

Centers for Medicare & Medicaid Services  
Transcript: Long-Term Services and Supports Open Door Forum  
Tuesday, May 7, 2024  
2:00 – 3:00 p.m. ET

Webinar recording: [https://cms.zoomgov.com/rec/share/pPlWbWiZ1HBrhx-LTSr\\_DyBOjuzzttzRRnJ4AlDkKfz7KeIUldeYpmYobNgwHFU.pg8APUC47zkSYt3m?startTime=1715104840000](https://cms.zoomgov.com/rec/share/pPlWbWiZ1HBrhx-LTSr_DyBOjuzzttzRRnJ4AlDkKfz7KeIUldeYpmYobNgwHFU.pg8APUC47zkSYt3m?startTime=1715104840000)

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**Jill Darling:** Hi, everyone. Good morning and good afternoon. I'm Jill Darling in the CMS Office of Communications, and welcome to today's Long-Term Services and Supports (LTSS) Open Door Forum (ODF). Before we begin our agenda, I have a few announcements. This webinar is being recorded. The recording and transcript will be available on the CMS Open Door Forum podcast and transcript webpage, and that link was on the agenda, and I will add it to the chat for you today. If you are a member of the press, please refrain from asking questions during the webinar. If you do have any questions, please email [press@cms.hhs.gov](mailto:press@cms.hhs.gov). All participants are muted upon entry. For those who need closed captioning, I will provide a link in the chat function of today's webinar. For today's webinar, you will just see the agenda slide for today on your screen. We will be taking questions at the end of the agenda today.

We note that we will be presenting and answering questions on the topics listed on the agenda during today's Open Door Forum call. We ask that any live questions relate to the topics presented during the call today. If you do have any questions unrelated to these agenda items, we may not have the appropriate person on the call to answer your questions. As such, we ask that you send any of your unrelated questions to the appropriate policy component, or you can send your email to the ODF resource mailbox, and we will try to get your questions to the appropriate component for a response. You may use the raise hand feature at the bottom of your screen, and we will call on you when it's time for Q&A. When the moderator says your name, please unmute yourself on your end to ask your question and one follow-up question, and we will do our best to get to your questions. And now, we will get into our agenda, and I'll hand it off to Mary.

**Mary Botticelli:** Hi everyone. I'm Mary Botticelli. I'm a Health Insurance Specialist in the Division of Community Systems Transformation, which is part of the Medicaid Benefits and Health Programs Group in the Centers for Medicare and Medicaid Services. Today, I wanted to speak about three rules that we finalized on April 22, the Ensuring Access to Medicaid Services Final Rule, which we refer to as the Access Rule, the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access Finance and Quality Rule, which we refer to as the Managed Care Rule, and the Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting Final Rule, which sets for the first time national minimum staffing requirements for nursing homes. This also requires that states report on a percentage of the Medicaid payments for certain institutional services, such as nursing facility services and services like intermediate care facilities for individuals with intellectual disabilities that is spent on compensation for direct care workers and support staff. The Access and Managed Care rules together advance access and quality of care and improve health

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outcomes across fee-for-service and managed care delivery systems. The Minimum Staffing Rule sets for the first time national minimum staffing requirements for nursing homes. On today's call, we're going to discuss the home- and community-based provisions that are in the Access Rule first, as well as the Medicaid institutional payment transparency reporting requirement and the Minimum Staffing Rule. And we'll also briefly discuss some guidance we received related to— we recently released on the HCBS (Home- and Community-Based Services) Quality Measure Set. Starting with the Access Rule, the home- and community-based provisions focus on specific challenges related to HCBS. Among other things, they are intended to help address HCBS workforce shortages, strength and oversight, and monitoring in order to improve quality and reduce risk of harm for people receiving HCBS and address gaps in measurement and reporting as well as reduced disparities in HCBS programs.

In response to the public comments we received in the Access Rule, we've made some changes to the HCBS provision requirements for what we propose, and I'll try to point out some of the key changes as I discuss each of these provisions. One thing I want to note at the outset is that to promote consistency across Medicaid HCBS authorities, the requirements in the HCBS section of the rule apply with certain exceptions to home- and community-based services under Sections 1915 (c), (i), (j), and (k) authorities and to a Section 1115 demonstration as well as to HCBS delivered under both fee-for-service and managed care delivery systems. In terms of the HCBS provisions, we are strengthening oversight of person-centered planning in HCBS by establishing new reporting requirements and minimum performance levels. Specifically, we are requiring that states report annually and meet a minimum 90% performance level related to whether HCBS beneficiaries who have been continuously enrolled for at least a year have had an assessment of functional need within the past 12 months and whether their service plan was updated, excuse me, was updated as a result of a reassessment of functional need within the past 12 months. These requirements are applicable in three years, and we will finalize these requirements largely as proposed.

Related to the incident management systems and critical incident reporting, we are requiring states to meet nationwide standards for monitoring their HCBS programs, including by establishing a minimum standard definition of a critical incident. We are also requiring states to have electronic incident management systems requiring provider reporting of critical incidents and requiring states to also use other data sources aside from provider reports, such as claims, to identify critical incidents. These requirements are applicable in three years with the exception of the requirement for an electronic incident management system, which we propose to also take effect in three years, but we finalize this as a five-year requirement. Other changes to these requirements from what we proposed were minor changes only.

Additionally, for states that refer critical incidents to other entities for investigation, we are requiring information sharing between the state and those agencies on the status and resolution of incident investigations and require states to separately investigate critical incidents if those agencies fail to report the resolution of an investigation within the state-specific time frames. We are also establishing new reporting requirements and minimum performance levels related to critical incidents. Specifically, states are required to report annually and meet a 90% minimum performance level related to whether critical incident investigations are initiated timely, whether

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critical incident investigations are completed and resolved timely, as well as corrective actions are completed timely. States must also report every 24 months on an incident management system assessment. Although the frequency of this assessment can be reduced to every 60 months, which states determined to meet the incident management requirements, these requirements are all applicable in three years, and we only made minor changes to these requirements from what was proposed.

We are requiring that states establish within two years grievance or complaint systems in their fee-for-service HCBS programs. This is to ensure that Medicaid beneficiaries receiving home- and community-based services through fee-for-service have the same opportunities as people enrolled in managed care to file complaints related to the state or the provider's compliance with person-centered planning and home- and community-based settings requirements. One key change we made to the grievance provision was to not finalize the proposed expedited grievance resolution requirements. We also made some changes to clarify that the beneficiary can file grievances related to the performance of person-centered planning and the home- and community-based settings requirements. We clarified that the role of authorized representatives—we added a provision to protect from punitive action authorized representatives and other individuals supporting beneficiaries with filing grievances. And as I noted, this requirement is applicable in two years. Related to the compensation for direct care workers, we are requiring that states report on a percentage of the Medicaid payments for certain HCBS that is spent on compensation for direct care workers. This provision begins in three years with the requirements that states report on the readiness to collect data regarding the percentage of Medicaid payments for homemaker, home health aide, personal care, and habilitation services spent on compensation to direct care workers. And this readiness reporting requirement is a new requirement compared to what was included in the proposed rule.

In four years, states are required to report, with certain exceptions, on the percentage of Medicaid payments for homemaker, home health aide, personal care, and habilitation services spent on compensation to direct care workers, and states are required to report separately on self-directed services and on facility-based services. Based on the public comment we received, we've made a number of changes to this requirement from what we proposed. Specifically, we added habilitation as a service subject to the reporting requirement. We exempted the Indian Health Service and certain Indian health programs subject to 25 U.S.C. 1641 from the reporting requirement, clarified that clinical supervisors are included in the definition of direct care workers, included costs associated with travel training and personal protective equipment or PPE for direct care workers from the calculation of the percent of payments spent on compensation, required states to include data on self-directed services in which the beneficiary sets the direct care workers' payment rate, and we've required states to report separately on facility-based services.

In addition to the home- and community-based payment adequacy reporting requirements, we are also requiring that a minimum percentage of payments for certain home- and community-based services be spent on compensation for direct care workers. Specifically, in six years, states will have to ensure a minimum of 80% of Medicaid payments for homemaker, home health, and personal care services are spent on compensation for direct care workers as opposed to

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administrative overhead or profit, subject to certain flexibilities and exceptions. The six-year applicability date for this requirement is changed from the four-year date we had proposed. And similar to the payment adequacy reporting requirement, we've also exempted the Indian Health and certain Tribal programs from the minimum performance requirement, clarified that clinical supervisors are included in the definition of direct care workers, excluded costs associated with travel, training, and PPE for direct care workers from the calculation of the percentage of payments spent on compensation, and required states to exclude data on self-directed services in which the beneficiary sets the direct care workers' payment rate.

And just to be clear, the HCBS payment adequacy reporting requirement applies to habilitation services, but we did not include habilitation services among the services subject to the HCBS payment adequacy minimum performance requirement. For the HCBS payment adequacy minimum performance requirement, we're also adding two new flexibilities for states. The first is to allow states to establish a hardship exemption for providers facing extraordinary circumstances. Any hardship exemption must be on a transparent state basis process and objective criteria. The second flexibility we included is to allow states to establish a separate performance level for small providers to meet state-defined criteria. And similar to the hardship exemptions, this small provider performance level must also be based on a transparent state process and objective criteria.

States that take advantage of these options will be subject to some additional reporting requirements. For the hardship exemption, states are required to report on the state's hardship criteria, the percentage of providers that qualify for a hardship exemption, and a plan, which is subject to CMS review and approval for reducing the number of providers that qualify for a hardship exemption within a reasonable period of time. For the separate small provider performance level, states must report on the state's small provider criteria, on the state's small provider minimum performance level, on the percentage of providers that qualify for the small provider minimum performance level, and a plan subject to CMS review and approval for small providers to meet the 80% minimum performance requirement within a reasonable period of time. However, for both the hardship exemption and the small provider level, CMS may waive the plan reporting requirements if the state demonstrates it has applied the small provider minimum performance level or the hardship exemption to at least 10% of the state's providers.

We are also requiring states to report annually on waiting lists in Section 1915(c) waiver programs and 1115 demonstrations, including how states maintain their waiting lists or their interest lists, the number of providers on their waiting lists, and the average amount of time people newly enrolled in a waiver in the past year were on a waiting list. Those requirements are applicable in three years and are finalized largely as proposed.

States are also required to report annually on access to personal care, homemaker, home health aide, and habilitation services, including how long it took from when services were approved to when individuals began receiving services and the percentage of authorized services that were provided annually. And those requirements are applicable in three years. The Access Final Rule requires states to report on a standardized set of community-based quality measures known as the

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HCBS Quality Measure Set, and the final rule sets requirements for CMS to develop and update the measure set.

The process for CMS to develop and update the HCBS Quality Measure Set allows for public input and comment, including through the Federal Register. In the final rule, we revised the frequency for updating the measure set from at least every other year to no more frequently than every other year, with the exception of annual technical updates and corrections. And CMS is required to establish the measure set no later than December 31, 2026. States are required to report every other year on the Home- and Community-Based Quality Measure Set, beginning in four years instead of three years as was proposed. States are also required to set performance targets for measures in the measure set and describe the quality improvement strategies they will pursue to achieve the performance targets. This provision also allows states to report on additional voluntary measures and for CMS to report on certain measures on a state's behalf.

The final rule includes phasing requirements for states to stratify their data for certain measures by demographic and other factors in order to assess disparities in advanced health equity. Consistent with the change to a four-year applicability date for reporting on the measure set, we have delayed the phasing schedule by one year, and we've also removed Tribal status as a stratification factor. Finally, we're promoting public transparency across all of the HCBS reporting requirements in the final rule by requiring states to publicly report the quality, performance, and compliance data that they report to us. And CMS will also publicly report the data and information across all states. Those requirements begin to take effect in three years, when states begin reporting data. And we made only minor changes to the website transparency requirements from what we proposed.

So now I'll turn it over to Jennifer Bowdoin to discuss the Medicaid institutional payment transparency provision in the Minimum Staffing Rule and the recent CMS guidance on the HCBS Quality Measure Set.

**Jennifer Bowdoin:** Thanks, Mary, and hi, everyone. It's nice to talk with you today. So, as Mary mentioned, I'm Jen Bowdoin, and I'm with the Medicaid Benefits and Health Programs Group. And we will, for folks who are interested in the Access Rule, we will stick in the chat a link to slides on all the provisions in the Access Rule. It also includes some Medicaid Advisory Committee provisions and some provisions around rate transparency and fee-for-service. And then it also includes slides on the Access provisions that Mary mentioned. And so those slides were presented during the all-state call last week on April 30. And so, if anyone is interested in more information, you can take a look at those slides. They have quite a lot of detail, including changes from what was proposed. So, I'm going to just talk briefly about the Medicaid institutional payment transparency provision, and then I'll talk briefly about some guidance on the HCBS Quality Measures Set. And then, we can open it up for any questions that you have on any of these topics.

So, as Mary mentioned, the Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting Final Rule, just the Minimum Staffing Rule for short, was issued on April 22, along with the Access Rule and the Managed Care Rule.

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And the Minimum Staffing Rule includes a provision that requires states to report annually at the facility level on the percent of Medicaid payments for certain institutional services that are spent on compensation for direct care workers and support staff. And we've largely finalized these requirements as proposed, but I'll try to point out some of the places that we've made changes from what was proposed based on the public comments that we received. So, the institutional payment transparency requirement applies, and this is as proposed, to nursing facility services and services in Intermediate Care Facilities for Individuals with Intellectual Disabilities, or ICF/IIDs. And the requirement applies regardless of whether a state delivers those Medicaid services, so ICF services and nursing facility services through managed care or fee-for-service delivery systems.

One change we did make from what was proposed was to not require states to separately report the data for fee-for-service and managed care. So we are in this final rule, we are promoting public transparency, and we're doing this largely as proposed by requiring states to publicly report the data they report to us. And then CMS will publicly report the data reported by each state, and we're providing states with four years to implement these requirements. Several other things that are important to note about this provision. So, we had proposed to exclude swing bed hospitals from reporting. We have finalized that exclusion. And we did this because we really didn't want to pose a burden on rural hospitals that provide long-term services and supports to relatively small numbers of beneficiaries. As proposed, payments for which Medicaid is not the primary care are excluded from the reporting, but beneficiary contributions to their care when Medicaid is the primary payer of the services are included. And we did this because we want the payments included in the reporting to be representative of the total payment amount a provider receives for the provision of Medicaid services to beneficiaries.

Similar to the HCBS payment adequacy reporting requirements in the Access Rule, we have included a new exclusion of certain costs from the calculation of the percent of Medicaid payments going to compensation. And specifically, we are excluding travel, training, and personal protective equipment costs from the calculation. And we did this because we think it recognizes the importance of those costs of quality of care and worker safety. We believe that by excluding these costs from the calculation, it will help to ensure that nursing facilities and ICFs continue to invest in these critical activities and items without the providers being concerned that these costs are going to count against their spending on compensation to direct care workers and support staff.

Similar to the HCBS payment adequacy provisions, we've also included a new exemption from the reporting requirements for the Indian Health Service in certain Tribal health programs that are subject to 25 U.S. Code Section 1641. And then, finally, as I've talked, you may have noticed that there are a lot of similarities between the institutional payment transparency provision and the HCBS payment adequacy provisions in the Access Rule. One key difference, though, to point out here, is that the HCBS payment adequacy requirement also includes a minimum performance level. In the Minimum Staffing Rule, this is a reporting requirement only. So, we are not requiring that a minimum percentage of Medicaid payments for nursing facility services and ICF services be spent on compensation to direct care workers and support staff. And that is consistent with what was proposed. We really view this institutional payment transparency requirement as a

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necessary step in gathering and making available more information about Medicaid institutional payments, and we think that that information can help to inform future policy development. So, for example, gathering and sharing this data about the percentage of Medicaid dollars that are going to worker compensation can help us, and it can help states identify ways that we can help to support the workforce and better address workforce shortages, including by addressing identifying national trends, and it can help us to identify facilities that appear to be outliers in terms of the percent of Medicaid payments going to compensation.

So, I'm going to shift gears now. I'm going to talk about the HCBS Quality Measure Set guidance, and it's actually a couple of pieces of guidance. So, I'm just going to walk through these at a high level because it's important to talk about them together. So, some folks on this call may be aware that in 2022, in July 2022, we released the first-ever HCBS Quality Measure Set through State Medicaid Director Letter 22-003. So, for anyone who's not familiar with it, the HCBS Quality Measure Set is a set of nationally standardized quality measures for Medicaid-funded home- and community-based services, or HCBS. And it's really intended to promote more common and consistent use within and across states of nationally standardized quality measures in HCBS programs. And it will also by creating more consistency and commonality across states, it really then creates opportunities for CMS and states to have comparative quality data on HCBS programs, and this can help to identify opportunities for improvement and to drive quality improvement in care and outcomes. And it can also help us in states to identify disparities in HCBS programs. So, we had previously, as you might be aware, notified the 41 states and territories participating in the Money Follows the Person (MFP) Demonstration that they would be required to report on the HCBS Quality Measure Set. And then earlier this year, on two calls—on a National Quarterly Call with MFP grant recipients and also on the CMCS (Center for Medicaid and CHIP Services) All-State Call—we provided additional information on those requirements. And then, a few weeks ago, we followed up by releasing two guidance documents on the HCBS Quality Measure Set. And those guidance documents were intended to confirm and put in writing essentially what we had shared on those calls.

So, the first guidance document, and these were actually released at the same time, they were released together. So, the first guidance document I want to talk about is an informational bulletin updating the HCBS Quality Measure Set. So, in this update, we added fee-for-service versions of four assessment and case management record measures and fee-for-service versions of two claim and encounter measures. And these were measures where previously there were managed care versions, but there were not fee-for-service versions available for state use. So, we think that was a really important update to the measure set to help address that gap in measurement and reporting for fee-for-service HCBS programs. And then we also removed an LTSS measure, a managed LTSS measure on flu vaccination. We removed it from the measure set because it's being retired by its measure steward, the National Committee for Quality Assurance.

So, we made that update, and along with the update to the measure set, we also released the 2024 Long-Term Services and Supports (LTSS) Quality Measures Technical Specifications and Resource Manual. And this was an update to previously released technical specifications for a set of managed LTSS measures for which CMS is the measure steward. And in this update, we

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added the corresponding fee-for-service versions for those managed LTSS measures that I had mentioned. So previously, that manual had eight managed LTSS measures, and there was one fee-for-service equivalent to one of those managed care measures. With this update, we now have seven fee-for-service versions. So, we have essentially corresponding fee-for-service and managed care measures for seven of the eight measures that are in that manual. And those fee-for-service versions of the LTSS measures that we've incorporated into that manual are the same ones that we added to the HCBS Quality Measure Set through that informational bulletin I mentioned earlier.

So, the second guidance document on the HCBS Quality Measure Set we released was another informational bulletin, and that informational bulletin described the HCBS Quality Measure Set reporting requirements for MFP grant recipients. So, you might remember I'd said earlier in this call that we had previously told MFP grant recipients of the 41 states and territories participating in the program that they would be required to report on the HCBS Quality Measure Set. This guidance was really intended to provide additional clarification on the HCBS Quality Measure Set requirements for those grant recipients.

So, I want to know just a few highlights from that guidance and then we can open up for questions. So, the first thing to note is that MFP grant recipients are required to report on the HCBS Quality Measure Set every other year for their Section 1915 (c), (i), (j), and (k) programs, as well as for that include HCBS. To be really clear about what this means, we are not requiring MFP grant recipients to report the measures specifically on their MFP participants, but instead, we are requiring that they report the measures for their HCBS programs as a whole. For MFP grant recipients, the first year of reporting will be 2026, using performance data for 2025. And for that first year reporting in 2026, we expect that the data will be due to CMS no earlier than September 1, 2026. For the initial implementation of the HCBS Quality Measure Set, MFP grant recipients are expected to report on the subset of the measures in the measure set and to develop a quality improvement plan related to two measures of their choice. So essentially, what we're saying is we want the grant recipients to use the data for quality improvement, but we're giving them flexibility around the specific measures they focus on for quality improvement purposes. And we will be providing some additional information on those quality improvement requirements in the future.

So, I mentioned that for the initial implementation, MFP grant recipients are required to report on a subset of measures in the measure set. So specifically, we are requiring that states and territories participating in MFP conduct an Experience of Care Survey for each of the major population groups included in the state or territory's HCBS programs. And we give MFP grant recipients consistent with what's in the HCBS Quality Measure Set; we give them a choice of four Experience of Care Surveys: the HCBS Consumer Assessment of Healthcare Providers and Systems, or the HCBS CAHPS survey; National Core Indicators of Aging and Disabilities, or NCIAD; National Core Indicators Intellectual and Developmental Disabilities, or NCIIDD; and Personal Outcome Measures.

So, they have to conduct an Experience of Care Survey, but we're giving them a choice of which specific experience of care surveys they conduct. In addition to that, MFP grant recipients are

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required to report on a subset of the other measures in the measure set. So, the mandatory measures include two assessment and case management record measures and three claims and encounter data measures focused on rebalancing LTSS systems, and then reporting on the other measures in the measure set is voluntary for 2026. And then we've also noted that for the claims and encounter measures, we will offer states the opportunity for CMS to report on those measures on the state's behalf and territory's behalf using T-MSIS (Transformed Medicaid Statistical Information System) data if the states would like us to.

So, because the reporting on the HCBS Quality Measure Set is a requirement of the MFP Demonstration, MFP grant recipients can also include the cost of implementing the measure set in their annual budget requests. And if we have any states or MFP grant recipients on the line, I would just encourage you to reach out to your CMS project officer and your OAGM (Office of Acquisition & Grants Management) grant management specialist if you have questions about the specific cost you can include and any associated questions related to the budget request. And with that, I think I'm going to hand it back over to Jill to open up for questions.

**Jill Darling:** Great, thanks, Jen, and thank you, Mary. If you do have a question, please use the raise hand feature at the bottom of your screen and we'll call on you. Please have one question and one follow-up.

**Jackie (Moderator):** OK. The first person I see is Sabrina. Sabrina, you're able to unmute. Sabrina, you're able to unmute yourself. OK, let's move on. We'll come back to her. Lisa. Lisa, you are able to unmute yourself. Lisa, you are able to unmute yourself. OK, let's move on. We'll come back to Lisa. Pete, you are able to unmute yourself.

**Pete Van Runkle:** Thank you. My question goes back to the 80/20 rule or the payment adequacy provisions of the Access Rule. And specifically, it is, do those requirements apply to the HCBS Waiver Program for assisted living that is categorized by the state as is not categorized by the state as personal care homemaker or home health aide, but it is categorized as other services? Is that covered by the requirement, the 80/20 rule?

**Jennifer Bowdoin:** So thank you for that question. I think you may be aware that states often refer to the same services with different names, and sometimes they use the same names for different services. And that can happen within a state, and it certainly happens across states. We plan to issue additional sub-regulatory guidance defining the specific services that are subject to this requirement and addressing some of the specific questions that have come up. We have gotten some questions about applicability to assisted living, and that will largely be the answer to the question in terms of applicability to assisted living. So assisted living, that is really a setting where Medicaid services are delivered. I think the specific response to that will be how those services are defined, and we will provide additional sub-regulatory guidance to help states determine whether services delivered in assisted living facilities in their states are subject to the payment adequacy requirements.

**Pete Van Runkle:** OK, thank you.

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**Jennifer Bowdoin:** You're welcome.

**Jackie (Moderator):** All right. The next person I see is Debbie. Debbie, you're able to unmute yourself.

**Debbie Jenkins:** Thanks. This question is for Jen. On the quality measures you mentioned that there's the four different surveys and that for the MFP states, they'll have a choice of which survey they want to use. Does the state need to use the same survey for all of their home community-based services programs? Or can they choose one that is specific to the population that's being served by the waiver? So, such as the NCIAD versus the NCIIDD?

**Jennifer Bowdoin:** Yeah, so states have flexibility in terms of the specific surveys that they use. So for instance, I would not be surprised to see a state that maybe wants to use NCIIDD for the IDD population served in a waiver specific to that. And then to use, say, NCIAD or HCBS CAHPS for waiver programs or HCBS programs that serve older adults or people with physical disabilities. I think we are providing some flexibility so that states, at their discretion, can use the surveys that best meet their needs.

**Debbie Jenkins:** Thanks.

**Jennifer Bowdoin:** You're welcome. And if there are questions about that, we're happy to work with states to work through those questions about, and we have technical assistance available to support states with helping them determine which surveys to use in their programs and which are applicable to which populations.

**Jackie (Moderator):** All right. The next hand that I see is Germaine. Germaine, you're able to unmute yourself. Germaine, you are able to unmute yourself.

**Germaine Cherry:** Hello?

**Jackie (Moderator):** Oh, there you are. Yes.

**Germaine Cherry:** Hi. Yes. OK. I'm a newly licensed home caregiver, and I keep getting the runaround with the long-term service providership for funding. And I'd like to know, is there a direct portal I can use to begin to try and get funding?

**Jennifer Bowdoin:** So, the answer is going to depend on the state where the services are being delivered. What I would suggest is maybe that we get your contact information and we can follow up separately after this call.

**Germaine Cherry:** Yes ma'am. Yes ma'am. Thank you very much.

**Jackie (Moderator):** All right. The last hand is Lisa again. Let's try to go back to her. Lisa, you are able to unmute yourself. Lisa Charlton, you are able to unmute yourself. OK. It looks like you're unmuted.

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**Jill Darling:** Check if you're double-muted?

**Jackie (Moderator):** Yeah.

**Jill Darling:** It does happen. Lisa, if you're unable to get your question in, I put the Long-Term Services and Supports Open Door Forum email in the chat.

**Jackie (Moderator):** It looks like Lisa was the last hand that is raised right now. Oh, I lied. I'm sorry. There's Debbie. Debbie, you are able to unmute yourself.

**Debbie Jenkins:** Sorry about that. This is actually a follow-up to Pete's question earlier on the 80/20 provision. I know, Jen, you mentioned that CMS will be providing some additional sub-regulatory guidance. Given that that doesn't take place for six years, I know the reporting is in four years. Do you have an idea of the timeline on when you will be issuing the additional guidance?

**Jennifer Bowdoin:** So, we are in the process of assessing not just for this provision but for all the provisions across the Access Rule where we think sub-regulatory guidance needs to be issued, what specific questions we need to address, as well as what technical assistance materials might be helpful. And so, we are putting, in the process of putting together a list and a release schedule for those materials. We're not ready to share it yet, but we would certainly welcome feedback. In terms of priority areas, we've certainly, we recognize the payment adequacy one that there are some specific questions that people have that we need to address, but we know that there are other areas too. So, we want to make sure that we're prioritizing specific pieces of guidance or technical assistance in a way that makes sense for states and providers and others that will be involved in implementation. And so, we would welcome feedback just in terms of what should be prioritized and also what specific questions people have so that when we issue guidance or technical assistance materials, that we can do our best to try to address those questions as clearly as possible.

**Debbie Jenkins:** Thanks, Jen, appreciate that. And as you mentioned, I think the 80/20 provision is definitely a high priority, understanding who all is involved in that and how CMS is going to determine which services are on that. So, can I ask one more follow-up question real quick? On the critical incidents requirements and reporting, can you confirm whether a state would be required to utilize one critical incident reporting system for all of their services or if they could potentially have different critical incident reporting systems for say, developmental disabilities versus aging services?

**Jennifer Bowdoin:** Mary, do you want to address that, or would you like me to?

**Mary Botticelli:** So, the requirement is to have an electronic critical incident system that includes all of the 1915(c) waivers—(c), (i), (j), (k), and 1115 waivers that have HCBS services. So, we recognize that states aren't starting from scratch and that many states have electronic systems that may be built based on specific waivers. And so, we'd be looking from a state

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perspective, the reporting requirement is on a state perspective across all of the authorities. So, we'd be looking for a system that has the capabilities to do that.

**Jennifer Bowdoin:** So, I'll just maybe add on a little bit. So, states have some flexibility in terms of how they meet the specific requirements. We are looking for aggregate state-level reporting, but we aren't necessarily requiring a single integrated electronic system. We would certainly encourage states to do that, and we would be happy to provide technical assistance for states around accessing enhanced match for their IT systems and other things that would be helpful for them to implement an integrated system. But states have flexibility—as long as they're meeting the specific requirements in the rule, they have flexibility in terms of how they meet those requirements.

**Debbie Jenkins:** Thank you. That's very helpful because we know that while CMS has defined the minimum set of critical incidents that need to be reported on, states often have additional critical incidents that they've included. And so, we want to make sure that there's the ability for that to be differentiated depending on the population that is being served by that waiver.

**Jennifer Bowdoin:** I'm going to put in the chat for folks who have questions. We do have a resource mailbox for the HCBS provisions in the Access Rule, so if folks have questions, you're welcome to email that mailbox directly.

**Jill Darling:** All right. Well, we currently don't have any hands raised. So, if Jen has any closing remarks, if not, that's all right.

**Jennifer Bowdoin:** No, I just want to take a moment to thank everyone for joining the call. We're really excited about all of the work that—all of the releases in this area around home- and community-based services and long-term services and supports that have happened over the past month. And we're really looking forward to working with states, providers, managed care plans, and other entities on implementation. If you have questions, please feel free to reach out to us, and we will do our best to get you answers as quickly as possible. So, thank you all so much. Really appreciate the time today.

**Jill Darling:** Great. Thank you everyone for coming. I just provided the Open Door Forum email and the link for where the transcript will be found. We thank you for your time today and this concludes today's call. Thank you.

**Germaine Cherry:** Thank you.