within my group, has joined us. Unfortunately, she's lost her voice, but hopefully, she'll be able to answer some questions. Jen and her team were the lead drafters of the HCBS (Home and Community-Based Services) provisions of the Ensuring Access to Medicaid Services final rule that we released in late April. Since April, we have been incredibly grateful for all of the feedback that we've received on the content of this landmark rule, and for the opportunity that we have in front of us to significantly

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improve access to care, quality, and health outcomes and better address health equity issues in the Medicaid program that includes Home and Community-Based Services.

Many of you provided feedback to—to—us through public comment at various stakeholder meetings and other venues, and I hope you saw the impact of that feedback in what was published in the final rule. We are pleased to have another opportunity today to share a brief overview of the rule, including a deeper dive into the payment adequacy provisions of the rule, and to hear your individual feedback on some of the questions we provided in advance of this session that will help us consider how we operationalize this provision. As always, we welcome your suggestions on ways to optimize—optimize—improvements in the provision of LTSS across our programs and how CMS can best support you and your efforts on the ground to improve the health and lives of the individuals we serve. With that, I'm going to turn it over to Melissa Harris to provide an overview of the newly finalized access regulations and other priority areas that we've been asked to share with you today. After that, we're going to open up the floor to questions and comments and how some of the questions that we posed in advance will help us with our discussion. Melissa, back to you.

Melissa Harris: Thank you so much, Alissa. And Jill, we can go to the next slide, please. I'm really happy to have this opportunity to speak with all of you today. I know we have a lot of individuals from the provider community who will be implementing the provisions of the Access rule, and it's so critical that we be able to have this opportunity to talk to you about what's in the final regulation, hear from you about what's on your mind and how CMS can be most helpful in releasing information on regulation implementation, and so that conversation is beginning today. And so, I look forward to walking through some things with you, and then opening it up, as Alissa said, for some Q&A (question and answer). And so, we're going to be concentrating on the access regulation and at that, some specific provisions in the Access rule, but I thought I would spend a minute on this slide talking about really the two big regs that were published on the same day a few months ago, not only the access final regulation, but a managed care final regulation. And this slide walks through some of the overarching principles that are found within those two regs and our attempt across delivery systems, fee-for-service, and managed care to really standardize and elevate provisions of the Medicaid program. So, we're going to be concentrating on just one segment of the access regulation today, but keep in mind that, you know, this is happening amidst a backdrop of a whole lot of regulatory change. And so, at the federal and state and provider and advocate and beneficiary levels, this is really an exciting time in the Medicaid program, but it also means there's a lot of change coming. And so, this conversation today is one of several that we will be having with you to kind of keep our line of communication open as we go. We can go to the next slide.

So here is the list of the HCBS provisions in the access regulation, and I'll highlight a couple of them that are on the screen in red. They are really going to be the topic of today's conversation. And those two bullets comprise what is called the “payment adequacy provision.” You may be hearing it in shorthand referred to as the “80/20 provision,” but it all kind of links back to the

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same thing. And so, we're going to be concentrating today's conversation on two requirements. One, that states report on the percentage of payments for certain services that are spent on compensation for the direct care workforce, and for some HCBS services, meet a minimum percentage of payments for certain HCBS that is spent on compensation for the direct care workforce. We're going to be unpacking what those provisions mean, definitions, etc. as we go, but again, it's worth noting that these two provisions are just a couple on a menu of provisions that have been issued in the Home and Community-Based Services space, and it really seeks to shine a spotlight on Medicaid-funded Home and Community-Based Services and make sure HCBS takes its place in the provision of long-term care in the Medicaid program. So, we're very excited about all of these changes coming to HCBS. The payment adequacy provisions tend to get a lot of attention, so that's what we're going to be focusing today's conversation on. We can go to the next slide, please.

So, here's a list, again, of some of the HCBS provisions and with the two we're going to be talking about highlighted in red. And you might be asking why there are so many reg citations for each provision, and that is because under the umbrella of Home and Community-Based Services in the access reg, all of the provisions that are in the rule have applicability across HCBS authorities. So, as we get into today's conversation, recognize that we're talking about services that could be authorized under 1915(c) HCBS waivers, state plan authorities for 1915(c), (j)—sorry, state plan authorities for 1915(i), (j), and (k), and Home and Community-Based Services that are offered under 1115 demonstrations. So, all of these regulatory citations are meant to remind everyone we have a consistent approach to these regulatory requirements across authorities for however the—the—HCBS services are offered. Next slide, please.

So here we're going to have a first look at the implementation dates, or the applicability dates associated with the provisions that we're going to be talking about, and you'll see that there's really three here. We've broken them up into three discrete parts. The—the—effective date of the access regulation is July 9, 2024. So, we are in effect now. The applicability dates are X number of years post that effective date, and so for a provision that kicks in two years after the effective date of the regulation, or three years, or however many years, we're using July 9, 2024, as the effective date of the reg.

So, the first thing that becomes effective under the heading of the payment adequacy provisions is the July of 2027. And you'll see that states need to be ready to report on the percentage of Medicaid payments that go to compensation of the direct care workforce. It doesn't mean that the 80/20 threshold has kicked in. It doesn't mean that states have to be actually reporting the percentages to us, but in 2027, states have to be ready to—to—compile the reporting that will then be effective the following year. So, the reporting requirements kick in in July of 2028. And that is when the states need to report to CMS the percentage of a couple of services—and we'll talk about those services in a second—the percentage of those services that are going to compensation of the direct care workforce. And then in 2030 is when the requirement to meet the 80% kicks in for three discrete HCBS services, personal care attendants, home health aide and

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homemaker services. So, you see that we've got a 2027, 2028, and 2030 time frame associated with each of the three components of the payment adequacy provisions and we're going to do a little bit deeper dive as we go. Next slide, please.

So, here's the first, and we're going to walk through a couple of slides that have this format, that walk through whether there was anything in the regulations prior to the Access rule, what the Access final rule required, whether there were any changes to that provision from the proposed Access rule, and then what the—the—applicability date is for the provision. So, this is again the readiness requirement, and it becomes applicable in July of 2027. It's the first of the three applicability dates for payment adequacy. And this again is states reporting on their readiness to collect the data that will be reported to CMS. This is a brand-new provision, and it was refined as part of the payment adequacy provision between the notice of proposed rulemaking and the final rule. We added some specificity to this requirement in the final rule as we learned from public comments about what kind of information states might need or what kind of infrastructure states might need to be able to report and then adhere to the payment adequacy requirements. Next slide, please.

And then here we're talking about the actual reporting requirement associated with specific HCBS. This becomes applicable in 2028. This, again, is not the 80%. This is states reporting to CMS on what percentage of Medicaid payments for four discrete services are going to compensation of the direct care workforce. And those four services that are going to be reported to CMS, again, are home health aide, personal care, homemaker, and habilitation. And I'll pause a second on habilitation, because, as you can see, this was added to the list of services that are under this reporting requirement from the proposed rule. It was not in the proposed rule, but many of you may remember that we specifically solicited comments in the proposed rule about how we should treat habilitation services. Based on those public comments, what you see in the final rule is that habilitation services are under the umbrella of a reporting requirement, which means that whatever percentage of Medicaid payments are going for compensation of the direct care workforce and the provision of habilitative services, that percentage needs to be reported to CMS beginning 2028 and then moving forward. The other services, home health aide, homemaker, personal care, they will begin to be reported in 2028. As we'll see on the next slide, they are the services that comprise the 80% threshold, and that 80% kicks in in 2030.

You'll see here that we also made some additional changes from the NPRM (notice of proposed rulemaking) to the final rule. We exempted the Indian Health Service and Tribal health programs and made a couple of clarifications about costs that are excluded in the reporting. We clarified that clinical supervisors are included in the definition of direct care workers, but clarified that costs associated with travel, training, and personal protective equipment (PPE) are excluded from the cost of compensation. And then we also—you'll see here on the last couple of bullets, that states are directed to exclude data on self-directed services in models in which the beneficiary sets the worker's payment rate and states also are to report separately on facility-based services. Those requirements are all in the name of making sure that the data that we're collecting and

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publishing is meaningful and provides a separate look at self-directed services versus agency services, taking into account the real differences in the models of self-direction and agency delivered care. We can go to the next slide, please.

And here are—here is the actual 80% threshold. You'll see that has an applicable date of 2030, and it is for, again, the three services, personal care, homemaker, home health aide. Note that habilitation services is not on this list. Habilitation, again, only has a reporting requirement associated with it. It's the three services, the other three services, that by July of 2020—excuse me, 2030, need to meet the threshold of the 80% of Medicaid payments going toward compensation of the direct service workforce. Some of the changes from the proposed rule is that we lengthened the applicability date from four years to six years. Again, we exempted the Indian Health Service and Tribal health programs, and again had the same clarifications that we did under the reporting requirements about clinical supervisors, excluded cost and excluding self-directed models in which individuals set the direct care payment rate. Now might be a good time to—to—pause for a second. Information that is not in the slides, which is taken directly from the reg, might be helpful here around the definition of compensation, and the types of direct care workers that we're talking about, when we—when we—mention these payment adequacy provisions, talking about compensation to the direct care workforce. And so again, this is right out of the regulatory text that defines compensation to include salary, wages, and other remuneration as defined by the Fair Labor Standards Act—benefits such as health and dental benefits, life and disability insurance, paid leave, retirement, tuition reimbursement, and the employer's share of payroll taxes for direct care workers delivering services authorized under the particular Medicaid authority. So again, the three categories are salary, wages, benefits, and the employer's share of payroll taxes. That all defines the compensation that we are talking about here in the calculation.

There's also a very comprehensive list in the regulatory text about who is a direct care worker, and I won't go through the entirety of the list because it is—it's quite involved, but it is a broad category that includes specific disciplines like registered nurse, a licensed practical nurse, nurse practitioner, clinical nurse specialist, a licensed or certified nursing assistant, a direct support professional, a personal care attendant, home health aide, and then there's an "other" category for—for—states to take a look at who is their universe of providers delivering personal care, home health aide, homemaker services. Is there anyone that we've missed in the list above? And these individuals can be employed directly by a Medicaid provider or a state agency. They can be under contract with a Medicaid provider, or they can be delivering service under a self-directed service delivery model. And again, all of this is spelled out, we think very clearly, in the regulation text itself in terms of the definition of compensation and the universe of who is a direct care worker. We can go to the next slide, please.

Some of the other things that we—that you'll see new in the final regulation around the payment adequacy are reflected on this slide. And again, this is taken directly from the public comments that we received on this provision, where we heard, you know, very consistently that there were

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concerns about the applicability of the 80% threshold to small providers. There might be other circumstances in which it would be a particular hardship for providers to meet the 80% threshold, and what you see here on this slide is born out of an analysis of all those comments, and our approach to—to—addressing those concerns. And so, at state option, there will be a couple of different categories of providers, and those two categories are on the slide. States can choose to develop a separate threshold with a percentage separate from the 80% for small providers and have those small providers meet that state-developed threshold instead of meeting the 80%. States need to do some things when they take advantage of that small provider threshold. They need to tell us what that threshold is, they need to tell us how many of their providers are going to be meeting that threshold, and then they need to give us a plan for how to bring those providers over time into compliance with the 80% threshold. Likewise, the state can choose to have a hardship exemption, which exempts providers from meeting a specific payment adequacy threshold at all. Again, the states need to determine, or to tell us, what that criteria is for defining a hardship, how many providers fall into that category, and what the state's plan is to bring those providers over time into compliance with the 80%.

You'll see here at the bottom, on the bottom row, that we may waive the requirement for states to give us a plan to bring either their small providers or providers under the hardship exemption into compliance with the 80% if the combined total of providers falling under both the hardship exemption and the small provider exemption is less than 10% of the state's providers. So, we're very hopeful that this provides some—some—opportunities for relief in specific circumstances, but we also stand behind the achievability of the 80% based on our conversations with a broad range of stakeholders. But should states, in their conversations with providers, decide to avail themselves of either of these opportunities, they are certainly available as long as states adhere to the requirements that surround both. Next slide, please.

And so, what are we going to do with all of this data? So, we are going to be requiring states to submit this data and make it available on their own websites, and we also regulated ourselves and require CMS to have all of this data available on our website, because all of this data is not collected just to say we're bringing it in house. It's to collect it and analyze it and reflect it back so it can be used within states, across states, you know, by a wide range of stakeholders to really get an understanding of the health of the state's HCBS system. And so, this website transparency applies not just to the payment adequacy provisions, but across the board on all of the HCBS provisions in the access regulation. And so here is a reminder of the requirements for this website transparency. This was largely unchanged between the notice of proposed rulemaking and the final rule, but it bears reiterating here that this data is to become public and usable as states are making decisions about adjustments to their HCBS programs. Health plans, providers, advocates, beneficiaries are aware of all of the—the—the—data surrounding their state's HCBS program. We can go to the next slide, please.

So now we're at the point where we have, over the next couple of slides, the set of questions that you should have seen in the agenda for today's meeting. We would love to hear from you on

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these questions, but also this is an opportunity for you to state what else is—is—on your mind. And so, this slide and the next couple of slides reiterate the questions that you saw in the advertisement for this meeting. I'm happy to kind of go down the list and kind of tee up individual questions, but this is also the open Q&A period associated with this conversation, and so we're not going to limit you to talking about just these questions. So, we've got about a half an hour left in this conversation, which I think is a great amount of time for dialogue. One of the things that I wanted to do before we kick off the Q&A session—and it's probably something you'll hear us say many times—is that there is a website, not a website, a mailbox that is dedicated to receiving questions or suggestions on implements the access reg, and it's found on the very last slide in the stack, but I'll give it a shout out now. The mailbox address is HCBSAccessRule, all one word, at cms.hhs.gov. Again, HCBSAccessRule@cms.hhs.gov. There it is right there, perfect. If we don't have an answer for you at the ready, you'll hear us say that's a perfect question to send into the mailbox. Please take us up on that opportunity, you know, for—please take us up on that opportunity for sharing your feedback. So, at this point, I'll stop. You're seeing some of my colleagues turn their cameras on. We're all in this Q&A session together and let me stop for a second and see if there are questions teed up. If not, then I'll pose this first question that you see here on the slide, and we'll go from there. Jill, does it make sense to reiterate how people can kind of queue up to ask a question?

Jill Darling: Yeah, sure. So, at the bottom of your screen is a raise hand feature. Please utilize that if you have a question or comment, and you will be put in the queue.

Alissa Deboy: And we note that we've had questions about whether the slides will be made available. I will note that the content provided in the slides are included, absent the questions in slides that we have available on—online, I believe. So, we're going to try to find that for you, otherwise to make the slides available.

Jackie (Moderator): All right. It looks like Debbie is the first person that had her hand raised. Debbie, you can unmute yourself.

Debbie Jenkins: Thank you. My name is Debbie Jenkins. I'm with the Ohio Health Care Association. And I actually have several comments on many of these questions, but I'll start with the major one, which is 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. There—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 to have a better understanding and clarification, and we're getting a lot of confusing interpretations of what's included, what's not included.

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Let me give you a couple examples. So, one, for habilitation, right? How do you define habilitation? You know, 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, you know, concerns of, will you be requiring those to be broken out? You know, 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, you know, three units of homemaker and two units of personal care, and it's, you know, whatever, 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, you know, are there services and what do they need to do? And then look towards budget processes within the state to say, you know, 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. You know, 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.

Melissa Harris: Thank you, Debbie. So, the good news, bad news. 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—so—thank you for that. The bad news is that, you know, 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, you know, 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, you know, 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, you know, are looking a couple of years down the road. So, you know, 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 we'll—

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we'll, you know, as guidance starts coming out, you know, we will be having additional conversations with this broad stakeholder group.

Debbie Jenkins: Thank you. Can I—while I have the mic, can I add one more comment to this? 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—there's—a lot of questions and clarification that's needed around the timing, you know, is this basically a cash accounting or accrual basis? How do those things work out, and what are the expectations? So just wanted to—to—plug that in there also.

Alissa Deboy: Thank you for that.

Jackie: All right. It looks like Melissa. Melissa, you are able to unmute yourself.

Melissa Moran: Hi, guys. I'm a provider in Kansas City, Missouri, and 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, but that's the—we can't—there's not a lot of expenses you get to decide. I mean, I wrote—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.

Melissa Harris: Thanks. I—I—you know, welcome the opportunity to attempt to clarify some of those things. So, you know, we took out of the calculation, personal protective equipment, training, and travel so they wouldn't unnecessarily skew the calculations. But direct support workers' time spent on those things is certainly part of the calculation of compensation. It's—it's—it's—the time spent, you know, mileage, you know, 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, you know, is certainly accounted for. You know, the time that they're accounted—the—the—the time that they are in training, the time that they are, you know, in travel, those things are accounted. But, you know, again, the time that the direct worker, you know, spends in training should already be accounted for, that the training costs are excluded. For example, are, again, those, you know, 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

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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.

Melissa Moran: I appreciate that because when people talk—have been talking—about this, 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 training, not just the—so yes, thank you for that clarification. The other—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%?

Melissa Harris: So, I would—I would say a couple of things and—and—partly, you know, I will suggest that you, you know, 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—by that I mean the—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 small provider threshold, the hardship exemption opportunity. And so, they will want to be hearing from their provider community with the very detailed concerns, you know, 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—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—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—to—be needing to hear from their provider communities in determining whether to make use of the small provider threshold, make use of the—the—hardship exemption. And so that kind of feedback would be really critical in shaping their implementation approach.

Melissa Moran: What is the definition of small? Is it by number of—

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Melissa Harris: 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—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—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.

Melissa Moran: Well, because this is coming all at the same time where our 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 a set—an example budget that you think people should, you know, 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, I'm—we're—we're—like, 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, unless you're at—yeah. Because the Medicaid folks, they call more, you need an extra office person just to—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.

Melissa Harris: 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, you know, 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.

Melissa Moran: Oh, I've read—I've read—I've read—everything I can come up with, but there's nothing that says, here, pay this percent to insurance and this percent—I mean, 20% is—there's no way 20% can cover your insurance and your phone or—or—your person answering the phone. It's—it's—I just don't see it. And I've been trying. And we're cheap in our area. We're low. We have low expenses in our area. So, in rent and things, so...

Alissa Deboy: Melissa, thank you for your perspective, and we hope that the information we provided is—is—helpful to you and you know, it's important to have that perspective. We really encourage you to listen to the other Melissa. What she suggested, and some of the conversations, you know, with the state as a starting point. We really put those exceptions in, and you know,

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believe that they're helpful, that this provision will be helpful, you know, to support the direct service worker. But I think at this point, any additional questions you may have, you might want to consider our mailbox for additional questions. So, we can have a chance to move on to some other questions in the queue.

Melissa Moran: You bet.

Jill Darling: All right, it looks like Barbara, you are able to unmute yourself.

Barbara Wilkins: Hello. I'm Barbara Wilkins. I have a 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.

Melissa Harris: And you know, thanks, Barbara. 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—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 Kentucky, I think what I'll do is—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 that's, you know, really 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.

Barbara Wilkins: OK, thank you very much.

Melissa Harris: Yep.

Jackie (Moderator): All right, Jill, your hand is raised. You're able unmute yourself. Jill, you're able to unmute yourself. OK, maybe she didn't mean to. We'll come back to her. Bruce, your hand is raised. You're able to unmute yourself.

Bruce Stovall: Yes, Bruce—Bruce—Stovall here. Provider in Connecticut at an Easterseals. 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?

Melissa Harris: So, great question. So, in the access regulation itself, these—these—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

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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—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, you know, that—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.

Bruce Stovall: Thank you.

Melissa Harris: Yep.

Jackie (Moderator): All right. Pete, you are able to mute yourself.

Pete Van Runkle: Thank you. This is Pete of OHCA (Ohio Health Care Association). I'm a colleague of Debbie's that was the lead-off—lead-off witness here. Couple of things I wanted to mention. I'll try to be quick because I know we're running out of time. First of all, kind of elaborating on what—what—Debbie had to say about the bundled services. I—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—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, as Debbie was articulating, a service that doesn't have those components, but may in fact include some, I guess you might say, subservices or pieces of that service that are, you know, 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—to—only spend 20% on “administrative things” because a lot of those are regulatory compliance, things of that nature

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that, you know, 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, you know, kind of the mandated administrative costs that they need to—they need to—expend to stay in business. So that's definitely something that I'd like to see CMS emphasize.

Melissa Harris: Thanks, Pete. One quick request. Would you submit your first suggestion about mirroring prior CMS guidance as we issue implementation guidance on the payment adequacy submission. If you send that to our access mailbox so we don't lose sight of that, that would be—that would be appreciated.

Pete Van Runkle: Sure.

Melissa Harris: And you know, as for the—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, you know, 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—the—Medicaid statute. I understand—we understand, you know, that that's the elephant in the room. And in the conversations that all providers should be having with their states, you know, part 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—that—you know, 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—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—including 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 number of providers who are left, who have to meet the 80%? All of those are varying by provider type, by—by—state. But we understand that a lot of these conversations are going to be necessary, and we encourage you to have those conversations with your state. And so that's—that's—what I can tell you now. Understanding that—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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Pete Van Runkle: Thank you.

Melissa Harris: Thanks, Pete. You know, you're voicing what's on the mind of a lot of your colleagues, I'm pretty sure. I know we're about out of time. I wanted to turn this back over to Alissa Deboy for closing remarks and then we'll—we'll wind down from here, but thanks very much.

Alissa Deboy: So, thank you. I'm really sorry we didn't get to more questions or hear comments from you all. So, I do want to encourage you to make sure you avail yourself of our email box, which is HCBSAccessRule@cms.hhs.gov. We'd love to hear from you. I will also note that we are planning some training sessions from our stakeholders on the rule much like we did today, sort of pulling apart different topics, and there will be opportunity and more information coming on that later. And so, we really just thank you very much for your participation, your frank feedback. It's helpful to us to consider this information as we go about planning and developing our sub regulatory guidance and TA (technical assistance) that we provide to states and other stakeholders. So, thank you very much. Jill, any final thing you need to say?

Jill Darling: Just note that we will be posting the transcript to the Open Door Forum podcast and transcript web page, so please note that it will be up in a week or two. So, thank you very much. That concludes today's call.

Alissa Deboy: Thank you.

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