Centers for Medicare & Medicaid Services
Long Term Services and Support Open Door Forum
Moderator: Jill Darling
August 11, 2020
2:00 pm ET

Coordinator: Welcome and thank you for standing by. At this time, all participants are in a listen-only mode. At the end of today's presentation, we will conduct a question-and-answer session. To ask a question, please press Star 1. Today's conference is being recorded. If you have any objections, you may disconnect at this time. I would now like to turn the meeting over to Jill Darling. You may begin.

Jill Darling: Great. Thank you (Brandon). Good morning and good afternoon everyone. I'm Jill Darling in the CMS Office of Communications. And welcome to our Open Door Forum of the Long-Term Services and Support. We would, you know, look forward to hearing from you during this pandemic. So we appreciate you holding as we always try to get more folks in.

So before we get into today's discussion I have one brief announcement. This Open Door Forum is open to everyone, but if you are a member of the press, you may listen in but please refrain from asking questions during the Q&A portion of the call. If you have any inquiries, please contact CMS at press@CMS.HHS.gov. And I will now hand the call off to Alissa DeBoy who is the Director of the Disabled and Elderly Programs Group.

Alissa DeBoy: Thank you very much. Good afternoon, everyone. I am Alissa DeBoy, Director of the Disabled and Elderly Health Programs Group. And this was actually my first time kicking off the LTSS Open Door Forum. And I wanted

to personally thank you all for being on this call during what I think we can all agree is a very unprecedented time. I want to acknowledge your continued efforts to support beneficiaries who use long-term services and supports in whatever capacity you do. And I also want to thank those of you who've worked with us to provide input on a variety of issues during this public health emergency. We're very grateful.

My team will talk - be talking to you today about guidance that we released a few weeks ago regarding (unintelligible) rule and our ongoing efforts to help states rebalance their LTSS systems. We're quite excited to do that. When we use the term "rebalancing," we mean achieving a more equitable balance between the share of spending and use of services and supports delivered in home and community-based settings relative to institutional care -- where the majority of LTSS has historically been provided.

High rates of COVID infection and death among nursing facility residents have led to a renewed interest in promoting the use of home and community services over institutional services in many states. And we are pleased to see and support these efforts. I know we have a lot to talk about today, so I'm - we'll hand it over to my deputy, Melissa Harris to get us started. Melissa?

Melissa Harris: Thanks, Alissa. And it's really my pleasure to be with all of you this afternoon. We wanted to provide some updates on an action CMS took a few weeks ago that you may be familiar with. But we wanted to provide you with a little bit of context for why we took this action, and how we hope it will resonate with states and all of our stakeholders in the foreseeable future.

So you're probably familiar with Medicaid's regulation for home and community-based services. Medicaid is really the primary payer of a lot of long-term care services in this country. And there is a mixture under the

umbrella of long-term care -- there is a mixture of institutional based services and what we call home and community-based services. And there are several different authorities in Medicaid that authorize services to be provided under the rubric of home and community-based services. And several years ago now -- 2014 to be exact -- we finalized a regulation that defined what it meant for Medicaid-covered services to be provided in a home and community-based setting. And the - the principles of a home and community-based setting are really designed to foster beneficiary independence and autonomy, meaningful choice in how they spend their time and with whom they spend their time, and their ability to exercise the same decision making abilities that many of us exercise every day without even being aware that we're making decisions.

And because we knew that there would be some time needed to, you know, really raise all boats across the country in terms of the various settings in which home and community-based services were being provided to ensure that all of the providers delivering home and community-based services met those requirements, we implemented a transition period associated with that criteria - that set of criteria for a home and community-based setting. The regulation was published in 2014, and the original transition period was set to expire in March of 2019. And so the states and the - are - the provider communities and our advocate communities really got to work to do an assessment of what home and community-based service provision looks like in their state, and what actions needed to be taken to achieve compliance with the regulatory criteria.

During the transition period, each state submitted a statewide transition plan to CMS that outlined what they were going to do at both the state level and at the provider level to make sure that compliance was achieved by the end of the transition period. And then as time was passing, CMS was continuing to issue updated guidance around implementation frameworks, best practices,

frequently asked questions. We also issued quite a bit of information around the provision of the regulation that defined settings that were not home and community-based, and settings that were presumed to not be home and community-based because they were presumed to have qualities of an institution. And we talked about the - the heightened scrutiny process that the regulation identifies which gives states a pathway to seek CMS review and potential approval of a setting that is presumptively institutional but really does adhere to the criteria of a home and community-based setting.

As we were nearing 2019, it became clear that there was a lot of good work underway but there was still a lot of progress still to be made in meeting the criteria of a home and community-based setting. And so one of the first things this current administration did in 2017 -- May of 2017 -- is we extended the transition period associated with the regulation. And so the transition period moved from ending March of 2019 to ending March of 2022. And it was that timeline that we were working on - working with up until just a few weeks ago. The action that CMS took this summer was to extend the transition period by an additional 12 months. And so now the transition period for complying with the requirements of a home and community-based setting is now March of 2023.

And we did that for a few reasons. We - I had mentioned a minute ago that there was a lot of good work, thoughtful work but work that takes time - already underway at the state level, at the provider level. One of the things that the states were doing as they solidified their statewide transition plans is they - they had to do an analysis of not only what actions needed to happen at the state level -- did they, for example, need to modify licensure and certification requirements for entities like group homes? Did they, for example, need to change managed care contracts, or provider agreements, or state regulations in order to facilitate provider compliance with the regulation?

And then as they started to work with their provider communities, the state needed to have a way to do an assessment of all of the settings providing home and community-based services, and figure out what kind of changes -- if any -- a setting would need to make by the end of the transition period in order to achieve compliance.

And that was a very setting-specific idea. Some settings only had some relatively minor changes to make to their operations or to their physical layout to - to achieve compliance with the regulatory criteria. Other settings needed to do more systemic amend - amendments or overhaul to their method of service delivery, and the state in their statewide transition plan had to identify how they were going to do those assessments, and how they were going to make sure that providers were doing all of their necessary remediation work.

At the same time, the states needed to identify a process for identifying settings that had - that were presumed to have qualities of an institution. Those settings were -- excuse me -- on the grounds of or adjacent to a public institution. So there we could be talking about a cottage on the grounds of a public (ICF). We're also talking about a setting that's inside a public or private institution. So here we could be talking about a wing of a nursing home that is either an assisted living center or maybe an adult day center. And then the third category of settings that could be - or settings presumed to be institutional are settings that were isolating to HCBS beneficiaries in comparison to the larger community.

And so in their statewide transition plan, states needed to have a way to identify the settings that fell into any of those three categories and then determine what remediation would be necessary to bring them into compliance with the regulation, or the state can make a decision that they no longer wanted to offer Medicaid-funded home and community-based services

in that setting -- in which case there would need to be some work with the setting and individuals receiving services there on next steps (unintelligible).

So work was plugging along. This is not quick work. It's the system change and it takes time. We're talking about a regulatory criteria that is not unachievable. We have said from the beginning that the regulatory criteria are inherently achievable, but sometimes this meant some relatively significant work to redo service provision in some settings. And so we were working very hard with our state partners and with other stakeholder groups to make sure everyone understood what the federal expectations were for the regulation, what types of decisions that states would be making at their level, and, you know, how - how those decisions would be communicated to providers and beneficiaries and families.

So then (unintelligible) the beginning of this year dawns and, you know, we are - are thinking that we are in a business-as-usual framework. And as the weeks passed and 2020 became apparent that we were not in a business-as-usual environment. And as our life in CMS started professionally to focus on COVID-19 relief activities, and we were having pretty frequent conversations with our state partners about what they were seeing, what assistance they were going to be needing from CMS in the short and long term in terms of a pandemic response strategy, one of the things - the things they started surfacing pretty quickly is they were fearful that they were losing time -- time that was supposed to be devoted to continuing the paperwork assessments of state level requirements -- those state level regulations, or licensure and certification standards and their work with their provider communities to make sure that providers were being correctly assessed, correctly identifying the steps they would need to take to achieve compliance, and were making progress in - in implementing those steps.

So certainly as, you know, the word "lockdown" became part of our daily vocabulary -- and "isolation," and "quarantine" did as well -- it became clear that states were not going to be able to continue providing the in-person assessments that they were doing for their HCBS providers. And equally if not more importantly, Medicaid beneficiaries were not experiencing their community the way they typically were because they also were on lockdown status and were quarantining in place.

And as we got further and further into the pandemic -- and we realized that there is no, you know, real bright line in terms of an end to this -- it became clear that we were losing many months and there would still be multiple months even as our heads start to poke - poke above the - the - the - the work that is totally dedicated to COVID. As we start to - to maybe in - infuse some non-COVID work into our daily lives, the - the bulk of the concentration at the state level was still going to be on - on COVID relief. And so in recognition of that, we started to think seriously about the wisdom of extending the transition period associated with the compliance timeline for this regulation by another year.

And that is in fact what we ended up doing in a letter to our state Medicaid Directors earlier this summer. Attached to that were a relatively small set of frequently asked questions. And they - they modify some guidance that we issued last year in March of 2019 -- particularly in the heightened scrutiny arena. Those 2019 FAQs were very technical in nature, and provided a lot of good guidance on the types of information that a state needed to send out for public comment on a setting that they had identified as being any of those three categories of being presumptively institutional. It provided some information about what a state needed to submit to CMS for our review of such a setting and provided information on how CMS would review that information and communicate back to the state.

It also provided some clarification of what an isolating setting was for purposes of a presumptively institutional setting, and provided some clarification around some flexibility that existed for states to make a determination by a date (unintelligible) that a setting that maybe had started out the transition period as an isolating setting had already remediated into compliance, and now satisfy the regulatory criteria. We had in our March 2019 FAQ that if a state had made a determination by July 1, 2020 that such a setting had remediated into compliance with the reg that setting would not need to be submitted to CMS for heightened scrutiny. But as 2020 progressed, states made it clear to us that they were not going to be able to take full advantage of that date because they were so consumed with pandemic relief.

And so the FAQs attached to the Medicaid Director letter provided some overall guidance about extending the - the - the transition date - the end date of the transition period to March of 2023 and also revised some of those date-specific provisions associated with heightened scrutiny that were clarified in our March 2019 guidance.

So I'm happy to go through that further if anyone wants to when we get to the - to the Q&A session. But I also want to spend some time talking about how we really encourage our state partners to use this extra time. You know, no one is thinking that this extra year between March 2022 and March 2023, you know, is - is just an additional padding. You know, we came to the conclusion that it was necessary because of the extraordinary nature of how 2020 has played out. And we know that it will be some time, and states will arrive at the decision in - in different time periods that they are able to again devote attention to their typical HCBS settings assessment.

But we want the states as even before they get back to resuming normal

business -- and I put normal business in some air quotes since that's going to be a very subjective term in the - in the short term anyway -- we want states to be thinking quite strategically about the provision of home and community-based services in their state.

You know, I think we have all learned some lessons as the pandemic has - has carried on, and we're seeing the numbers of the rates of infection and the rates of mortality that are coming out of congregate settings like nursing homes -- certainly not specific to nursing homes, but that's one example. And - and so states are looking to chart a course in a post-COVID environment. Where do they want home and community-based services funded by the Medicaid program to - where - where do they want them to be furnished?

And how do they want that funding stream and that service package to figure into their larger whole state strategy for the provision of long-term care? I mentioned that Medicaid is the primary payer of long-term care, and so we, you know, kind of are the - have a seat at the table in all of the states' conversations around the provision of long-term care. And so how does a state want to use the Medicaid program? And how do they want to offer services to individuals on the Medicaid program moving forward? This was a conversation that states were having before the public health emergency, but I imagine in some states it could look pretty different now.

Some states were already looking at our federal regulation as kind of a floor that they wanted to meet and maybe even exceed. Other states were looking to declare success at just meeting the floor of our federal requirements. And so now what does the - what do the outcomes of this pandemic mean to those conversations -- those kind of strategic discussions about the - the vision for long-term care provision in that state. And so we have signaled to our state partners in our one-to-one technical assistance conversations -- and more

explicitly in this letter to them announcing the additional 12 months for the settings compliance -- that we are - are quite interested in engaging with them on something that we're calling rebalancing conversations.

You know, Alissa mentioned that's a little bit of a misnomer because frankly the scales have never been quite balanced in the provision of long-term care more in the community than an institution. That's always been a work in progress. We hit a - a great milestone in 2013 when we - in the universe of long-term care spending we started to spend more as a country in the provision of home and community-based services as opposed to institutional care. But the story is very different across states. And we have long been available and interested in partnering with states on rebalancing initiatives to enhance the provision of home and community-based services. It's safe to say those conversations take on even more criticalness now, more time sensitivity and the - the lessons from public health emergency, like I said, may be infusing those conversations with a different outlook on the - the types of settings that a state wants to increase reliance on.

None of these rebalancing conversations happen quickly, either. We are talking about, you know, as you start to lessen reliance on institutional care, you need to make sure that your infrastructure in the community is sufficient to absorb extra people -- and not only absorb them, but offer them the - the services that they had been assessed to receive in a strength and quality that will improve the health outcomes of those individuals, do so in a cost effective way, and be sustainable.

And so none of those are - are quick and easy fixes. We're talking about the need to have adequate housing stock. We're talking about the need to have a sustainable provider infrastructure. We're talking about the need to - for states to re-evaluate their reimbursement mechanisms and a host of other variables.

But those are the kinds of things that we are interested in rolling up our sleeves to - to meet with states about. And we gave a shout out to that in the letter. The states - and states are being quite receptive to it.

We've had several conversations with several states who wanted to kind of get out front and say, "Here's what we've been seeing during the COVID era. Here's where we are right now. Here's where we want to go. How do we get there?" And - and that invitation is available to all states. We are happy to meet them where they are and figure out, you know, how they can improve their system in a meaningful way, a realistic way, you know, but in a way that really moves the ball and provides some additional choices - meaningful and informed choices to individuals receiving Medicaid services.

So I'm going to stop there. I will to - so to wrap up - and I'm going to - I'm going to punt this over to my colleague (Jodie) who can provide a little more in-depth analysis of some of the rebalancing conversations that we're having. But in a nutshell, if you haven't seen it, we did issue a letter to state Medicaid Directors earlier this summer extending the transition period for the home and community-based settings (unintelligible) from March of 2022 to March of 2023. We also pushed back by a year some individual dates that had been associated with the provision of heightened scrutiny, the evaluation of settings that are presumed to have institutional characteristics that we had first talked about in March 2019 FAQs.

And we remain available for states if they have questions on the continuing work on ensuring compliance with the settings rule and as they want to start infusing those conversations with larger rebalancing efforts. And here is where I will turn it over to my colleague, (Jodie). So thanks very much.

(Jodie Sumeracki): Great, thanks Melissa. This is (Jodie Sumeracki). I'm the Senior Advisor

for the Disabled and Elderly Health Programs Group. And I'm just going to pick up from the conversation that Melissa was having with you all just now -- really about the re - rebalancing efforts that we're - we're kind of diving into. Again - not again - and it's not - it's not new that these are recon - renewed efforts that we're working on with states and with lots of stakeholders. And there are plenty of people on this call that have also given us some time and a lot of good thoughts about ways that we can do things in this space -- both in the short-term and the long-term.

So you know, we - we continue to have those conversations as well -- not just with states but with our state associations, with providers, with provider associations, with individuals and advocates. So we're really trying to - and have been trying to get as many good ideas as we can that we can, you know, kind of continue to harvest so that we can work through those and - and get some quicker wins and figure out as we kind of look to the future and what the long-term care environment is going to be and needs to be, how we can meet the needs of individuals -- particularly in the Medicare - Medicaid program but also in the Medicare program. So you know we continue that work.

And in some of what we have done - since Melissa was mentioning that we've had a few states that have come to us to say you know, "We want to kind of get ahead of the game," we started kind of at CMS looking at what - what could we do? What do we think states can do? What - what can we do to continue to push this work forward? And you know, we had a lot of internal conversations to - to think about things that are kind of already in the menu of availability - the available menu to say in terms of programs and authorities that they can provide HCBS services to beneficiaries - you know, ways that those might be able to be tweaked if - if we're able to do that, ways that we can provide some best practices and promising practices about what states -- who have really already excelled in this space -- are doing and - and how - and

how they've done those so that other states don't have to start from scratch.

And it can be a bit more of accelerated effort.

And we really just have talked to a lot of our partners and other areas of CMS and our - and our Medicaid coll - Medicare colleagues, and folks in the Administration for Community Living, and some of our other federal partners across the administration to say, "You know, what all do we have in our arsenal to really help states and providers be able to continue to do some work to transform their systems into more home and community-based supports and services for individuals versus relying so much on institutional services or - or settings?" So we continue to have a conversation. So we are going to continue to have those ongoing. As Melissa said, this isn't a thing that we're going to solve in the next month or the next four months. I mean, this is something that folks have been working hard on for 30 years. So we're not, you know, under the illusion that we're going to fix it all.

But I will say that this has been an unprecedented time for all of us. And during that time we've had a lot of really great conversations with states and with stakeholders, as I was mentioning earlier. And we really have gotten a lot of really positive feedback and good ideas that we think we're going to be able to continue to learn and implement over the coming months and coming years.

Ultimately, our goal is to really kind of take a step back and look at the long-term care system -- not just in the long term -- in terms of being able to really have an infrastructure that can support the - the influx of people that we know are heading our way, (unintelligible) more sustainable system, but also how to - you really support faith efforts to get ahead as much as they can in looking at transforming their long-term care systems now in an effort to address the COVID-19 infection and spread. And you know, one of the things that some

of our stakeholder colleagues reminded us of is really, you know, how HCBS settings criteria that were laid out in the rule as well as transformation efforts at large can be used -- as a tool really -- to, you know, address the COVID-19 pandemic, and look at how to, you know, transition individuals out of institutional settings and into the community.

And - and really while there, you know - while there is a delay, there really is a lot of work that we encourage folks, you know, to look at and try to do because any building of HCBS infrastructure is - is going to be a positive way to be able to have, you know, the - the settings in order to be able to actually provide services to people in the home community versus being in an institution.

So you know really a lot of the - a lot of that work could be used as a tool. So we hope that states will continue to - to, you know, strategize and use that as a tool in what they're trying to do for the days coming. So again, we continue to have conversations with folks and hope that we, you know, can get any good ideas as people move forward. And we look forward to hearing from more folks in the weeks to come. So Jill, I think we could probably start taking some questions and answers if you're ready.

Jill Darling: Yes, we are. Thank you very much to (Jodi), (Melissa) and (Alissa). So (Brandon), will you please open the lines for our Q&A please?

Coordinator: Thank you. We will now begin the question and answer session. If you would like to ask a question, please press star 1, please unmute your phone and record your first and last name clearly when prompted. Your name is required to introduce your question. To withdraw your question, you may press star 2. Once again at this time, if you would like to ask a question please press star 1. One moment please, as we wait for our first question. And once again, if you

would like to ask a question at this time, please press star 1. One moment, please. I'm showing no questions at this time.

Jodie Sumeracki: We can give folks a couple of minutes. And just let me know if anybody kind of pops on and I'll stop talking. But I would also just add that, you know, our colleagues have been really remarkable in this time as well. We've talked to a lot of folks in the Medicare and Medicaid Coordination Office. We've talked to a lot of folks in Medicare. Our partners in TCSQ and our partners at ACL and the Federal Administration, other partners there.

And, you know, we've been trying to come up with a lot of ideas and the roads are really converging in a way that they haven't in the past, or at least in the past 10 years that I've been here, in that folks are really trying to think about how to continue to drive quality incentives and top quality to payments and really kind of look at transforming the long term care system as we know it. And, you know, we're actually talking and not, you know, I know people have heard the word silo more than they care to, but, you know, we've actually been doing a really good job of working across those and trying to partner and align as much as we can with our colleagues across the administration so that we're kind of all singing from the same book.

Because we all know and see the wave of people that will be coming into the long term care system. And we know that there are lots of challenges there, absent the pandemic, including direct service workforce and making sure that we have the capacity that we need there to support people. Again, as (Melissa) was mentioning, making sure we have the housing stock to support people in the community. And any number of things.

So, you know, I just wanted to point out that we really are doing a lot of work internal to CMS and reaching out with our partners across the administration

and states and stakeholders, to really take a long hard look at what we need to do together to check - to transform the system and make it a higher quality better outcomes-focused system that will be able to support people and be sustainable over the years to come.

So I just wanted to kind of add that and again, ask that, you know, as folks anywhere out there have ideas about how states could do things, how providers might be able to look at culture change, you know, how folks in other areas are doing that. And, you know, how people want to share that feedback. You know, we welcome that. And I think Jill was going to go over for the questions that folks didn't think to ask today or if something else, you know, kind of pops into your mind or that you really think folks should think about. There's a mailbox that folks can submit questions to as well. So we'll be checking that and I'm happy to take questions there as well.

Coordinator: And we do have a question on the line from (Bonnie). Your line is open.

(Bonnie): Thank you. My question is, are there plans in the future, to allow Medicare beneficiaries to get home-based services.

Jodie Sumeracki: So that's a good question. (Melissa), I don't know if you wanted to start with that. I know that there are some programs now and I believe it's related to the Medicare Advantage, a program that actually offers a lot of, or some of the similar services that (HCBS) can offer. So I think that that is available to some people in the Medicare program. But I'm not a Medicare expert. And none of the folks on this phone call are today. But I don't know if there's anybody else who wanted to add onto that.

But there are some (HCBS) services that are available or (HCBS)-like services that are available I believe, through the Medicare Advantage

program. But I think that there's a lot of thought being done right now as to how that could be enhanced and aligned across the administration in both programs.

Melissa Harris: This is Melissa. And that's exactly right. There are what's called supplemental benefits under the (rubric) of Medicare Advantage which is Medicare managed care, that can approximate some home care services, not the full extent of the home and community-based services package authorized in Medicaid. But it does represent a great step forward in addressing social determinants of health for example, and some home care needs. But it is, you know, as more and more attention nationally, is given to long term care across all of the insurance programs, you know, I think it's going to be a little more - Medicare is going to become part of those conversations.

And, you know, we will largely find out together if there are any more substantive changes made to the Medicare program which would largely require a change to the legislation authorizing Medicare in the Social Security Act. But it's a great question; very relevant to this conversation.

Coordinator: And I'm showing no further questions on the phone lines.

Woman: Well, I think we're probably happy to give people back 15 minutes of their time. We know everybody is really busy. But Jill, did you want to give the mailbox if folks have feedback, they can share it?

Jill Darling: Sure. Sure. So, if you're on today's call and you don't have the agenda please feel free to send in your questions to L-T as in Tom, S-S as in Sam at CMS dot HHS dot gov. And everyone, enjoy your day. Thank you so much for joining today's call.

Woman: Thanks, everybody.

Coordinator: Thank you for participating in (unintelligible). All lines may disconnect at this time.

End