

Centers for Medicare and Medicaid Services
Long Term Services and Support
Open Door Forum
Moderator: Jill Darling
Tuesday, August 15, 2017
2:00 p.m. ET

Operator: Good afternoon. My name is (Tiffany) and I will be conference facilitator today. At this time, I would like to welcome everyone to the Centers for Medicare and Medicaid Services Long Term Services and Support Open Door Forum.

All lines have been placed on mute to prevent any background noise. After the speaker's remarks, there will be a question and answer session. If you would like to ask a question during this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key. Thank you.

Ms. Jill Darling, you may begin your conference.

Jill Darling: Thank you, (Tiffany). Good morning and good afternoon everyone. Thank you for joining us today. And as always we appreciate your patients as we wait for more folks to dial in. So they're able to listen to today's agenda. I am Jill Darling in the CMS Office of Communications.

So, before we get in to today's agenda, I have one brief announcement. This Open Door Forum is not intended for the press. And the remarks are not considered on the record. 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 do have any inquiries, please contact CMS press@CMS.hhs.gov.

So first we have Melissa Harris, who is a Senior Policy Advisor in the Disabled and Elderly Help Programs Group, who have some Home and Community-Based Services updates and other key HCBS updates.

Melissa Harris: Thanks, Jill. Hi. This is Melissa Harris. And I thought we would start today since we haven't spoken in this forum in awhile on the provision of Home and Community-Based Services. I thought I would start by making sure everyone is aware of an informational bulletin that was issued by CMS a couple of months ago extending the transition period that applied for settings that were in existence when the Home and Community-Base Services regulation was published in January of 2014.

You'll probably recall that when the final regulation was issued, states at that point were given until March of 2019 to bring their existing settings into compliance with the regulatory criteria defining a home and community-based setting. And for a couple of reasons as time was passing, it became clear to us that 2019 probably was not a feasible date for any kind of national compliance or adherence to the settings criteria.

And so we did issue an informational bulletin extending that time period to 2022. So it's an additional three years. And so, the settings that had the transition period to 2019 now have a transition period that runs through March 17th, 2022. It's important to note that the informational bulletin did not really do anything other than extends that time period by three years. For instance, it did not apply the transition period to a broader universe of settings.

So a setting that was under the transition period originally now has three more years. A setting that was not under the original transition period still does not have any kind of transition period and must ensure compliance with the criteria for home and community-based setting.

The purpose of the informational bulletin was solely to announce that extra three years. There was no ability in that guidance to apply extra protection to settings that were not afforded the transition period under the regulation. And CMS does not have any ability to authorize a setting to come under a transition period unless it was in existence as of the date the final regulation become effective which was March 2014.

We have gotten a couple of questions on that point asking, if the extension applies to a broader swath of settings. And the answer to that question is, no.

But we're hopeful that the extra three years being made available to the settings that are working to gain compliance with the regulation because they were providing services before the regulation was finalized. We hope that that will be helpful.

We have heard good feedback from our state partners and the provider community in general. And it felt like it really made some good sense to take a little bit of the pressure off of a 2019 date that was very quickly approaching. And we had heard from several stakeholders that they did not want speed to really be controlling the decisions that were being made in the name of achieving compliance with the regulation. And that certainly is a statement that we have agreed with.

So 2022 is the new date for settings that have a transition period. We have – as we said in the informational bulletin, CMS really hopes that states will continue to work on their statewide transition plans and keep those documents moving and out for public comments. And we have been happy to see that states really have done exactly that. We have not noticed any kind of slowing down of the movement of statewide transition plans.

And with me here today is George Failla who is the deputy director of the Division of Long Term Services and Support. And he can correct me if I'm wrong. But we have about 35 states with initial approval of their statewide transition plan. And four states with final approval of their statewide transition plans.

And that represents good progress on the movement of those documents. And its further evidence to us that states are taking seriously the need to work with their stakeholders, work with their providers. And get at least the documentation of the statewide transition plan in a condition that is suitable for initial or final approval. So that the extra three years of time is not used for planning purposes but really is used to implement any kind of modifications or remediations that states need to make either at the state level or at a particular provider level.

And so we're – we continue to be very appreciative of the – of our state partners in doing a lot of good work. And we recognize that it's often not quick work. And so we hope that the extra time will allow states to continue to have collaborations at their level and continue to receive any technical assistance that they need from us.

So in a few minutes, you know, we will be happy to answer any questions that you have on the three year extension but did want to start out with making sure that that was on your radar screen.

The other thing I would clarify is that, the rest of the regulation that is separate and apart from the criteria of home and community-based settings continues to be in effect and really was in effect with the March 17th, 2014 effective date with – of the regulation. In a lot of our conversations, the regulation seems to be equated with the settings criteria and that's understandable. It really was a premier component of the regulation.

But there are other things that the regulation did including; conflict of interest, requirements, person-centered planning requirements. The ability for states to choose to consolidate waiver populations inside one document. And all of those things remain live portions of the regulation and remain in effect.

And so we recognize that particularly both the person-centered planning provisions and the conflict of interest provisions might still be giving states and providers or might still be requiring conversation among state and providers including CMS. And so while the effective date of those provisions was in 2014, CMS is still very interested and very willing in talking with states on how to make sure both person-center planning and conflict of interest provisions are implemented correctly. And it's really necessary to have a state by state and even waiver by waiver conversation about, you know, what the state is interested in doing and what the existing system looks like and how to make any necessary movements to ensure adherence to the regulatory requirement.

But we encourage states to seek us out to make sure that the implementation of those things is going along as smoothly as possible. And we're happy to

figure out what makes the most sense in terms of actions going forward, you know, to make sure that happens. But we don't expect to see for example conflict of interest or a person-center planning provisions to be part of a statewide transition plan because these provisions are really in effect.

And so, the other thing I'll say, I know we haven't spoken in the last few months. But it's worth reiterating that in mid March the agency sent out a letter that was jointly signed by secretary of Health and Human Services, Dr. Tom Price and Seema Verma who is the administrator of CMS.

And in that letter there were – the address to the nation's governors. And it talked about several topics, the Home and Community-Based Services rule being one of those topics. And there were two specific provisions mentioned in the letter to the governors as elements of the HCBS regulation that were on our radar screen is needing to be addressed. One of them was the extension of additional time in the transition period. And so that was brought to fruition in the informational bulletin.

The other mention in the letter to the governor was process efficiencies in the framework of heightened scrutiny that's found in that HCBS regulations. Heightened scrutiny, means the process of CMS doing a review of a particular setting that the state elevated to us. That type of setting would meet the criteria for what the regulations defined as a setting that has a – that is presumed to have those qualities of an institution. But the state believes that that presumption is overcome.

And there are three types of settings that have the – that the regulation defines as presumed to have the qualities of an institution. The first is a setting on the grounds of or adjacent to a public institution. The second is a setting that is in the same building as a public or private institutional provider. And then the third is a setting that could be isolating to HCBS recipients.

And if states encounter any of those three types of settings that are currently providing HCBS. The state should do a review of those settings. And if the state believes that the setting adheres to the regulation they can submit information to CMS about that setting and CMS would perform what's called

the heightened scrutiny review to determine if the setting in fact does comply with the regulation thereby overcoming an institutional presumption.

As time passed after the regulation was issued, we had put forward some sub regulatory guidance. That's on our website, the Medicaid.gov/hcbs website. It's also fair to say that the heightened scrutiny framework in general was generating a fair amount of questions from states and providers and other stakeholders. And it deserved a lot of attention to make sure that we were implementing it in a way that not only ensured fidelity to the regulation. But that it was clear enough that the states would be able to understand which settings needed to be assessed under heightened scrutiny and which did not.

And so in the letter to the governors in mid March, the secretary and the administrator made mention of heightened scrutiny because they've had it elevated to their radar screens. It's something that states really want to, to be at the table as CMS made some implementation decisions and it has touched of some collaboration that we have had with our state partners.

And we are in the middle of continuing conversations about where to take heightened scrutiny. I know it is – sometimes an elephant in the room, to be honest, because it is a framework that is part and parcel of the regulation. And there are some settings who wonder if they will be implicated in that. And others that are pretty sure they will.

One thing to reinforce is that, if a setting does need to come to CMS under the approach of heightened scrutiny, there is no kind of preconceived answer as to whether the setting really does overcome an institutional presumption or not. That determination will be made based on the information submitted to CMS by the states. And will be very setting specific based on the life experience of beneficiaries who are receiving services in that setting.

But we understand that, you know, until the heightened scrutiny guidance is nailed down, there will continue to be some questions. So our commitment to all of you is to have guidance firmed up as quickly as possible. But we did want to make sure since you saw the reference to heightened scrutiny in the

letter to the governors we did want to keep you addressed of the conversations that were happening.

Our goal is to, you know, to take the framework that is the regulation and figure out how to make it implementable by the states and understandable and understandable as well to the providers. The rest of our HCBS stakeholders and try to remove as much uncertainty as we can. And so those conversations will continue.

In the mean time, you know, we do have guidance on our website. I cannot tell you now what kinds – what parts of our existing guidance may or may not change during the processes. But there are active conversations underway. And we understand that all of our stakeholders will be aided in their understanding of where things are headed when that guidance, you know, gets confirmed.

So, I'm looking at George and asking if there are other like big headings of things that we'd like to discuss today before we maybe open it to some questions and answers.

George Failla: No. The only things I would add then again, this is George Failla, the deputy division director in Division of Long Term Services and Supports within the Center for Medicaid and CHIP Services. The only thing I would add is that, in addition to the broad scale work that we're doing, we also continue to work individually with states to provide specific technical assistance and guidance on their plans.

And in addition to the 35 initial approvals and the four final approvals, the statewide transition plans that are in place as of today's date. We have other states that are working in the queue and will be moving forward even across the next few weeks and months before we'd have the opportunity to meet with this group again. So, additional states will also move in to various stages of approval during that time.

And we also are certainly both meeting with, talking with, and corresponding with groups of advocates, individuals that have particular concerns or interest in the HCBS settings rule. And also certainly, you know, responding in

correspondence to questions that may come from other stakeholders beyond our partners in the states as we look to implement this rule.

And then, I guess the other large scale item that we're working with the states to implement moving forward is to address electronic visit verification as it relates to the 21st Century Cures Act particularly with regard to the 2019 requirement for all states to have in place an Electronic Visit Verification System for personal care services.

There are also deadlines for Home Healthcare Services that are – in 2023. We have engaged with the states in conjunction with the National Association of Medicaid Directors to gather information about the current state of affairs for states that are using Electronic Visit Verification Systems or EVV for short.

And we will be producing a state Medicaid director letter in January of 2018 that will identify where states are and some opportunities for best practices. And indeed some lessons learned from states that are implementing Electronic Visit Verification. But those efforts are ongoing. So if you're hearing states trying to gather information or look to implement their processes, they are acutely aware that these deadlines are coming up particularly regarding to personal care services for January of 2019.

And CMS has plans to – has planned multiple training activities with states based on the information we gather and additional support both individually and in groups as we work with states to meet the requirements of the 21st Century Cares Act as it relate to Electronic Visit Verification.

And we really look forward to continuing that partnership with our states and other advocates. Because if we can appropriately identify how services are delivered, where they are delivered and support the amount scope and duration as they are needed. It improves the quality of services. It improves our ability to detect and avoid fraud waste and abuse. And it further supports our efforts to ensure that individuals who are living in the community have health and welfare needs met.

So all of these – all of these steps working together give us the opportunity to enhance Home and Community-Based Services, and we really do appreciate

all of the states working with us and those who work with the states either advocating directly. And the states who are advocating to CMS that address these issues, because without all of us working together the system itself does not benefit, improve and progress.

Melissa Harris: And George, it's shaping up to be kind of an iterative process that we issue guidance implementing the EVV provisions. I think we're looking to move some guidance that has a focus on funding availability for states as they are building their EVV systems. And then, we know we need to follow that up with some more in-depth Q&A on the more programmatic provisions of the legislative language.

And so, we are moving a couple of pieces of guidance and, you know, welcome any, you know, questions or suggestions on what that guidance should entail. But we're also cognizant of the fact that the statute requires as to have a letter to state Medicaid directors on best practices within the next six months. And then it's about 18 months until the provisions for Personal Care Services kick in. So, we're working as quickly as possible to get some good guidance on the street about that.

George Failla: Right. And I do want to emphasize, we have looked at Personal Care Services through the lens of self-direction and Agency Directed Services because there's both those aspects of delivery of Personal Care Services are very important to those that we served within the community. And we are certainly working with those – with both aspects of the rule in that regard. And we'll continue to do a similar outreaching information gathering and best practice identification where it relates to Home Healthcare Services as moving forward in that timeline as well.

Melissa Harris: So, I think Jill that we could open up for some Q&A. And I know we have about half of the time left. And I think that's fine to, you know, to hear what's on people's minds. To the extent, we don't have the answers to your questions, we will either, you know, try to find a way to circle back with you or we'll indicate that something is very much a work in progress at the agency level. But let's go ahead and open it up to some Q&A.

Operator: And to remind here ladies and gentlemen, if you would like to ask a question, please press star on your, star then one your telephone keypad. If you would like to withdraw your question, please press the pound key. Please limit your questions to one question and one follow-up to allow other participants time for questions.

If you require any further follow-up, you may press star one again to rejoin the queue. Your first question comes from the line of Kathy Carmody with the Institute on Public. Your line is open.

Kathy Carmody: Hi. Thank you. My question is being from a state that has not gotten their initial approval on the STP. I know you can't give a time frame but is there an ideal timeframe when CMS is hoping to resolve any outstanding issues and put states on the path moving forward. Thank you.

Melissa Harris: Now, that's largely a very state specific answer, you know, as George said, there are a lot of states who we would characterize as being a very close to having their initial approval. I think we're looking probably the majority of the remaining states as being in good shape to have initial approval within the next six months or so.

You know, without knowing the state that you're from and it's fine that we don't know the state that you're from. You know, that's – I say that is kind of a generality, you know. But by in large, we think that the remaining states are in good shape to at least to be on the right path to initial approval.

I will also say that we try to keep our website updated as quickly as we can with a lag of a couple of days in between issuing letters of the initial and final approvals to states and then uploading them online so everyone can keep track of what states have initial and final approval.

And again, is the [Medicaid.gov/HCBS](https://www.Medicaid.gov/HCBS) page. And then there's a link for Statewide Transition Plan. And so please do check back there periodically to see an update of how your specific state is doing and how states are doing in general. But I think, you know, with a couple of outliers as always tends to happen, you know, we think the majority of states in the next several months should be in relatively good shape.

George Failla: And we really do want to emphasize that it is – that it can be a state specific response time or there may be a specific aspect of their plan that the state is working on that may take a little more time to do it well. And I think that when Melissa mentioned the extension of time for compliance, that's really helping states to keep moving forward but also to be willing to make difficult decisions and really look hard at getting the work done well.

And I think it is noteworthy that of the four states that have final approval, they vary in size. So, there's – and the combination of factors. But again, among the 35 with initial approval that is small states, large states, rural states, you know, mountain states. We really have a lot of a good variance. And so I think we're starting to see how any state can address these issues.

And they are working together. And it is obvious from our review with states that they are looking at the work of other states and building off that with the unique aspects of their own states. So, I really think we're getting to a point where our progress is able to go more quickly because of the success of the prior states. And I absolutely agree with Melissa that we would expect to have, you know, more than 40 states probably, even sooner than six months.

And then, the remaining states have all submitted at least two versions of a Statewide Transition Plan that has gotten review and feedback and gone out for public comment in multiple levels. So it's all of the states are working with us to make progress which is whether or not they at each point can get to an initial or final approval. But that timing is well in play. And I absolutely agree within the next six months, we expect the great majority of states to be through the initial and even more than our present into final approval.

Operator: Your next question comes from the line of (Michelle Lovejoy) with Oregon Research. Your line is open.

(Michelle Lovejoy): Hi. This is (Michelle Lovejoy) from the Oregon Research Association. I had a question about the EVV. When you talked about the Personal Care Services for the first part of the implementation and this might be something that's very specific question. But does that apply to direct service

professionals or is that more just personal support workers, home healthcare aids, who does that apply to specifically?

Melissa Harris: That's a really good question. And we've heard a lot of questions about, you know, what exactly is the scope of services impacted by reference in the legislation of personal care and home healthcare services. That latter home healthcare services doesn't match neatly to a particular benefit package in the Medicaid Program. And so, we do have some guidance underway that will seek to start fleshing that out.

We're not trying to necessarily, you know, encompass as many different programs as possible under the label of personal care or home healthcare – home health – well of the acronym, home health care services. But we're trying to do our best to make sure that we and the states are focusing on the services that were in the mind of Congress as they were writing the 21st Century Cures Act.

So, I do expect there to be some guidance on the street in the next couple of weeks on that point. I don't necessarily want to get out ahead of it. But understand that you have a lot of company in asking that question. And we hope to have something a little more public soon.

George Failla: With the – again, the act does, as we're reading in at present does broadly impact both direct service professionals and agency based providers. And there's a – and certainly we read them. And we believe the statutes impacts both, those settings where individuals are directing their own services or being – or receiving services through an agency, base or traditional model and or some combination.

Personal Care Services certainly encompasses those aspects of the assistance with activities of daily living or instrumental activities of daily living that many people on our waivers or are receiving services through state plan authority do

And again, the requirements in general are we need to document the type of service being performed, the person who's receiving it, when that service

occurs the location of service delivery the individual who is providing that service and when the service begins and ends.

Again, there's a variety of flexibilities for states in their design systems. They may be able to develop their own system or use a system that I will describe as off the shelf. There may be – it may be a close system or a system that could be used to aggregate or gather data from multiple settings. Maybe a provider or managed care organization might have their own Electronic Visit Verification System that would address those required elements and it could be able to be aggregated.

But again, as states are working through those specific and tactful details, the responses may vary state by state. So that is important. The applicable Medicaid authority for Personal Care Service, do certainly include 1905(a) State Plan Personal Care benefits that's at section 24, 1915(c), home and community service waivers, 1915(i), home and community based service state plan amendment. Self-Directed Personal Care services under 1915(j) certainly any serves that are personal care in nature, that are delivered under community first choice option or 1915(k).

And also, those within 1115 or 1115 demonstrations as well, because we know a certain state may implement home and community based services with the broader, flexibility that may be available through 1115 demonstrations.

And then, certainly, applicable authority for Home Health Care Service and again that's – that will be up applicable in 2023, is that consistent with 1905(a) subsection 7 of the Social Security Act. And Personal Care Services broadly again. It's the state plan option or waivers or demonstrations. It can be those kinds of service like, you know, those ADLs like assistance with movement behaving, dressing using the restroom and other personal hygiene aspects.

And it also can address instrumental activity daily living certain types of, you know, preparation, many of your finance support and some of the others things. But again, some of the services are going to be defined individually by state based on the waiver or state plan authority and how they deliver those

services. So, it also has state based component. But broadly, it's within ADLs and IDLs and across all those authorities.

(Michelle Lovejoy): Thank you.

Operator: Your next question comes from the line of (Leah) (Inaudible) with State of Colorado. Your line is open.

(Leah): Hello. My question is whether CMS is planning to issue additional guidance regarding that application of the settings rule to the day settings. And if so, when could we expect about?

Melissa Harris: That's another really good question. And the short the answer is a qualified, yes. Qualified in that, we recognized that non-residential settings need some good practices and some good guidance on how they can best implement the regulation and something that we hear about quite frequently as something that would really help all of our stakeholders.

And so, we certainly acknowledge that it's been our intention for some time to have public guidance on the application of the (rule) to non-residential settings. And we are still working on that. You know, obviously, we need to, you know, go through our internal process to, you know, to make sure policy is sound. And, you know, it's goes to clearance process. I don't have any idea of a suggested timeframe. I think it's also fair to say that there's quite a variety of settings under the umbrella of non-residential.

You've got some settings that are geared for younger populations with the employment focus. You've got some settings that are geared for older adults with may be more of socialization aspect and then receipt of some primary or long-term medical services.

And so, recognizing that variation is pretty critical as we deliberate internally and with our state partners as to what really the right responsibility is for these settings to be facilitating the community integration principle that are found in the regulation.

So, I would not look for anything imminently, but we are – it is very much on radar screen that those conversations need to continue. We have, you know, had many internal conversations on that topic. We know we need to have more. We need to have conversations with our state partners and other stakeholders. And we do have an intention of continuing that conversation in the form of public sub regulatory guidance.

Operator: You next question come from the line (Terry Morgan) with that the State Medicaid. Your line is open.

(Terry Morgan): Hi. This is (Terry Morgan) with Virginia Medicaid. And I just wanted to, you know, first, you know, thanks for CMS for the wisdom of delaying the full transition period and just make – just a couple of brief comments. One of the things that we realized we're working really hard doing our self-assessment of setting to having providers complete the self-assessment and was about 3800 self-assessment when we really took a hard look at it, and the requirement that all of the self-assessments be validated which is very understandable.

The timeframe that it takes to actually do that, you know, we're looking at 12 to (16) months to really be able to a good job at validating our provider self-assessments. And the added time is really going to be helpful given, you know, the support we want to provide to providers and coming into compliance which is really one of our primary goals. So, I just wanted to say that, and also as we look for additional guidance from CMS, you know, we are really interested in additional guidance on residential settings for children, and applying the regulations to those settings. Thank you.

Melissa Harris: Thanks for that, (Terry), you know, I appreciate your support for the extension of three years. And your point on children is well taken, you know, that questions comes up every now and then, and certainly it is worthy of discussion. You know, you've got a lot of principles in the regulation that have nothing but common sense behind them as they are applied to adults, being able to come and go as they please, have access to food at any time, you know, things like that.

It does kind of raise some natural questions about the applicability of those requirements to children. You know who often need some of the boundaries and structure about where they go, with whom they associate, et cetera. And so, you know, we do tend to think that those kinds of natural boundaries that any parent would apply to a child certainly can be implemented within the context of this regulation without any kind of an explicit blessing of CMS or the states. I mean the goal is not to, you know, to carry implementation of the reg to such a degree that, you know, some pretty typical, you know, age normative boundaries cannot apply.

And so, we will take back the suggestion that we issue guidance on it. I think as general statement off the cuff today, you know, we would say that, you know, we certainly don't intend for the regulation to interfere with that type of boundaries that are in place in the lives of children. The way that they would be in their own homes, by their own families and, you know, we're happy to help, you know, flesh out how the rule would apply to children, you know, perhaps in a particular setting or if there is a specific question that's being generated about a particular elements of the settings criteria. We're happy to kind of pull that thread with you.

You know, but do generally – you know, reiterate the ability of those typical types of boundaries to be made without out running afoul of anything in the reg.

Operator: Your next question comes to (Lillian Juma) with American Health Care.
Your line is open.

(Lillian Juma): Hi. Thank you. Thank so much for having this open door forum on this topic. We really appreciate it. My question comes from concerns that we're hearing my association represents assisted living, many of which are Medicaid providers and the HCBS program. There's a lot of concerns around last year's planned construction guidance. And we're already starting to see some effects on that. I just wanted to get your feedback specifically as (A.L.) providers want to build new assisted living settings and they want to participate in Medicaid.

They may be doing memory care with secure egress or they may be co-located, and therefore considered presumed to be institutional. And they'll be impacted by this planned construction guidance, which from what we're seeing in a variety of states is creating a catch 22 where Medicaid provider has to be operational and occupied before it can be a Medicaid provider. Which creates a real challenge for assisted living Medicaid provider that they can't have – they can't be reimbursed for those Medicaid residents on day one.

So, they probably won't open their building admitting Medicaid residents. But they have to be operational and occupied to be approved. So, it's become unclear from a business plan perspective. How that would be operationalized and the more immediate almost crisis that we're starting to hear about is that for those long-term care providers that want to use HUD financing. HUD and other lenders as well are requiring that the state or CMS, there's some sort of certification that this setting will be an approved Medicaid provider, which obviously now they can't provide those assurances under the planned construction guidance.

And so, as a result, it's jeopardizing funding which I think it's going to result in reduced number of planned construction in the future, and could really impact access towards assisted living as the Home and Community based setting in the coming years. So, I wanted to get feedback. If there'll be additional guidance to how you're advising state to interpret guidance going forward.

Melissa Harris: Thanks for that and just to give a tiny bit of context for those who might not be familiar. CMS had issued some FAQs in 2016 I think, that were talking about the ability of the agency or more like the inability of the agency to make any kind of binding decision on whether a setting overcame an institutional presumption before individuals were actually receiving service there.

That set of FAQs was generated by a couple of real life examples that states had brought to us where they were newly implementing a setting that fell into any of those three categories of being presumed to have the characteristics of institution. And they wanted to submit the information to us for heightened scrutiny review as the building was either physically being constructed or

even before grounds have been broken. You know, based off blue prints and proposed design and implementation.

And the more we at CMS look at the information that was available to us at the time and how to determine if the setting was going to be operating in accordance with reg. We realized that it really was not feasible for us to do that before individuals were living particular – I mean in the sense of residential settings before individuals were living their or receiving services there.

If you look at the criteria of Home and Community base setting, many if not most of them are really geared towards the life experience of the beneficiary. Does the setting facilitate the individual being integrated into their community to the extent that they desire. Does the setting, you know, facilitate their access to employment services, et cetera. And it's really quite hard to make that determination when you are either just looking at blue prints or looking at proposed operational designs.

And so, we issued the set of FAQ that said, you know, to our state and funders and the providers to be aware that if a state was thinking about building new settings that would require heightened scrutiny review that the submission to CMS really should not come until individuals are receiving services there.

That understandably have kicked off a lot of real life implication that you heard (Lilly) describe. And so, you know, we do tend to hear – we do hear about them. And the thing that we can say in response to those is that we're happy to get on a phone with the state and whomever they would like to bring be it the developers, the funders of provider, and kind of walk through some ways that states can mitigate the risk of ending up with the setting that is not in compliance with the regulation.

We continue to not see how we can make a formal and final decision about whether a setting overcomes this institutional presumption before individuals are receiving services there. That doesn't necessarily mean that it has to be Medicaid beneficiaries receiving services there, particularly for assisted living that might have a broad reach across funders. It could be that there are non-

Medicaid beneficiaries living there. And those people, you know can be or the ability of those people to integrate with their communities, can be described for us in a way that sets the tone enough to understand how the setting would be complying with reg for Medicaid beneficiaries. But we understand that's not always going to be possible depending on the funders of individual who are receiving services in that setting.

It's also really important to make sure that we're all in the same page in determining that the setting really does need to come to CMS for heightened scrutiny. So it's also wise to have a conversation with us to talk about the specifics of the setting to make sure we're all agreed that it even meets any of the three scenarios that have a presumed institutional designation. It's possible that, you know, that based on the location of where the setting is going, it can avoid coming to CMS. No guarantees of that but we're, you know, we're happy to kind of walk through those implications.

I will also put in the plug for a set of FAQ's that we issued in the December of last year on memory care units on individuals with Alzheimer's and another forms of dementia and those that might be implementing wandering behavior. And we did provide some best practices, they're not requirements in any way but there are examples of how settings in operation today are implementing some really person centered ways of delivering services to people who might be in one of any number places on the spectrum of impairment with the dementia diagnosis.

And the FAQ's also clarified that, you know, settings with delayed egress are not prohibited under the regulation. And but also describe some ways that a one sizes fits all approach like having, having everyone who lives in a particular setting, have the same kinds of modification can be avoided. It goes to some – it goes to how nimble these settings can be when they assess each individual as to where they are and what kind of modifications might be appropriate for one person and not the other.

How individuals who don't for example need a delayed egress can be accommodated while the individuals who do need to have some extra precautions taken, you know, really do have those precautions implemented.

So, you know, this is a long winded answer and there's not really a way to say, we have thought of ways to, you know, to kind of wipe away any kind of implications of our planned construction guidance. It's more like an acknowledgment that we understand there are real life effects of it. And we are happy to jump on the phone with you to mitigate them to the extent possible

George Failla: And I think that the others aspects of the rule that Melissa referenced earlier in our call is that really strong person centered planning is also very important for any individual that may need any sort of restricted intervention, whether it's because of needs for dementia or traumatic brain injury or some other condition that (makes) someone more subject to wandering or other (exit) taking behavior or other aspects of their supports that, that need to be specifically address for that individual, I'm certainly demonstrating when you would use other interventions not as say restrictive as some sort of delayed egress or if you will, some sort of locked unit and how that impacted an individual.

And I know that you also reference concern about how to garner funding and support through our partners at Housing and Urban Development. And we've certainly been engaged in discussions with HUD and with individual states where circumstances arose, where there may have been concerns. So that we are able to sort of isolate the issue if it's possible and assist states in the best ways to address some. So that if – so that if it is possible, and it is again, a new setting, and I do want to emphasize that.

A new setting that would be subject to one of the areas with characteristic that would be presumed institutional, that we can work with the state and with our partners with HUD to try to come up with. Also, I suppose solution to allow for the states to move forward whatever approach, maybe best for them. So, I think that while there are some broad strokes that we have been able to do in some partnerships that we're able to make here at CMS.

I think it also does sometimes fall on the specific circumstances whether it's in-person on their planning for an individual or whether it's in the specific

state based on the specific new setting that might be appropriate. But we will continue to work with states and other partners to come to resolution where we can.

(Lillian Juma): Thank you. I really appreciate hearing that you guys understand some of that concern that's come up in the difficult spot with working through this issue. For those providers and financers, developers that do need to have this conversation, what's the way forward because I think in some states the response that they're getting is just – this is the guidance we – there's nothing that can be done for you. And so working through the state Medicaid office is not provided any relief. Is there an opportunity to come directly to CMS to talk about it with the state?

Melissa Harris: You know, on the one hand, I would say, you know that no one is ever prohibited from coming to CMS. And so that remains an avenue really for anyone. The practical reality though is, that if a state is not supportive of moving forward with a particular setting that CMS won't have any, you know, any recourse to effectuate a different decision. So we're happy to have a conversation with you, our gold standard is absolutely to have the state on the phone with us and those meetings. So everyone is hearing the same thing.

But do understand that the state really does need to be the one to say, I want to support this particular setting, I want to have Medicaid funding for services provided to Medicaid beneficiaries in that setting and be willing to, you know, to submit information on behalf of the setting to CMS. So if you are encountering some delays there or some uncertainty there, you know, that does need to be taken pretty seriously.

(Lillian Juma): Got it. Thank you very much. I really appreciate your time. Thanks.

Jill Darling: And (Tiffany), we'll take two more questions, please.

Operator: Your next question comes from line of (Cathy Cubit) from (Caring). Your line is open.

(Cathy Cubit): Hi, thank you very much for your commitment to implementing this very important rule. I have a question about the heightened scrutiny process and

that is, if a provider's successful in getting through that process, is that a permanent decision, will it vary among on each provider, in decision in terms of the timeframe for approval. And to follow up on that, if the stakeholders find that there providers out of compliance, I know we can go to the state but is there also an opportunity to report problems to CMS? Thank you.

Melissa Harris: Thanks for that. So, the first question is, about the kind of permanency of a determination of heightened scrutiny. And you know, I would say that the – let's assume that CMS has looked at the information submitted by the state. And so, yes we agree with the state that the institutional presumption is overcome. That determination would stand unless, something happens to really impact the specifics of what we approve, like if all of the sudden, the states, the setting starts delivering services in a different way that is not in compliance with the information that CMS reviewed.

That would kind of call into questions, that the ongoing applicability of this – the CMS initial determination that the institutional presumption was overcome. But by and large we're assuming that unless something really happens in which the setting changes course, the determination would stand. The state is also going to be doing some on going monitoring, you know, to make sure that any setting, including those that are submitted to CMS for heightened scrutiny really kind of stays the course on a permanent basis after the end of the transition period and maintains fidelity to the home and community based setting requirements.

So, in that regard, you know, the state will be, you know, kind of over seeing how the setting maintains compliance and nothing would happen to bring that setting back to CMS for another review unless something really happen to change the way that the services were being provided on the ground.

George Failla: Another way that that the public might be involved in sharing information, is when each waiver goes to its renewal process, there is public notice on the waiver itself and the settings and the services that are delivered under each waiver. And that's another opportunity if there are any concerns about the services over the setting where those services are delivered, that that

information could be part of the public notice process, get to the state and then by extension also to CMS in the process of our work.

So there's a number of ways. And certainly, we would maintain our broad authority over any of delivery of services so that if there were concern, they could still be address through all the typical channels you might bring concerns, either to the state or directly to CMS.

Melissa Harris: You'll also find on the [medicaid.gov/hcbs](https://www.medicaid.gov/hcbs) website mailbox link that would take you directly to CMS where you can, you know, kind of communicate, you know, anything that you want us to be aware of directly. In a certainly, your best option is to always, you know, have the states, you know, here any concerns or suggestions you might have but that resource is available for a direct communication link to CMS.

Operator: Your last question comes from a line in Bonnie-Jean Brook with OHI. Your line is open.

Bonnie-Jean Brook: Good afternoon, this is Bonnie, I'm from Maine. And I wonder if you could give any direction, if you are from a state that has not had any sort of approval yet for the transition plan, and you're not able to find out from your state what the status is of the assessment process? We haven't had assessments, we don't know anything about the assessment and we can't find out. We're worried that we won't have enough time if we don't begin to have some action soon on these assessments since we're such rural state.

Thank you for any suggestion you could give and I really appreciate the opportunity that this afternoon has presented.

Melissa Harris: Sure, thanks. You know, of the top of my head, I would say that you can at least – you should at least be able to find the latest version of the state, statewide transition plan on a website in the state of Maine. And if you're having trouble doing that, you know, you can get in touch with us and we'll – we can follow up more on that point directly.

So what the statewide transition plan should at least have is a rough idea of when the assessments will be done. Certainly, it sounds like you have not

been contacted yet. So its worth, you know, following up with your contacts at either the Medicaid office or if you are a provider that serves a particular population such as individuals with the developmental disability, individuals with the mental illness. There are often operating agencies at the state level that oversees programs for specific population, you might also inquire of them, what the status is. But if you're having some more systemic difficulty then we're happy to have that conversation with you offline.

Bonnie-Jean Brook: Thanks...

(Crosstalk)

George Failla: Thanks. And I don't have in front of me but a number of the statewide transition plans are available on medicaid.gov/hcbs. If Maine is not there, you can certainly just contact that there's a direct website for HCBC or mailbox or inquiries by e-mail, just reach out to hcbs@cms.gov. I don't have – I apologize, I don't have the direct address but it's available to you on our website.

And I know that it's monitored by a members of our statewide transition team and we'll be able to get some additional information here if it's not – if the plan itself is not directly available on our website.

I do know that we have worked with Maine and they had made multiple submissions and we've provided them feedback. They are not yet at a point where we're at either initial or final approval but they are – they are certainly still working with us.

Bonnie-Jean Brook: Thank you.

Jill Darling: All right. Well, thank you everyone for joining today's call. If you were unable to get you question through, we do have the Long-Term Services and Support Open Door Forum, e-mail on today's agenda. So please feel free to send your question into that. Thank you all and have a wonderful day.

Operator: Thank your for participating in today's Long-Term Care Service and Supports Open Door Forum conference call.

This call will be available for replay beginning today at 5:00 p.m. Eastern Time, through midnight on August 17. The conference I.D. number to replay is 60583452, the number to dial for the replay is 855-859-2056.

This concludes today's conference call. You may now disconnect.

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