Centers for Medicare & Medicaid Services
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Adrienne Delozier: Well, hello, everyone. I think we're going to go ahead and get started. Good afternoon or good morning, depending on where you are. My name is Adrienne Delozier, and I'm in the Medicaid Benefits and Health Programs Group within the Center for Medicaid and State Operations and CHIP operations. Welcome to today's training session, which is part of our special training series focused on the Home and Community-based Services (HCBS) provisions of the Medicaid Access Rule. This training will focus on incident management systems and critical incident reporting provisions. Before we begin our agenda, I have a few announcements. For those who need closed captioning, a link has been provided in the chat function of the webinar. This webinar is being recorded. The recording, transcript, and slides will be available on a designated page for this training series on Medicaid.gov. That page will be launching soon, and we will get the link out once it is live on the site.

If you member of the press, please refrain from asking questions during the webinar. If you do have any questions, please email press@cms.hhs.gov. Please note that all participants are muted upon entry. For today's training, we will be displaying a series of slides throughout the call. At the end of the agenda today, we will be posing a series of discussion questions and soliciting feedback from participants. At that time, we encourage you to provide feedback however you feel most comfortable. You may take comments or feedback into the Q&A box, or you may raise your hand using the button at the bottom of your screen, and we will unmute individual lines. When the moderator says your name, please unmute yourself on your end and provide your feedback. We will do our best to get to each person, but with over a thousand participants, we may not have adequate time to hear from each person who raises their hand. If we do not get to you, please consider entering your comments into the Q&A, which we will review after the call. Also, please limit your feedback to the topics and questions presented on this training session. If you have any additional comments or questions on this topic or any HCBS Access Rule provisions, you can submit them at any time to the HCBS mailbox at hcbsaccessrule@cms.hhs.gov. I will now turn the call over to Alissa Deboy, the Director of the Medicaid Benefits and Health Programs Group, who will provide some opening comments.

Alissa Deboy: Thank you very much, Adrienne, and good afternoon, everyone, and welcome to our inaugural HCBS Access Rule Training. CMS has established this new training series to focus on several key provisions of the *Ensuring Access to Medicaid* final rule to ensure that all fully understand the various HCBS provisions within the rule and have an opportunity to ask questions and provide feedback on the implementation of the new rule. Today's training will focus on the Incident Management System and critical incident reporting requirements in the Access Final

Rule. CMS and states share collective responsibility in protecting Medicaid HCBS beneficiaries from incidents that harm or place a beneficiary at risk of harm. This means establishing effective incident management systems that reliably identify, report, triage, investigate, resolve, track, and trend critical incidents. This is why CMS included standardized requirements for incident management systems and minimum performance criteria for critical incident reporting in the Access Final Rule.

During today's session, we will provide an overview of these requirements and then open up the floor for discussion with you all. Your feedback will help shape future guidance as CMS works with states and its partners on implementing this vital Access rule provision. We strongly believe that these requirements support protecting the health and welfare of individuals receiving Medicaid HCBS, and we thank you again for your attendance and participation during today's session. So, with that, I will hand it over to Ryan Shannahan, Deputy Director at the Division of Long-Term Services and Supports, to begin walking you through the requirements for incident management in the Access Rule. Thank you very much.

Ryan Shannahan: Thanks so much, Alissa. We can go to the next slide, please. So, in April 2024, CMS issued two significant rules with the goal of strengthening access to coverage and care and improving the quality of care in an effort to ultimately improve health outcomes for Medicaid beneficiaries across the country. Those were the *Ensuring Access to Medicaid Services* final rule, which we refer to as the Access final rule, and the *Managed Care Access Finance and Quality Managed Care* final rule. And really, they established new standards and rules intended to increase transparency and accountability to standardized data and monitoring and create opportunities for engagement across both managed care plans and fee-for-service programs.

The Managed Care final rule included such requirements as maximum standards for appointment wait times, secret shopper surveys to understand the beneficiary experience, annual experience surveys, and establishing a quality rating system to allow enrollees to compare plans. Meanwhile, the Access rule, which has applicability across fee-for-service and managed care, including the home and community-based services authorities, created new rate transparency requirements as well as strengthened the state's use of Medicaid Advisory Committees. It also established new requirements for HCBS oversight, monitoring, quality assurance, and payment adequacy. And that's really what we're going to dig into today, is a specific provision included in these HCBS requirements focused on incident management. So, if we could please go to the next slide.

So here is an overview of the HCBS specific provisions in the Access rule, and among those we included oversight of person-centered service planning, as well as grievance systems and requirements that a percentage of payments for certain home community’s services be spent on compensation for direct care workers. We're also requiring states report on waiting list and waiver programs and service delivery timeliness, as well as a standardized set of HCBS quality measures and public transparency requirements related to the administration of Medicaid covered services. And what you'll see highlighted here is the focus of our discussion today. We are requiring states to meet nationwide incident management system standards for monitoring HCBS programs. Next slide, please.

So, here we have the regulatory citations that were created along with the Access rule to implement the provisions specific to incident management systems. The major takeaway from this slide is just to emphasize that the incident management requirements apply to programs established under 1915(c), 1915(i), 1915(j), and 1915(k) programs, as well as any 1115 demonstration programs that deliver home and community-based services. Next slide, please.

So, here we'll discuss the implementation timelines for the key provisions in the Access rule. I think specific to today's conversation, the incident management system requirements will go live in 2027. That's when states will be required to meet the provisions in the Access rule specific to incident management, as well as start reporting critical incident data to CMS. In 2029, that's when the provision specific to the electronic incident management system requirement applies. I think we can go to the next slide, please.

OK. So, these next three slides, I'm going to walk through the specific provisions of the rule regarding incident management. And I think one thing that I want to highlight is that these weren't invented whole cloth. These were the result of intensive work with states over many years in which we conducted a nationwide survey to assess states' incident management systems to identify strengths and challenges and any gaps and to identify promising practices and approaches that we could consider incorporating into standardized criteria for states. And some of that work was also hinged on investigations from the OIG (The Office of Inspector General) and GAO (Government Accountability Office) into home and community-based services programs. So, we base these criteria on extensive experience and consultation with states over the years.

So with that, the first key provision is that the Access rule requires that states establish a minimum definition for critical incidents, and that would include verbal, physical, sexual, psychological, or emotional abuse, neglect, exploitation, including financial exploitation, misuse or unauthorized use of restrictive interventions or seclusion, a medication error resulting in a telephone call to or consultation with a poison control center or an emergency department visit, or an urgent care visit or hospitalization or death, as well as an unexplained or unanticipated death including but not limited to death caused by abuse or neglect. The next requirement – and that requirement kicks into place in 2027.

The next requirement is specific to the electronic incident management system, that atates are required to develop an electronic incident management system that identifies, reports, triages, investigates, resolves, tracks, and trends critical incidents. And that's that provision that states must implement by 2029. Next slide, please. Also, taking place in 2027 is a requirement that providers report to the state within state-established time frames and procedures any critical incident that occurs during the delivery of services or as a result of the failure to deliver services. And that second piece is to identify those incidents that may have occurred because, for example, a personal care attendant did not arrive at the house to provide services to assist somebody with activities of daily living in which an incident occurred. So, in that case, it would be a failure of the service delivery that may have resulted in harm to the participant. And that's what we're trying to capture there, as well as those incidents that occur throughout the course of service delivery.

The rule also requires that states use other data sources, like Medicaid fraud control units, Child and Adult Protective Services data, law enforcement data, etc., to the extent that is allowable under state law to identify critical incidents that are unreported by providers and occur during the delivery of services or as a result of the failure to deliver services. So, that is meant to capture those incidents that have gone unreported to the greatest extent possible and understanding that the incident data is only as good as what is ultimately reported to the state. And not all data, not all incidents are reported, so this establishes a requirement for working out with other state entities to obtain that data to the greatest extent possible. Next, the Access rule requires that states ensure there is information sharing about the status and resolution of investigations between the state and the entities responsible for investigating critical incidents if the state refers critical incidents to those other entities for investigation. Next slide, please.

All right, final three requirements are that states are going to be required to separately investigate critical incidents if the investigative agency fails to report the resolution of an investigation within state-specified time frames. States are also going to be expected to report requirements – to report through critical incident data and meet a 90% minimum performance threshold across three reporting metrics, including whether the critical incident investigation was initiated within state-specified time frames, whether the critical incidents are investigated and resolved within the state time frames and finally, whether the corrective actions related to the critical incidents were completed. So again, the states will be held to a 90% minimum performance threshold for those three measures. Finally, states will be required to submit an incident management system assessment every 24 months to indicate how they are meeting all of the requirements that we just discussed. And that time frame may be reduced to every 60 months if the state does demonstrate that they meet all of those incident management systems requirements, and those provisions also take place in 2027. Next slide, please.

So, we wanted to highlight some takeaways from the preamble that weren't specifically addressed in the regulation itself but to help us answer some of the more frequently received questions we've been getting. So, for example, we want to highlight that the minimum definition is just that—it's the federal minimum definition, but states can expand on that as needed for their own purposes, for their own goals, for their HCBS programs. If there are specific populations that tracking an additional type of incidents may be worthwhile for the state, there's no reason they would not be able to do that. Just when it comes to reporting to CMS, the incidents that were included in that minimum definition standards are the ones that should be captured, and CMS does not intend to necessarily require specific sub definitions of those types of incidents. So, there is some flexibility there for states to further refine the definition. However, we do intend to provide guidance on recommended or promising practices for those incident management types. So, we also want to emphasize that we've received a question about whether self-neglect should be included in the minimum definition, as CMS does not intend to fold that into the minimum definition. However, just like with anything else, states could include those in their own definitions. Next slide, please.

The Access rule preamble also discusses dual eligibles, and in the preamble, we clarified that the incident management system requirements will apply to sections 1915(c), (i), (j), and (k) services delivered through managed care plans, and that dually eligible beneficiaries enrolled in managed care plans and highly integrated dual eligible special needs plans are subject to the incident

management requirements, and we do intend to provide additional technical assistance there as well. And finally, as it relates to fair overlap with the grievance systems requirements, we do certainly recognize that some states may want to integrate those systems, particularly if grievances do result in a critical incident or if someone has a complaint that is tied to a critical incident. We're not requiring that states integrate those systems, but again, they have flexibility to do so if it makes sense for their system. Next slide, please.

So here we wanted to pose our questions for discussion. We have two slides of questions, so we'll go ahead and start with the four we have here, and I'll just read through them.

Adrienne Delozier: Actually, Ryan, I think we have at least one kind of technical question about your presentation. So, I was hoping we could maybe take a couple of minutes to see if there's any technical questions on the presentation. And then, yes, we want to move into posing some questions where we're looking for some feedback from our participants. But the one question we have in the Q&A at the moment is for the requirement regarding providers reporting critical incidents which occur as a result of the failure to deliver services. Are critical incidents in this instance still the following: abuse, neglect, extortion, death, and medication error?

Ryan Shannahan: Yes.

Adrienne Delozier: OK. So, let's take, I think, just a couple of minutes. If anyone would like to ask any technical questions on what has been presented, you can either raise your hand and we can call on folks and have them unmute their lines, or you're free to put them in the Q&A.

Karen Mohr: You have a raised hand from Barbara Recknagel; you are able to unmute and ask your question.

Barbara Recknagel: I'm sorry. I did not mean to raise my hand. I apologize. I don't have a question.

Karen Mohr: No worries. Thank you.

Barbara Recknagel: I'm trying to put it down.

Adrienne Delozier: So, we do have another question in the Q&A box, which is: Are managed care plans also required to report critical incidents, or only providers?

Ryan Shannahan: Managed care plans would be expected to report critical incidents.

Adrienne Delozier: OK. We don't have any other questions in the Q&A and no raised hands at the moment. Oh, one more question. Oh, a few more. So, we are a social day center, have so many denials for requests for services violating the Access rule. Who can help us?

Ryan Shannahan: So, we would certainly recommend you reach out to your state Medicaid agency, and if you would like to reach out to CMS for questions regarding the Access rule, we do have an email that is for general questions, and that's hcbsaccessrule@cms.hhs.gov. So, you're

welcome to submit some questions there as well. But yeah, in the interim, given that there's so much flexibility in how these provisions will be implemented by states, we think that your state Medicaid agency would be a great place to start. But again, if you have questions with any regulatory criteria, then yeah, please feel free to reach out to us.

Adrienne Delozier: OK. Will there be additional guidance on how to deal with incidents such as psychological, where verbal or emotional abuse is a part of the incident?

Ryan Shannahan: So again, I think we will release some examples of how states have defined that specific subtype of incident. Again, we'll not necessarily be requiring it, but we do have lessons learned that can draw from the 2019 incident management survey that we conducted. And we do intend to flesh out some additional guidance regarding some of the commonly used approaches from states and how they've defined these types of incidents, including for psychological harm.

Adrienne Delozier: All right. So, what about services not delivered through MCOs (managed care organizations)? Is the incident reporting requirement the same?

Ryan Shannahan: Sorry, one more time.

Adrienne Delozier: For services not delivered through MCOs, are the incident reporting requirements the same?

Ryan Shannahan: Yes. Yes. Applies across managed care and fee-for-service populations.

Adrienne Delozier: OK. And then, will there be sub-regulatory guidance coming from CMS, and if so, when?

Ryan Shannahan: So, timeline on that could vary. We are looking at next year and releasing some additional guidance, and I think you're certainly welcome to go ahead and email us at that HCBS Access rule email address, and we can keep reprising of any guidance that will be coming out. But yeah, that's something that we are actively working on with states and stakeholders, and part of the reason for today's listening session as well is to learn what kind of guidance would be helpful and kind of providing additional clarity on provisions of the Access rule. So yeah, your feedback here, what specifically might be helpful as you work to implement these provisions, would be really appreciated by us here at CMS, and we again, it is our intent to release further sub-regulatory guidance on these provisions.

Adrienne Delozier: All right. So, we have a couple of raised hands that we can take questions. Can we go to those, please?

Karen Mohr: Dee, you are able to unmute and ask your question. Dee Decimus?

Dee Decimus Holmes: Yeah, sorry, I couldn't. I was like, I don't have an unmute button, but then it popped up to me. I provide service. I have a QSP (Qualified Service Provider) agency. We do not have any ICF (Intermediate Care Facilities) homes. And then I also provide services on the

DD (developmental disabilities) side, and we don't have any homes there that are licensed. Does this still pertain to us?

Ryan Shannahan: It would depend on if you are delivering services through any of the authorities that are implicated in the Access rules. So, if you were a 1915(c), 1915(i), 1915(j), or 1915(k) provider, or an 1115 home and community-based services provider, then it could apply. If you have questions about that, we would encourage you to reach out to your state Medicaid agency. They'll probably be able to let you know which authorities that, which Medicaid authorities I should say, you would be implicating.

Dee Decimus Holmes: OK. OK, perfect. Thank you so much.

Ryan Shannahan: And while we're waiting for the next question, I think I heard in one of the questions that extortion was mentioned, but extortion is not included, it's exploitation. So, I just wanted to clarify that.

Karen Mohr: OK. Kimberly Custer, you may unmute and ask your question.

Kimberly Custer: I don't have a question. Thank you, though.

Adrienne Delozier: All right, so another question that we will take from the Q&A box: Will there be a standard definition or guidance on reporting incidents that are a result of failure to deliver services? Or can you provide an example?

Ryan Shannahan: Yeah, I mean, I think an example could be, again, a personal care assistant who was a no-show for an appointment to meet with somebody to let's say help them with their toileting needs for the day. And if that didn't occur, that could trigger – it could cross a threshold for a critical incident of neglect. So that could be like the case manager discovers that the person hasn't been seen by their personal care assistant, and they alert the provider agency that this occurred, and then that would generate a critical incident report potentially. We're not going to necessarily require anything beyond what is already published in the rule, but again, we will work with states to identify those best approaches and strategies for identifying those types of incidents as they occur.

Adrienne Delozier: OK. So, we will keep note of the open questions that we have not had a chance to answer, and we may be able to circle back to them towards the end of the call, but we do want to take some time to actually get some feedback from our participants. And please feel free to reach out to the mailbox if your question is not answered today, and that mailbox is in the chat if you want to take a look and make sure everything's spelled correctly. So, Ryan, do you want to go through our first set of discussion questions? Then, we can open it up to raised hands, or if folks are more comfortable, they can also provide their feedback in the Q&A box, which we will get a record of and be able to take your feedback into account.

Ryan Shannahan: Yeah. So, to kick us off, we've already gotten a few questions pertaining to this, so that's great, about asking what additional information or clarification do you need from CMS to define specific types of critical incidents? We know that these are kind of broad

categories of incidents. Next is what major changes or enhancements do you think your state would need to make to its existing incident management systems in order to meet the Access rule requirements? Understanding that states, particularly for 1915(c) programs, will already have incident management systems in place. However, states might need to refine those to fold in the other authorities to meet the baseline requirements in the Access rule. So yeah, I just want to get you all thinking about what some of those changes might be and how CMS can help with that.

And that leads into our next question, which is what resources do you think you will need from CMS for your state to develop, operate, and maintain compliant electronic incident management system? And finally, what are the steps states will have to take to implement these requirements? So, given that we're a few months into the publication of the Access rule, what steps have you already taken? What are your immediate next steps? And finally, what are your long-term milestones that you'll be looking to achieve as you work towards that 2027 and later 2029 implementation date? So, happy to hear from anyone who wants to speak to any of these. I think your feedback will be really helpful. So, we're here to listen. Yeah.

Adrienne, you're on mute.

Adrienne Delozier: I'm talking away. So, first of all, do we have any raised hands?

Karen Mohr: Yes, we do. Robert, you may unmute and ask your question. Robert Bryant. I see that you're unmuted. Oh, OK. Thank you. Leslie, you may unmute and ask your question.

Leslie Fuld: Sorry, took a moment to unmute.

Karen Mohr: No problem.

Leslie Fuld: I have a question about psychological abuse, and I just want to go back to that once more and make it clear really what I find confusing about it, just so you guys are able to give us really helpful guidance. New York State has psychological abuse, and oftentimes, things such as verbal abuse or emotional abuse, or both, might be part and parcel of psychological abuse. So, my question is really kind of will these be like separate and distinct categories, or will we have to report on incidents where those are pieces of the incident? I'm just trying to figure out what we're going to have to do with our regulations to meet the requirements.

Ryan Shannahan: I think that's definitely a helpful nuance to understand. So, I think we can look to include that in future guidance. I think that's a really helpful point for us to consider as we develop that. So yeah, we really appreciate it. I don't know if I have a specific answer now, but we will definitely take that into consideration.

Leslie Fuld: Thank you.

Karen Mohr: April, you are able to unmute and ask your question.

April Goebel: Hi, thank you. Can you hear me?

Karen Mohr: Yes.

April Goebel: OK. I'm in West Virginia, and we have what I consider a very, very good incident management system. I'm very happy with it, but one of the things that I think we would need guidance on is CMS' expectation as far as substantiation of abuse, neglect, and exploitation reports. Our system does a great job of separating out abuse, neglect, versus other types of critical incidents. But as far as, and we even have the capability to, once the report is made to protective services, to grab the reference number for the report from them, put that into our incident management system. But coming back around to whether or not the protective services organizations have substantiated the incident is kind of, I think we frankly need to do better with that. So, I think it would be really helpful to, first of all, maybe get some examples on how other states are managing to do that and then, of course, what CMS' guidance and expectations would be on that.

Ryan Shannahan: Sure. Got it. Yeah, and I think, yeah, that's definitely going to be critical to tease out the reporting aspects of these substantiated versus unsubstantiated incidents. So yeah, definitely something we'll keep in mind. So, appreciate the question. Yeah.

April Goebel: Thank you. That would be great.

Karen Mohr: OK, Mary, you may unmute and ask your question.

Mary Brogan: Thank you. This is Mary Brogan from Hawaii. These are very good questions that you've posted in terms of what resources are needed, what major changes or enhancements we will have to do. I think the challenge is to be able to define all the requirements that we'll need in order to start the enhancements. And it looks like some of them are defined, like what type of – things define a critical incident, but these other things, like your response to result of failure to deliver services and no show for an appointment, make me think about a whole other use case that if we could automate that data collection is going to be a big build for us. So, I think defining all the requirements and use cases, helping the states to do that before we start to make the enhancements as much as possible. Because even things like the data sharing agreements with other agencies, being able to capture data in other systems, all of that is a little bit vague and there's examples, but can it be from a Medicaid claims data system like unreported events, or does it have to be from an adult protective service or child protective service? So, I think that there's so many requirements and details that states to be allowed to work with you to get as many of those finite user cases and definitions as possible because 2027 is right around the corner. Thank you.

Ryan Shannahan: Good comment.

Karen Mohr: All right, Bobbi, you may unmute and ask your question.

Bobbi Garber: Hi, this is Bobbi Jo. I want to reiterate a little bit of what the previous caller was saying, but in a state, basically, my question is, in a state where the Medicaid agency overall has operating agencies, and we have multiple incident management systems per se, like having an expectation from CMS of who the ultimate, if it's still OK for the operating agencies, if there are

multiples of them, to funnel up the reports through the state Medicaid agency. So, in other words, we're trying to work through and make decisions about the type of system we're going to have when we have mostly a critical incident management system, but there's some tweaking that has to be done, making – it's difficult for a state to make a decision in a timely manner anyway to ask for funds, etc., not knowing some of these definitions. So, I guess I'm reiterating a little bit of what the previous caller said, but also wondering what CMS' expectation is for the Medicaid agency as a whole to own the system. Or is it acceptable for the bifurcated operating agencies to have more than one incident management system as long as all of the definitions are being met by both and it's funneled to the Medicaid agency?

Ryan Shannahan: So, both approaches would be acceptable because the Access rule does not require that a state establish a single incident management system. However, the preamble does recommend that states consider doing so. So, that might be helpful language for you to take a look at. And that is partially because the state is going to be expected to obtain that data from the various operating agencies/incident management systems for the purpose of creating a centralized reporting process for the incident management system as a whole for that assessment that's due every 24 months as well as the critical incident reporting data that's required to meet that 90% threshold. But again, the state does have some flexibility there. I think a similar analog, if you're familiar with electronic, there's verification requirements. Some states choose to implement one system across their state, while others have different EDU vendors to meet the requirement, and then the state pulls that data. So yeah, it's really up to the state in some regards. We do think as a recommendation CMS included in the preamble that a single statewide system might be the preferred approach just in terms of ease of reporting, but again, it's state flexibility. We certainly keep those nuances in mind as well.

Karen Mohr: OK. Michael, you may unmute and ask your question.

Michael Lawler: My question was answered. Thank you.

Karen Mohr: All right, thank you very much. And we don't have any additional raised hands at this time.

Adrienne Delozier: Hey, we have one more slide with some additional questions for discussion. We can go through those and see if we get some more raised hands, and then, if not, we can circle back into some of the Q&A.

Ryan Shannahan: Yeah, so to walk through these, you know, want to get the state's perspective on how they plan to facilitate coordination with multiple entities like Child and Adult Protective Services to ensure that you're getting reliable incident data, and those incidents are being reported. What challenges do you anticipate regarding collecting information on the statuses and outcomes of investigations? Which I think we touched on a little bit. What additional information or clarification do you need from CMS to be able to meet the minimum performance level? So that could be your questions about data collection and reporting, for example. As we've mentioned, the incident management system and reporting requirements apply across fee-for-service and managed care authorities and incorporate 1915(c), 1915(i), (j), and (k), as well as 1115. Some of these authorities did not previously require incident management systems, so this

could be a new requirement for those populations. So, how do you plan on consolidating data across those authorities in order to meet the reporting requirements and folding in programs that were not previously required into your critical incident reporting procedures? So yes, interested in state feedback, questions, or basically just any initial thoughts that you might have regarding these as well.

Adrienne Delozier: Ryan, while we wait to let a couple of folks get into the queue and raise their hands, I think there are a couple of clarifying questions in the Q&A box that might be helpful. The first is: Is this a correct understanding? States will build their incident reporting systems, and providers will report this within this system. States will then report back to CMS, not the individual providers, correct?

Ryan Shannahan: Correct, yes.

Karen Mohr: We do have one hand raised. Musa. You may unmute and ask your question.

Musa Camara: Could you hear me?

Karen Mohr: Yes, we hear you now.

Musa Camara: Yeah. Thank you so much. My question is regarding the critical incident. Initially, if there's an incident that is reported to the state and it's required to do an investigation and close the case, and do resolution within the time frame that is specified to resolve those cases. But if that does not happen, then the state is required to do an investigation of why that was not done. So, can the single Medicaid agency delegate that responsibility to another entity within it to do that investigation? Or does it have to do it itself?

Ryan Shannahan: I think there is some flexibility there in how the state will approach that. Yeah, those specific outcomes. Certainly, you would want to have an understanding about why an investigation may have not occurred in the state specified time frame so that you could prevent that instance from happening again and provide any necessary training that you might need to provide as well as issuing any potential corrective action plan. So, I think it would be a process to have in place if you don't already have one. So yeah. But as far as the Access rule requirements, I think there is flexibility there.

Musa Camara: Could you hear me?

Karen Mohr: Yes, we hear you now.

Musa Camara: Yeah. Thank you. So, the other question I have is that the rule is about a thousand pages long. Do you guys have a clean-cut, simple without all the comments? Just the rules, as it is somewhere that we can pick up to read.

Ryan Shannahan: So, I think, I'm trying to think, I don't know if we can, if you'd like to email us, we can maybe send you kind of a just listing of the regulations that are included in the rule. I think there are a few tables in the Access rule preamble itself that summarize the criteria. I don't

know if Jen's still in, if you have any thoughts on that question, or if we've provided anything to date that we can easily pull, but I think it's a good question.

Jennifer Bowdoin: I think it depends on specifically what you're looking for. I think the regulatory text, which is towards the end of the rule, I mean that lists everything that is codified in the regs that we included for the HCBS provisions. There isn't a simple form at this point of everything we said in the preamble, all the clarifications, and things like that. But we can take that back and see what additional info we can provide. You're always welcome to email us at hcbsaccessrule@cms.hhs.gov if you need clarification on something. And we do have this slide deck, which will be publicly posted. We have presented the requirements and the rule in other places. So, the slide decks provide some, I think, helpful summaries of what's included in the requirements, too.

Musa Camara: OK, thank you.

Ryan Shannahan: Thanks, Jen. Appreciate it.

Karen Mohr: You may unmute and ask your question.

Stacey Didato: Hi, thank you very much. I appreciate that. It goes in line a little bit with the other question, I think, with trying to find out information about how things are being done across different states. My feedback is specific to the required timelines. If I'm understanding, are defined by each state itself, each state will define its required timelines regarding the critical incident reporting, investigating, and feedback. But if each state does define themselves, you're going to have a difference in that. And the 90% requirement for one state, they may have a specific timeline that's, say, longer than another state. They may meet that criteria easier one than the other. So, I'm wondering if there'll be some kind of information sharing on that as well. I'd be interested to see kind of across the board what the timelines requirements are across the states.

Ryan Shannahan: Yeah, I think that is something that we'll certainly incorporate into our sub-regulatory guidance. Also Medicaid.gov on the HCBS training page does have the results of the – summarized results of the 2019 incident management survey, which includes some of that data on what is the turnaround time for investigating a critical incident. Most states wouldn't say it's—or responding to a critical incident—most states would say it's 24 hours, something like that. So, I think we do have some of those lessons learned already available for you to take a look at, and we're certainly going to be taking the results of that survey, as well as some updated information from states and additional stakeholder feedback, into any additional guidance. But I think the trainings that we have on Medicaid.gov on the incident management survey would be a great place to start digging into some of that information.

Stacey Didato: Thank you.

Karen Mohr: There are no additional raised hands at this time.

Adrienne Delozier: Okay, we want to give folks a couple more minutes to see if they have some additional comments to share. We have a couple, I think, additional just kind of clarifying

questions, Ryan, that we could maybe go through. Can you please repeat the entities that the rules apply to?

Ryan Shannahan: Yep. They are here on the screen. So, it is the fee-for-service and managed care again applies across both fee-for-service and managed care for service beneficiaries across 1915(c), 1915(i), 1915(j), 1915(k), and 1115 demonstration authorities that include home and community-based services. So, any providers of those services would be expected to adhere to the reporting requirements. The state's critical incident management system would be expected to account for the services included within those authorities, and the critical incident reporting data that ultimately gets reported to CMS would be expected to be reflective across the population included in those authorities.

Adrienne Delozier: Okay. Will providers report incidents both to the critical incident system and Adult Protective Services, or will those systems link?

Ryan Shannahan: So, I think it'll depend on the state's requirements. Certainly, in order to reduce provider burden, you would want to have a one-stop shop for critical incident reporting. A centralized reporting system that enables a provider to submit it once, and then it gets triaged and sent to the appropriate entity from there, or it could get sent to the adult protective services first, and then if it's a participant that's receiving services and any of those Medicaid authorities, then the state Medicaid agency gets alerted to that as well so that they can capture it in their data. So certainly, as working with states on implementing that electronic provision of this rule, I think reducing provider burden will be a critical element of that, and it's something that we can also think about in potential guidance. So yeah, it's good nuanced.

Adrienne Delozier: Do we have any raised hands?

Musa Camara: Hi Adrienne. It is me, Musa, again. I was just wondering if there's somebody who is from West Virginia and do like their system. I was wondering if I can exchange information with her to learn what the system does and how that could help us in our state.

April Goebel: Hi, Musa. This is April Goebel with the state of West Virginia. I'd be happy to help you out and answer any questions that you might have. I'll put my email address in the chat, and then maybe we can talk that way.

Musa Camara: Thank you so much, I appreciate it.

April Goebel: Oh, you're welcome. I look forward to hearing from you.

Karen Mohr: I'm sorry, the chat is not open for this event. I don't know if you want to contact one of our organizers.

Jennifer Bowdoin: If you want to email hcbsaccessrule@cms.hhs.gov. If both of you could email us, we will connect the two of you.

April Goebel: Thank you.

Musa Camara: Thank you, April.

April Goebel: You're so welcome.

Adrienne Delozier: Alright.

Karen Mohr: We have one more hand raised from Tina, and you may unmute and ask your question.

Tina Chance: Can you hear me?

Karen Mohr: Yes, we hear you now.

Tina Chance: Yes. My question was regarding the term investigate. So, I wondered if you would be providing clarification or guidance on that. We currently triage and thoroughly review all our critical incidents to ensure the individual's safety and to address preventive measures. But we only refer out suspected abuse, neglect, or exploitation to our investigative authority for that investigation. Of course, they don't always choose to pursue an investigation or refer for investigation. Sometimes, they take other measures. Will all of the new or the minimum critical incidents have to be referred to this level of investigation? If A and E is not suspected, is there another level of investigation that we could pursue? So, I guess I wanted to know if, is that up to states to determine, or will there be guidance provided regarding what investigation means?

Ryan Shannahan: Yeah, it certainly is up to states to determine, but if it doesn't necessarily reach a threshold of abuse, neglect, or exploitation, but it does fall into a medication error that results in poison control visit or call, then that could be something that the state Medicaid agency determines it would like to investigate itself and establish its own time frames, criteria for resolution, corrective actions, or other responses that you would need to take in order to prevent further instances and that. So, it certainly could depend on the incident type, and we are not intending on requiring anything further than what's in the Access rule. However, we do anticipate providing additional guidance in that regard.

Tina Chance: Thank you.

Adrienne Delozier: Do you have any more raised hands?

Karen Mohr: No further raised hands at this time.

Adrienne Delozier: OK. Then I think there is a couple of wrap-up messages we have for you, and then we're going to close for today. The first is that we are going to be getting a full accounting of everything that was submitted in the Q&A. And so, for those of you who provided your feedback there, we will absolutely take that into account as well as we go through implementation and develop additional guidance. If you have any additional feedback to provide for us, the hcbsaccessrule@cms.hhs.gov email is in the chat box that you are welcome to take note of it. We will also be—fantastic, thank you—we will also be making sure that we get out to

all participants the website where we will be posting the transcripts, the recordings, and the slides. We are in the final stages of getting those up on a very specific site on Medicaid.gov, but we will get those out as well to everyone so that you can come back and listen or take a look at the slides if that's helpful. Ryan, is there anything else, or Jen or Jodie, that you wanted to say in conclusion?

Ryan Shannahan: I would say, I appreciate everyone's participation today. I found it very helpful and enlightening, and I'm looking forward to further discussion. So, thank you very much. Appreciate it.

Adrienne Delozier: All right, well, we want to thank everybody very much for your feedback because that was the primary purpose of our call today. Thank you so much, and have a good rest of your day.