Access Regulation: State Self-Assessment

Background

The final Access regulation, Medicaid Program: Ensuring Access to Medicaid Services, was filed on April 22, 2024 and published in the Federal Register on May 10, 2024. The regulation aims to improve access to home and community-based services (HCBS), quality and health outcomes, and better address health equity issues across fee-for-service (FFS) and managed care models.

This far-reaching regulation will impact key areas of state policy and operations, including many aspects of HCBS.

Purpose

This self-assessment tool is intended to be a resource for states to determine their current level of compliance with requirements in the final Access regulation and to identify areas where action steps will be needed to achieve compliance. This tool also can be used on an ongoing basis to track progress as states move toward full compliance. The Centers for Medicare & Medicaid Services (CMS) is expected to release sub-regulatory guidance on many of the provisions of the regulation, which will provide additional operational details and guidance to states.

This self-assessment is intended to be a comprehensive assessment tool and used collaboratively by state agencies and divisions that administer all the state's HCBS programs.

NOTE: CMS will ultimately make compliance determinations.

How to Use This Tool

The assessment tool is divided into sections of the Access regulation. It does not follow the order of the regulation text. Instead, sections are organized by significance and level of anticipated impact to state systems.

The main sections are:

- Payment adequacy and transparency of Medicaid payment rates to direct care workers;
- Critical incident management;
- Quality measure set;
- Timeliness of access to services;
- Person-centered service planning;
- Establishing a grievance system in fee-for-service (FFS) programs;
- Medicaid Advisory Committee (MAC) and Beneficiary Advisory Council (BAC); and,
- Website transparency.

At the beginning of each section, you will find a summary of the corresponding regulation requirements and deadlines to guide the state's compliance determinations. These can be collapsed by clicking on the triangle next to the section heading.

Respond to each question using the available responses (Yes, Partially, No, and Unsure) to indicate whether the state currently has elements in place to meet each requirement in the regulation.

- **Yes** = The state has elements in place to address this provision.
- **Partially** = The state has some, but not all, elements in place to address this provision.
- **No** = The state does not have elements in place to address this provision.
- **Unsure** = Additional research is needed to confirm whether the state has elements in place to meet this provision.

Use the "Notes/Comments" column to add any additional information about how the state currently complies or does not comply, anticipated action steps, relevant regulation or policy, questions, etc.

Other Tips

Many of the Access regulation requirements are entirely new, and you may find that you respond "No" to many or all of the assessment questions in these sections. We included questions that address next steps/actions for implementing the new requirements to highlight important considerations for planning and hope you will **return to the assessment as a guide throughout the implementation process.**

We recommend **completing individual iterations** of the self-assessment, as needed, to determine current compliance levels and identify where action is necessary for each HCBS program the state administers.

We suggest the **state work collaboratively**, upon completion of the individual assessments, to determine areas where work can be coordinated to achieve compliance with the regulation across programs.

The assessment tool has been divided into **seven main sections** (see below). Each section of the tool can be completed separately, based on a state's assessment needs.

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Payment Adequacy: Reporting

Summary of Regulation Requirements

42 CFR §§ 441.302(k), 441.311(e), 441.464(f), 441.570(f), and 441.745(a)(1)(vi)

Reporting Requirements

- The state must report to CMS annually on the percentage of total payments that goes to compensation for Direct Care Workers (DCWs) who deliver:
  - Personal care
  - Homemaker services
  - Home health aide services
  - Habilitation services
- Report separately for each service and, within each service, must separately report services that are self-directed.
- Separately report services delivered in a provider-operated physical location for which facility-related costs are included in the payment rate.
- Indian Health Service and Tribal health programs are excluded.
- **Compliance deadline:** 4 years (July 9, 2028)

Definitions (apply to both Reporting and Minimum Performance Standard)

- DCWs include the following:
  - A registered nurse, licensed practical nurse, nurse practitioner, or clinical nurse specialist who provides nursing services to Medicaid eligible individuals receiving HCBS;
  - A licensed or certified nursing assistant who provides such services under the supervision of a registered nurse, licensed practical nurse, nurse practitioner, or clinical nurse specialist;
  - A direct support professional
  - A personal care attendant;
  - A home health aide;

  - Other individuals who are paid to provide services to address activities of daily living or instrumental activities of daily living, behavioral supports, employment supports, or other services to promote community integration directly to Medicaid eligible individuals receiving HCBS; and,
  - Clinical Supervisors.
- Specifies a DCW may be:
  - employed by a Medicaid provider, state agency, or third party;
  - contracted with a Medicaid provider, state agency or third party; or delivering services under a self-directed service model.
- Compensation includes:
  - Salary, wages, and other renumeration as defined by the Fair Labor Standards Act (FLSA);
  - Benefits, such as health and dental benefits, paid leave, and tuition reimbursement; and,
  - Employer share of payroll taxes for DCWs delivering services.

Excluded Costs (apply to both Reporting and Minimum Performance Standard)

- Excluded costs are defined as costs that are not included in the calculation of the percentage of Medicaid payments to providers spent on DCW compensation. Excluded costs are:
  - Costs of required trainings for DCWs;
  - Travel costs; and
  - Costs of personal protective equipment.

NOTE: Self-directed services delivered through models in which the beneficiary sets the worker's payment rate are exempt from BOTH the minimum performance standard and reporting requirement.

Compliance deadline: 4 years (July 9, 2028)

Self-Assessment

Payment Adequacy: Reporting						
		Yes	**Partially**	**No**	**Unsure**	**Notes/Comments**
Affected Services: Has the state identified which program service(s) fall under the following service categories and therefore must be included in reporting?						
	Personal Care Services					
	Homemaker Services					
	Home Health Aide Services					
	Habilitation Services					
Compensation: Does the state have a definition of *compensation* to DCWs for the affected services?						
	Personal Care Services					
	Homemaker Services					
	Home Health Aide Services					
	Habilitation Services					
Compensation: Does the state's definition align with the definition in the regulation?						
	Personal Care Services					
	Homemaker Services					
	Home Health Aide Services					
	Habilitation Services					

Payment Adequacy: Reporting					
	Yes	**Partially**	**No**	**Unsure**	**Notes/Comments**
Data Collection: Does the state have ***process(es)*** (e.g., established provider reporting requirements, identified data elements, reporting timeframes) to collect data from each provider regarding the percentage of the payment rate that goes toward compensation to the DCW for the affected services?					
Personal Care Services					
Homemaker Services					
Home Health Aide Services					
Habilitation Services					
Data Collection: Does the state have ***IT/data management system(s)*** to collect data from each provider regarding the percentage of the payment rate that goes toward compensation to the DCW for the affected services?					
Personal Care Services					
Homemaker Services					
Home Health Aide Services					
Habilitation Services					
Excluded Costs: Does the state have system(s) and/or process(es) in place					

Payment Adequacy: Reporting						
		Yes	**Partially**	**No**	**Unsure**	**Notes/Comments**
to identify and remove excluded costs from the payment adequacy report?						
	Personal Care Services					
	Homemaker Services					
	Home Health Aide Services					
	Habilitation Services					
Separate Reporting: Can the state report separately on the percent of total payments spent on DCW compensation for each of the affected services?						
	Personal Care Services					
	Homemaker Services					
	Home Health Aide Services					
	Habilitation Services					
Facility-Related Costs: Can the state report separately on services under the following service categories that are delivered in a provider-operated physical location for which facility-related costs are included in the rate?						
	Personal Care Services					
	Homemaker Services					
	Home Health Aide Services					
	Habilitation Services					

Payment Adequacy: Reporting						
		Yes	**Partially**	**No**	**Unsure**	**Notes/Comments**
Self-Directed Services: Can the state report separately on services under the following service categories that are self-directed?						
	Personal Care Services					
	Homemaker Services					
	Home Health Aide Services					
	Habilitation Services					
Exemption for Budget Authority: Can the state remove self-directed services with budget authority from the reporting for the affected services?						
	Personal Care Services					
	Homemaker Services					
	Home Health Aide Services					
	Habilitation Services					

Use this section to describe any necessary modifications to your IT and data management systems.

Payment Adequacy: Minimum Performance Standard

42 CFR §§ 441.302(k), 441.311(e), 441.464(f), 441.570(f), and 441.745(a)(1)(vi)

Summary of Regulation Requirements

- The state must ensure 80% of Medicaid payments go to compensation for DCWs for:
    - Personal care services
    - Home health aide services
    - Homemaker services

Note: CMS has indicated verbally that this requirement does not apply to other services that include elements of the three specified services, such as adult day services that include components of personal care. This would mean it does not apply to other facility-based services such as adult day health, psychosocial rehabilitation services, day treatment or partial hospitalization services, or clinic-based services for individuals with chronic mental illness. We have requested that CMS provide formal clarification on this through sub-regulatory guidance.

Definitions (apply to both Reporting and Minimum Performance Standard)

- DCWs include the following:
    - A registered nurse, licensed practical nurse, nurse practitioner, or clinical nurse specialist who provides nursing services to Medicaid eligible individuals receiving HCBS;
    - A licensed or certified nursing assistant who provides such services under the supervision of a registered nurse, licensed practical nurse, nurse practitioner, or clinical nurse specialist;
    - A direct support professional;
    - A personal care attendant;
    - A home health aide;
    - Other individuals who are paid to provide services to address activities of daily living or instrumental activities of daily living, behavioral supports, employment supports, or other services to promote community integration directly to Medicaid eligible individuals receiving HCBS; and,
    - Clinical Supervisors
- Specifies a DCW may be:
    - employed by a Medicaid provider, state agency, or third party;
    - contracted with a Medicaid provider, state agency or third party; or delivering services under a self-directed service model.
- Compensation includes:
    - Salary, wages, and other renumeration as defined by the FLSA;
    - Benefits, such as health and dental benefits, paid leave, and tuition reimbursement; and,
    - Employer share of payroll taxes for DCWs delivering services.

- Small provider minimum performance level:
  - The state may set a percentage requirement for compensation to DCWs for small providers.
  - The state must develop criteria to identify small providers (through a transparent process with public comment period).
  - Report annually to CMS on:
    - Small provider criteria;
    - Provider minimum performance level set by the state;
    - Percent of providers that qualify for small provider performance level; and,
    - A plan for small providers to meet the 80% minimum performance standard within a reasonable timeframe.
- Hardship exemption:
  - The state may develop criteria to exempt a reasonable number of providers who face extraordinary circumstances that prevent compliance.
    - Transparent process with public notice/comment period
  - The state must report annually to CMS on:
    - Hardship criteria;
    - Percent of providers that qualify for the hardship exemption; and,
    - A plan for reducing the number of providers receiving the hardship exemption.

Compliance deadline: 6 years (July 9, 2030)

Self-Assessment

Minimum Performance Standard: Payments to Direct Care Workers					
	Yes	**Partially**	**No**	**Unsure**	**Notes/Comments**
Affected Services: Has the state identified which program service(s) fall under the following service categories and therefore must meet the minimum performance standard?					
Personal Care Services					

Minimum Performance Standard: Payments to Direct Care Workers					
	Yes	**Partially**	**No**	**Unsure**	**Notes/Comments**
Homemaker Services					
Home Health Aide Services					
Data Collection: Does the state have ***IT/data management system(s)*** in place to collect data from each provider regarding the percentage of the payment rate that goes toward compensation to the DCW for the affected services?					
Personal Care Services					
Homemaker Services					
Home Health Aide Services					
Data Collection: Does the state have ***process(es)*** (e.g., established provider reporting requirements, identified data elements, reporting timeframes) to collect data from each provider regarding the percentage of the payment rate that goes toward compensation to the DCW for the affected services?					
Personal Care Services					
Homemaker Services					
Home Health Aide Services					
Data Aggregation: Does the state have system(s) in place to aggregate data from provider payment adequacy reports to demonstrate that at least 80% of all payments					

Minimum Performance Standard: Payments to Direct Care Workers					
	Yes	**Partially**	**No**	**Unsure**	**Notes/Comments**
are spent on compensation to direct care workers for the affected services?					
Personal Care Services					
Homemaker Services					
Home Health Aide Services					
Reporting: Does the state have a system or process in place to report separately on services under the following service categories the services that are self-directed?					
Personal Care Services					
Homemaker Services					
Home Health Aide Services					
Small Providers: Will the state establish a separate minimum performance standard for small providers for the affected services?					
Personal Care Services					
Homemaker Services					
Home Health Aide Services					
Small Providers: *Complete the following questions (a-f) only if the state will establish a minimum performance standard for small providers.*					
a. Has the state set criteria to identify small providers?					
b. Has the state determined an alternative minimum performance standard through a					

Minimum Performance Standard: Payments to Direct Care Workers					
	Yes	**Partially**	**No**	**Unsure**	**Notes/Comments**
transparent process that includes public notice/comment?					
c. Has the state developed a plan for bringing small providers into compliance with the 80% minimum standard?					
d. Does the state have a process to track and report to CMS on the percentage of providers who qualify as small providers?					
e. Is the state able to exclude data collected from these providers in its calculations of the minimum performance standard?					
f. Is the state able to include data collected from these providers in the reporting requirement?					
Hardship exemption: Will the state establish a hardship exemption for providers of the affected services who are unable to meet the 80% minimum performance standard or small provider standard?					
Personal Care Services					
Homemaker Services					
Home Health Aide Services					
Hardship exemption: *Complete the following questions (a-e) only if the state will implement a hardship exemption.*					

Minimum Performance Standard: Payments to Direct Care Workers					
	Yes	**Partially**	**No**	**Unsure**	**Notes/Comments**
a. Has the state developed hardship criteria through a transparent process that includes public notice and opportunities for comment?					
b. Has the state developed a plan for reducing the number of providers that qualify for the hardship exemption over time?					
c. Does the state have a process to track and report to CMS the percentage of providers who qualify for the hardship exemption?					
d. Is the state able to exclude data collected from these providers in its calculations of the minimum performance standard?					
e. Is the state able to include data collected from these providers in the reporting requirement?					

Use this section to describe any necessary modifications to your IT and data management systems.

Payment Adequacy: Rate Disclosure and Publication

Summary of Regulation Requirements

42 CFR §447.203(b)(2) to (4)

- The state must publish a rate disclosure for:
  - Personal care services;
  - Home health aide services;
  - Homemaker services; and
  - Habilitation services.
- The disclosure must include:
  - Average hourly payment rates, separated by agency and self-directed options, and stratified by:
    - Population,
    - Provider type, and,
    - Location.
  - Number of Medicaid-paid claims; and,
  - Number of beneficiaries who received a service within a calendar year.
- **Compliance deadline**: July 1, 2026 (then updated every 2 years)

Rate Publication [42 CFR §447.203(b)(1)]

- The state must publish all Medicaid FFS fee schedule rates on the state's website.
- If rates vary, the state must separately identify rates by:
  - Population;
  - Provider type; and,
  - Geographical location.
- **Compliance deadline**: July 1, 2026 (then updated within 30 days of a rate change)

Self-Assessment

Rate Disclosure and Publication					
	Yes	**Partially**	**No**	**Unsure**	**Notes/Comments**
Affected Services: Has the state identified which program service(s) fall under the following service categories and are therefore subject to the rate disclosure and publication?					
Personal Care Services					
Homemaker Services					
Home Health Aide Services					
Habilitation services					
Data Collection: Does the state have ***IT/data management system(s)*** in place to collect data from each provider regarding hourly payment rates for the affected services?					
Personal Care Services					
Homemaker Services					
Home Health Aide Services					
Habilitation Services					
Data Collection: Does the state have ***process(es)*** (e.g., established provider reporting requirements, identified data elements, reporting timeframes) to collect data from each provider regarding hourly payment rates for the affected services?					
Personal Care Services					

Rate Disclosure and Publication						
		Yes	**Partially**	**No**	**Unsure**	**Notes/Comments**
	Homemaker Services					
	Home Health Aide Services					
	Habilitation Services					
Self-Direction: Can the state currently separate the payment rates for each of the required services by agency and self-direction options?						
	Personal Care Services					
	Homemaker Services					
	Home Health Aide Services					
	Habilitation Services					
Stratification: Can the state currently stratify the payment rates for the required services by **population**?						
	Personal Care Services					
	Homemaker Services					
	Home Health Aide Services					
	Habilitation Services					
Stratification: Can the state currently stratify the payment rates for the required services by **provider type**?						
	Personal Care Services					
	Homemaker Services					
	Home Health Aide Services					
	Habilitation Services					

Rate Disclosure and Publication					
	Yes	**Partially**	**No**	**Unsure**	**Notes/Comments**
Stratification: Can the state currently stratify the payment rates for the required services by **location**?					
Personal Care Services					
Homemaker Services					
Home Health Aide Services					
Habilitation Services					
Claims Data: Does the state have a system and/or process to collect and report Medicaid paid-claims data for the required services?					
Personal Care Services					
Homemaker Services					
Home Health Aide Services					
Habilitation Services					
Beneficiaries: Does the state currently have a system and/or process to collect and report the number of beneficiaries who received a service within a calendar year for the required services?					
Personal Care Services					
Homemaker Services					
Home Health Aide Services					
Habilitation Services					
Fee Schedule Publication: Does the state currently publish all Medicaid FFS fee schedule rates on the state's website?					

Rate Disclosure and Publication						
		Yes	**Partially**	**No**	**Unsure**	**Notes/Comments**
Rate Variation: Do rates vary within individual services?						
Rate Variation: If rates vary, can the state currently identify rates by the following criteria?						
	Population					
	Provider type					
	Geographical location					

Use this section to describe any necessary modifications to your IT and data management systems.

Payment Adequacy: Interested Parties Advisory Group

Summary of Regulation Requirements

Interested Parties Advisory Group [42 CFR §447.203(b)(6)]

- The state must establish an interested parties' advisory group to advise and consult on:
  - Payment rates for direct care workers:
    - To ensure rates are sufficient to access:
      - Personal care;
      - Home health aide;
      - Homemaker; and,
      - Habilitation services.

  - Current and proposed payment rates;
  - HCBS payment adequacy data; and,
  - Access to care metrics.
- The interested parties' advisory group must include:
  - Direct care workers;
  - Beneficiaries;
  - Beneficiaries' authorized representatives; and,
  - Other interested parties impacted by the services rates in question.
- **Compliance deadline:** 2 years (July 9, 2026)

Self-Assessment

Interested Parties Advisory Group						
		Yes	**Partially**	**No**	**Unsure**	**Notes/Comments**
Does the state currently have an advisory group that advises and consults on the required criteria?						
	Payment rates for direct care workers					
	Current and proposed payment rates					
	HCBS payment adequacy data					
	Access to care metrics					
Does the state currently have an advisory group that includes the following members?						
	Direct care workers					
	Beneficiaries					
	Beneficiaries' authorized representatives					
	Other interested parties impacted by the services rates					

Interested Parties Advisory Group					
	Yes	**Partially**	**No**	**Unsure**	**Notes/Comments**
Does the state have an established process for creating an advisory group?					

Use this section to describe any necessary modifications to your IT and data management systems.

Critical Incidents: Reporting

Summary of Regulation Requirements

Critical Incident Management System [42 CFR §§441.302(a)(6), 441.311(b)(1) to (2), 441.464(e), 441.570(e), and 441.745(a)(1)(v)]

Reporting Requirements

- The state must report to CMS on its Critical Incident Management System compliance every 2 years.
- Once CMS determines that the state's system meets all requirements, reporting can move to every 5 years.
- **Compliance deadline:** 3 years (July 9, 2027)

Minimum Performance Standard

State must ensure that 90% of all reported critical incidents meet each of the below performance standards:

- An investigation was initiated within state specified timeframes;
- A resolution to the investigation was determined within state specified timeframes; and,
- Where corrective action was required, the corrective action was completed within state specified timeframes.
- **Compliance deadline:** 3 years (July 9, 2027)

State Requirements:

- The state must establish an electronic system that (at a minimum) enables:
  - Electronic critical incident data collection;
  - Tracking (including status and resolution of investigation); and,
  - Trending.
- For critical incidents that occur during the delivery of services authorized in the person-centered service plan or incidents that occur as the result of a failure to deliver services authorized in the plan:
  - Require providers to report critical incidents within state specified timeframes;
  - To the extent permissible under state law, use data from the following sources to identify *unreported* critical incidents:
    - Provider claims;
    - Medicaid Fraud Unit; and,
    - Other state agencies, such as Adult Protective Services (APS) or Child Protective Services (CPS).
- If the state refers critical incidents to other entities for investigation, the state must ensure that the entity who received the critical incident referral for investigation shares information about the results of the investigation with the state.
  - If the investigative agency fails to report a resolution within state-specified timeframes, the state must separately investigate critical incidents.
- **Compliance deadlines**:
  - 3 years (July 9, 2027) for all requirements (except the requirement for an electronic system)
  - 5 years (July 9, 2029) for electronic system

Self-Assessment

Critical Incidents: Reporting					
	Yes	**Partially**	**No**	**Unsure**	**Notes/Comments**
Electronic Incident Management System: Does the state have an ***electronic*** incident management system?					
If yes, does the *electronic* incident management have at a minimum:					
Critical incident data collection					

Critical Incidents: Reporting						
		Yes	**Partially**	**No**	**Unsure**	**Notes/Comments**
	Tracking (including status and resolution)					
	Trending					
Has the state considered implementing a single state-wide electronic system that manages critical incidents across all the state's HCBS authorities?						
Critical Incident Performance Threshold Requirements: Has the state established timeframes for:						
	Time from incident referral to investigation					
	Time from incident investigation to resolution					
	Time from determination of corrective action and completion of corrective action for incident					
	Time between providing identification of incident and reporting of incident					
Does the state have the ability to track data on the number of critical incidents that meet state-established timeframes for:						
	Time from referral to investigation					
	Time from investigation to resolution					
	Time from determination of corrective action and completion of corrective action					

Critical Incidents: Reporting						
		Yes	**Partially**	**No**	**Unsure**	**Notes/Comments**
Does the state have the ability to annually report data on the number of critical incidents that meet state-established timeframes for:						
	Time from referral to investigation					
	Time from investigation to resolution					
	Time from determination of corrective action and completion of corrective action					
Critical Incident System Requirements: Does the state have a policy for providers to report critical incidents that:						
	Occur during the delivery of waiver services.					
	Occur as a result of failure to deliver wavier services.					
Data Sources: Does the state use the following data sources from other state agencies (to the extent permissible under state law) to identify critical incidents that are unreported by the provider:						
	Claims data					
	Medicaid fraud control unit data					
	Other state agency data					
Does the data source indicate whether the critical incident occurred during the delivery						

Critical Incidents: Reporting						
		Yes	**Partially**	**No**	**Unsure**	**Notes/Comments**
of services or as the result of a failure to deliver services?						
Critical Incident Referral: *Only complete this section if the state refers critical incidents to other entities for investigation.*						
a. Does the state ensure that there is information sharing on:						
	Status of investigation					
	Resolution of investigation					
b. Does the state separately investigate the incident if the investigative agency fails to report the resolution of the incident within state-specified timeframes?						
Reporting Requirements: Does the state have a mechanism to demonstrate compliance with the following critical incident management system requirements:						
	Critical Incident minimum definition					
	Electronic critical incident system					
	Provider incident reporting requirements					
	Use of other data sources					
	Referral source information sharing (when applicable)					
	Separately investigate incidents when entity that receives incident fails to					

Critical Incidents: Reporting					
	Yes	**Partially**	**No**	**Unsure**	**Notes/Comments**
report outcome of investigation (when applicable)					
Does the state have a mechanism to report compliance with these requirements to CMS on a bi-annual basis?					

Use this section to describe any necessary modifications to your IT and data management systems.

Critical Incidents: Minimum Definition

Summary of Regulation Requirements

Critical Incidents Minimum Definition [42 CFR §441.302(a)(6)(i)(A)]

The state must establish a *minimum* definition of critical incident that includes:

- 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 a consultation with a poison control center, an emergency department (ED) visit, an urgent care visit, a hospitalization, or death; and
- An unexplained or unanticipated death, including but not limited to a death caused by abuse or neglect.
- A provider must report a critical incident that occurs during service delivery or because of failure to deliver services as authorized.
- **Compliance deadline:** 3 years (July 9, 2027)

Self-Assessment

Critical Incidents: Minimum Definition					
	Yes	**Partially**	**No**	**Unsure**	**Notes/Comments**
Does the state have a definition of critical incident that meets *all* the minimum criteria?					

Use this section to describe any necessary modifications to your IT and data management systems.

HCBS Quality Measure Set (HCBS QMS): Adoption and Reporting of HCBS Measures

Summary of Regulation Requirements

Adoption of the HCBS Quality Measure Set [42 CFR §§441.312, 441.474(c), 441.585(d), and 441.745(b)(1)(v)]

- The state must adopt the HCBS Quality Measure Set (HCBS QMS).
  - Originally shared as guidance in SMD Letter #22-003.
  - Applies to all HCBS authorities (except 1905 state plan personal care) and all delivery systems, as well as self-directed programs, and all major population groups.
  - Requires stratification and sampling phase-in.
  - Updated every other year by the Health and Human Services (HHS) Secretary.
    - The process includes soliciting public comments including the Federal Registrar.
- The state must establish performance targets for each mandatory measure in the QMS.

  - Those targets must be reviewed and approved by CMS.
  - Each measure must have a quality improvement (QI) strategy that the state will implement to meet the performance target.
- The state may establish performance targets and QI strategies for measures that are not yet required but will be, and on populations for whom reporting is not yet required but will be.
- The Secretary will make technical updates and corrections to measure set annually, as appropriate, and must ensure that all measures:
  - Reflect an evidence-based process including testing, validation, and consensus among interested parties; and,
  - Are meaningful for states and are feasible for state-level, program-level, or provider-level reporting as appropriate.

Timeframe: The Secretary begins identifying quality measures no later than December 31, 2026.

HCBS Quality Measure Set Reporting Requirements [42 CFR §§441.311(c), 441.474(c), 441.580(i), and 441.745(a)(1)(vii)]

- The QMS replaces the minimum 86% performance level for states' performance measures described in the CMS guidance updating quality measure performance and reporting released in 2014.
- The state must report every other year on all measures in the HCBS QMS that are identified by the Secretary (following phased in approach).
- CMS will publicly report on a subset of the measures.
- Stratified data reporting will be required on these factors:
  - Race, ethnicity, sex (biological), age, rural/urban status, disability, language, or other factors.
  - Stratified data reporting will be phased in as follows:
    - 25% of measures by 4 years after effective date.
    - 50% of measures by 6 years.
    - 100% of measures by 8 years.
- **Compliance deadline:** 4 years (July 1, 2028)

Self-Assessment

Adoption and Reporting of HCBS Quality Measure Set					
	Yes	**Partially**	**No**	**Unsure**	**Notes/Comments**
Has the state identified all programs and populations the HCBS QMS applies to,					

Adoption and Reporting of HCBS Quality Measure Set					
	Yes	**Partially**	**No**	**Unsure**	**Notes/Comments**
including: 1915(c), 1915(i), 1915(j), 1915(k), and 1115 waivers that include HCBS.					
Does the state have a plan to comply with the requirements outlined for approved **Experience of Care Surveys (i.e., NCI IDD/AD, CAHPS, POM)**?					
Does the state have a plan to comply with the requirements outlined for approved **administrative measures in the QMS?**					

Use this section to describe any necessary modifications to your IT and data management systems.

Timeliness of Access: Access Reporting

Summary of Regulation Requirements

Access Reporting [42 CFR §440.180(b)(2)-(4) and (6) and §441.311(d)(2)]

- The state must report annually on timeliness of access to:
  - Personal care;
  - Homemaker;
  - Home health aide; and,
  - Habilitation services.

- The report must include:
  - Average amount of time from initial authorization to initiation of services.
  - Percent of authorized service hours provided in the past 12 months, for individuals newly receiving services in that time.
- The state may report this metric using statistically valid random sampling of beneficiaries.
- **Compliance deadline:** 3 years (July 1, 2027)

Self-Assessment

Timeliness of Access Reporting Requirements						
		Yes	**Partially**	**No**	**Unsure**	**Notes/Comments**
Affected Services: Has the state identified which program service(s) fall under the following service categories and therefore must be included in timeliness of access reporting?						
	Personal Care Services					
	Homemaker Services					
	Home Health Aide Services					
	Habilitation Services					
Has the state determined when services are considered to have been *authorized* and when services are considered to have been *initiated*?						
Data Collection: Does the state have system(s) or process(es) in place to collect the dates of initial authorization of the affected services?						
	Personal Care Services					
	Homemaker Services					
	Home Health Aide Services					

Timeliness of Access Reporting Requirements						
		Yes	**Partially**	**No**	**Unsure**	**Notes/Comments**
	Habilitation Services					
Data Collection: Does the state have system(s) or process(es) in place to collect the dates of the initiation of the affected services?						
	Personal Care Services					
	Homemaker Services					
	Home Health Aide Services					
	Habilitation Services					
Data Calculation: Does the state have system(s) or process(es) in place to calculate the average amount of time from initial service authorization to the initiation of affected services?						
	Personal Care Services					
	Homemaker Services					
	Home Health Aide Services					
	Habilitation Services					
Statistically Valid Sample (*optional*): Does the state intend to report the average amount of time from initial authorization to initiation of services using a statistically valid sample? If so:						
	Has the state established the criteria to determine a statistically valid sample?					

Timeliness of Access Reporting Requirements						
		Yes	**Partially**	**No**	**Unsure**	**Notes/Comments**
	Does the state have a mechanism to capture data on a statistically valid sample?					
Reporting: Can the state report on the average amount of time from initial service authorization to the initiation of each of the affected services?						
	Personal Care Services					
	Homemaker Services					
	Home Health Aide Services					
	Habilitation Services					
Data Collection: Does the state have system(s) or process(es) in place to collect data on total number of service hours authorized in the past 12 months for individuals newly receiving affected services in that time?						
	Personal Care Services					
	Homemaker Services					
	Home Health Aide Services					
	Habilitation Services					
Data Collection: Does the state have system(s) or process(es) in place to collect data on service hours actually provided in the past 12 months, for individuals newly receiving affected services in that time?						
	Personal Care Services					

Timeliness of Access Reporting Requirements						
		Yes	**Partially**	**No**	**Unsure**	**Notes/Comments**
	Homemaker Services					
	Home Health Aide Services					
	Habilitation Services					
Data Calculation: Does the state have system(s) or process(es) in place to calculate the percentage of authorized services actually provided in the past 12 months for individuals newly receiving affected services in that time?						
	Personal Care Services					
	Homemaker Services					
	Home Health Aide Services					
	Habilitation Services					
Statistically Valid Sample *(optional):* Does the state intend to report the percentage of authorized services provided in the last 12 months using a statistically valid sample? If so:						
	Has the state established the criteria to determine a statistically valid sample?					
	Does the state have a mechanism to capture data on a statistically valid sample?					
Reporting: Can the state report on the percentage of authorized service hours actually provided in the past 12 months for						

Timeliness of Access Reporting Requirements						
		Yes	**Partially**	**No**	**Unsure**	**Notes/Comments**
individuals newly receiving each of the affected services in that time?						
	Personal Care Services					
	Homemaker Services					
	Home Health Aide Services					
	Habilitation Services					

Use this section to describe any necessary modifications to your IT and data management systems.

Timeliness of Access: Waiting List Reporting

Summary of Regulation Requirements

Waiting List Reporting [42 CFR §§441.303(f)(6), 441.311, 441.474(c), 441.580(i), and 441.745(a)(1)(vii)]

- If the state limits enrollment in its 1915(c) waiver program and maintains a waiting list, the state must report to CMS annually:
  - Description of how the state maintains the list of individuals waiting to enroll in the waiver program, including:
    - Whether the state screens individuals for eligibility for the waiver program;
    - Whether the state periodically re-screens individuals on the waiting list;
    - Frequency of re-screening;
    - Number of people on the waiting list; and,
    - The average amount of time individuals newly enrolled in the waiver program in the last 12 months spent on the waiting list.

- **Compliance deadline:** 3 years (July 1, 2027)

Self-Assessment

Timeliness of Access: Waiting List Reporting Definition					
	Yes	**Partially**	**No**	**Unsure**	**Notes/Comments**
Does the state limit the size of its 1915(c) waiver program(s) (e.g., waiver caps or enrollment limits)?					
Does the state maintain a list of individuals who are waiting to enroll in the waiver program(s)? If yes, respond to the following questions (a-d):					
a. Does the state screen individuals for eligibility for the waiver program before adding them to the waiting list (optional)?					
b. Does the state periodically re-screen individuals who are on the waiting list (optional)?					
If yes, can the state identify the frequency of that rescreening?					
c. Can the state identify the number of people who are on the waiting list for each waiver program?					
d. Does the state have system(s) or process(es) in place to collect data on the average amount of time individuals newly enrolled in					

Timeliness of Access: Waiting List Reporting Definition						
		Yes	**Partially**	**No**	**Unsure**	**Notes/Comments**
each waiver program in the last 12 months spent on the waiting list?						
Reporting: Does the state have a process for reporting to CMS on an annual basis each of the following (when applicable)?						
	Whether the state screens for eligibility before adding a person to the waiting list.					
	Whether the state periodically re-screens people on the waiting list, and if so, at what frequency.					
	The number of people who are on the waiting list for each waiver program.					
	The average amount of time people newly enrolled in each waiver program were on the waiting list.					

Use this section to describe any necessary modifications to your IT and data management systems.

Timeliness of Access: Person Centered Planning Reporting

Summary of Regulation Requirements

Person Centered Planning Reporting [42 CFR §§441.301(c)(1), 441.301(c)(3), 441.450(c), 441.540(c), and §441.725(c)]

- The state must ensure the person-centered service plan is reviewed and revised, as appropriate, based upon the reassessment of functional need:
  - At least every 12 months;
  - When the individual's circumstances or needs change significantly; or,
  - At the request of the individual.
- The state must ensure that at least 90% of individuals continuously enrolled for at least 365 days in an HCBS program (based on a statistically valid sample):
  - Have had an annual reassessment of functional need AND
  - Have had a review and update of the person-centered service plan based on that reassessment.
- **Compliance deadline:** 3 years (July 1, 2027)

Self-Assessment

Timeliness of Access: Person Centered Planning					
	Yes	**Partially**	**No**	**Unsure**	**Notes/Comments**
Annual Functional Needs Reassessment:					
Does the state require annual functional needs reassessments for individuals continuously enrolled for at least 365 days on the waiver?					

Timeliness of Access: Person Centered Planning					
	Yes	**Partially**	**No**	**Unsure**	**Notes/Comments**
Does the state have a mechanism to identify individuals who are continuously enrolled in the waiver and are due for an annual reassessment?					
Does the state have a mechanism to capture the number of annual reassessments that were completed for individuals continuously enrolled in the wavier?					
Does the state have a process to report on the percent of continuously enrolled individuals who received an annual reassessment?					
Does the state have a procedure to ensure that 90% of continuously enrolled individuals receive an annual reassessment?					
Statistically Valid Sample: *Only complete the following section (questions a. and b.) if the state intends to report on a statistically valid sample of annual reassessments:*					
a. Has the state established the criteria to determine a statistically valid sample?					
b. Does the state have a mechanism to capture data on a statistically valid sample?					
Annual Service Plan Update:					

Timeliness of Access: Person Centered Planning					
	Yes	**Partially**	**No**	**Unsure**	**Notes/Comments**
Does the state require annual updates to the service plan based on the annual reassessment?					
Does the state have a mechanism to capture data on the number of individuals who had their service plan updated as a result of their annual reassessment?					
Does the state have a process to report on the percent of annual reassessments that were completed based on the annual reassessment?					
Does the state have a procedure to ensure that 90% of the service plans are updated based on the annual reassessment?					
Statistically Valid Sample: *Only complete this section (questions a. and b.) if the state intends to report on a statistically valid sample of annual service plan updates:*					
a. Has the state established the criteria to determine a statistically valid sample?					
b. Does the state have a mechanism to capture data on a statistically valid sample?					

Use this section to describe any necessary modifications to your IT and data management systems.

Fee For Services (FFS) Grievance Process: Establishing the System

Summary of Regulation Requirements

Establishing Grievance Systems in FFS [42 CFR §§441.301(c)(7)(i), 441.464(d)(5), 441.555(e), and 441.745(a)(1)(iii)]

- The state must establish a process through which a beneficiary who receives HCBS through a FFS delivery system can file a grievance regarding the state's or a provider's performance of:
  - Person-centered planning; and,
  - Service requirements and HCBS settings requirements.
- The state may have grievance system activities performed by a contractor or other government entity, provided the state retains responsibility for ensuring performance and compliance.

Definition of Grievance [42 CFR §441.301(c)(7)(ii)]

- An expression of dissatisfaction or complaint related to the state's or a provider's performance of the person-centered planning and service plan requirements and the HCBS settings requirements, regardless of whether the beneficiary requests that remedial action be taken to address the area or dissatisfaction or complaint.

Self-Assessment

Establishing a FFS Grievance System					
	Yes	**Partially**	**No**	**Unsure**	**Notes/Comments**
Does the state have a grievance system that allows beneficiaries who receive HCBS to file a grievance at any time?					

Establishing a FFS Grievance System						
		Yes	**Partially**	**No**	**Unsure**	**Notes/Comments**
	Does the system have a definition for grievance that aligns with this rule's definition?					
Has the state ensured the grievance system and notices provided through the grievance system are accessible to people with disabilities?						
Has the state ensured the grievance system and notices provided through the grievance system provide meaningful access to people with Limited English Proficiency and ensured auxiliary aids and services are available when necessary?						
Does the state currently contract with or intend to hire a contractor or other government entity to manage the FFS grievance system?						
	If yes, does the state have a monitoring process in place to monitor performance and compliance of the grievance system?					
Does the state's grievance system allow beneficiaries or their authorized representatives to file grievances related to state or provider performance of person-centered service planning requirements?						

Establishing a FFS Grievance System						
		Yes	**Partially**	**No**	**Unsure**	**Notes/Comments**
Does the state's grievance system allow beneficiaries or their authorized representatives to file grievances related to state or provider performance of the HCBS Settings Rule?						
Written Consent: Does the state's grievance system allow for another individual or entity to file a grievance on a beneficiary's behalf, or provide the beneficiary with assistance or representation throughout the process, with written consent from the beneficiary or their authorized representative?						
	Has the state determined how written consent is to be obtained and verified when an individual or entity files a grievance on behalf of a beneficiary or their authorized representative (e.g. electronic signatures, voice signatures or other methods)?					
	Does the grievance system allow for documenting that written consent has been obtained and verified when another individual or entity files a grievance on behalf of a beneficiary or their representative?					
Has the state confirmed that the grievance system prevents providers from filing a						

Establishing a FFS Grievance System					
	Yes	**Partially**	**No**	**Unsure**	**Notes/Comments**
grievance that would violate the state's conflict of interest guidelines?					
If the state determines it is necessary for a service provider to operate the grievance system, has the state established firewalls to ensure that grievances are reviewed by a neutral decision maker within the provider agency?					

Use this section to describe any necessary modifications to your IT and data management systems.

Fee For Services (FFS) Grievance Process: General Requirements

Summary of Regulation Requirements

FFS Grievance Procedures [42 CFR §441.301(c)(7)(iii)]

- The state must:
  - Have written policies and procedures for grievance processes.
  - Provide beneficiaries with reasonable assistance in ensuring grievances are appropriately filed with the grievance system.
  - Ensure punitive or retaliatory action is not taken or threatened.
  - Accept grievances and requests for timeline extensions.
  - Provide beneficiaries with appropriate notice and information.
  - Review grievance resolutions with which beneficiaries are dissatisfied.

- Provide information on the grievance system to providers and subcontractors.

Self-Assessment

FFS Grievance Process: System Procedures						
		Yes	**Partially**	**No**	**Unsure**	**Notes/Comments**
Does the state have written policies and procedures for its grievance processes?						
Reasonable Assistance: Does the grievance system provide beneficiaries or their authorized representative with reasonable assistance in ensuring grievances are appropriately filed with the grievance system?						
	Does the state have a process for ensuring, on a case-by-case basis, what constitutes reasonable assistance for beneficiaries or their authorized representatives?					
	Has the state created a process for helping beneficiaries identify whether their concern should be filed in the grievance system and, to the greatest extent possible, redirect grievances filed with other state systems to the grievance system when appropriate (e.g., grievances filed as a critical incident or fair hearing request)?					
Does the state ensure that punitive or retaliatory action is not taken against a						

FFS Grievance Process: System Procedures					
	Yes	**Partially**	**No**	**Unsure**	**Notes/Comments**
beneficiary or their authorized representative who files a grievance, or who has had a grievance filed on their behalf?					
Does the state accept requests for extensions of timeframes from the beneficiary or their authorized representative?					
Does the state provide to the beneficiary and their authorized representative information on their rights and how to file grievances?					
Does the state have a process to allow for review of any grievance resolution with which the beneficiary is dissatisfied?					
Does the state provide information about the grievance system to all providers and subcontractors approved to deliver services?					

Use this section to describe any necessary modifications to your IT and data management systems.

Fee For Services (FFS) Grievance Process: Handling Grievances

Summary of Regulation Requirements

Handling Grievances [42 CFR §441.301(c)(7)(iii)]

- The process for handling grievances must:
  - Allow beneficiaries to file a grievance orally or in writing.
  - Ensure decisions on grievances are not made by anyone previously involved in a review or decision making related to the problem.
  - Provide beneficiaries with reasonable opportunity to present evidence and testimony.
  - Provide beneficiaries, free of charge and in advance, with their own case files and any evidence used related to the grievance.
  - Provide beneficiaries, free of charge, with language services to support their participation in grievance process.

Self-Assessment

FFS Grievance System: Handling Grievances						
		Yes	**Partially**	**No**	**Unsure**	**Notes/Comments**
Does the state's grievance process allow the beneficiary or their authorized representative to file a grievance either orally or in writing?						
Does the state's grievance process acknowledge receipt of each grievance?						
Decisions: Does the state's process ensure that decisions on grievances are:						
	Not made by anyone previously involved in the review or decision making related to the problem or issue?					

FFS Grievance System: Handling Grievances						
		Yes	**Partially**	**No**	**Unsure**	**Notes/Comments**
	Are made by individuals with appropriate expertise?					
	Are made by people who consider all the information submitted by the beneficiary or their authorized representative?					
Does the state process provide the beneficiary or their authorized representative with reasonable opportunity, face-to-face (including through the use of audio or video technology) and in writing, to present evidence and testimony and make arguments related to their grievance?						
Does the state process provide the beneficiary or their authorized representative, with the beneficiary's case file and any evidence considered related to the grievance?						
	Is this information provided free of charge and sufficiently in advance of the resolution timeframe?					
Does the state process provide beneficiaries, free of charge, with language services, including written translation and interpreter services, to support the beneficiary's participation in the grievance processes?						

Use this section to describe any necessary modifications to your IT and data management systems.

Fee For Services (FFS) Grievance Process: Timelines for Resolving Grievances

Summary of Regulation Requirements

Timelines for Resolving Grievances [42 CFR §441.301(c)(7)(v)-(viii)]

- The state must ensure that a grievance is resolved within 90 calendar days of receipt of the grievance.
- The state can extend the timelines up to 14 calendar days under certain circumstances (including at the request of the beneficiary).
- The state must also keep specific records on the grievance process.

Compliance deadline for all provisions: 2 years (July 1, 2026)

Self-Assessment

FFS Grievance System: Timelines for Resolving Grievances						
		Yes	**Partially**	**No**	**Unsure**	**Notes/Comments**
Timeframes: Has the state established timeframes for resolving grievances and providing notice to beneficiaries?						
	Is this timeframe within the required timeframe of within 90 calendar days					

FFS Grievance System: Timelines for Resolving Grievances						
		Yes	**Partially**	**No**	**Unsure**	**Notes/Comments**
	from the day the state received the grievance?					
	Does the timeline allow for the state to resolve each grievance and provide notice as expeditiously as the beneficiary's health condition requires?					
Extensions: Does the state process allow for extension of resolution by up to 14 calendar days if one of the following conditions are met:						
	The beneficiary requests the extension					
	The state documents there is need for additional information and how the delay is in the beneficiary's interest					
Extensions: If the state extends the timeframe (not at the beneficiary's request), does the state process include the following?						
	Making reasonable efforts to give prompt oral notice					
	Within 2 calendar days of determining the need for a delay, giving written notice of the reason to extend the timeframe					

FFS Grievance System: Timelines for Resolving Grievances						
		Yes	**Partially**	**No**	**Unsure**	**Notes/Comments**
	Resolving the grievance as expeditiously as the beneficiary's health condition requires					
Has the state established a method to notify a beneficiary of the resolution of the grievance?						
Does the state have a process to maintain records of grievances?						
Record Keeping: Does the record keeping of grievances include the following:						
	A general description of the reason for the grievance					
	The date the grievance was received					
	The date of each review or review meeting (if applicable)					
	The resolution of the grievance, as applicable					
	The date of resolution, if applicable					
	The name of the beneficiary for whom the grievance was filed					
Are the records maintained in a way that would make them available upon request to CMS?						
Does the state have an ongoing monitoring procedure to review the records of the grievance system?						

Use this section to describe any necessary modifications to your IT and data management systems.

Medicaid Advisory Committee (MAC) and Beneficiary Advisory Council (BAC)

Summary of Regulation Requirements

42 CFR §431.12

Although the MAC and BAC sections of the final rule are the purview of the Single State Medicaid Agency (SSMA), state Developmental Disability (DD) and Aging operating agencies could collaborate and provide support, input, and nominations for potential members of these committees to ensure adequate representation and input.

The final rule restructures the current Medical Care Advisory Committee into two distinct bodies: a Medicaid Advisory Committee (MAC) and a Beneficiary Advisory Council (BAC).

Membership

- MAC and BAC members are selected by state Medicaid agency leadership with mandatory rotating terms.
- MAC must include, but is not limited to:
  - State and/or local consumer advocacy groups representing interests of Medicaid recipients;
  - Clinical providers or administrators (with suggestions of categories to consider, including providers of services to people with disabilities and people over age 65) ;
  - If applicable, Medicaid managed care organizations (MCOs) or their state associations; and,
  - Other state agencies serving Medicaid members, serving as non-voting ex officio members.
- BAC must be composed of people with lived Medicaid experience, including current or former recipients of Medicaid services and their caregivers (including family members and unpaid caregivers).
- A minimum of 25% of the MAC members must be drawn from the BAC members. The membership requirement may be phased in according to the following timeframe:
  - 10% from effective date up to 1 year after effective date (July 9, 2024, through July 9, 2025).

- 20% from 1- 2 years after effective date (July 10, 2025 –July 9, 2026).
- 25% after 2 years after effective date (July 10, 2026, and beyond).

Scope

- MAC and BAC advise the state Medicaid agency on an array of topics, including:
  - Additions and changes to services;
  - Coordination of care;
  - Quality of services;
  - Eligibility, enrollment, and renewal processes;
  - Beneficiary and provider communications;
  - Cultural competency, language access, health equity and disparities, and biases in the Medicaid program; and,
  - Access to services.

Other requirements

- MAC and BAC must each meet separately on a quarterly basis.
  - BAC meetings must precede MAC meetings.
  - At least two MAC meetings must be open to public comment.
- The state provides staff assistance, participation, and financial help to support planning and execution of the MAC and BAC.
- MAC activities, topics discussed, and recommendations, along with the state Medicaid agency's response to the recommendations, must be published in an annual report and posted on the state's website within 30 days of being finalized.

Compliance deadlines:

- 1 year (July 9, 2025) for MAC and BAC meeting requirements (aside from phased in BAC requirements outlined above).
- 2 years (July 9, 2026) for state Medicaid agency formal MAC annual report.

Self-Assessment

MAC & BAC					
	Yes	**Partially**	**No**	**Unsure**	**Notes/Comments**
Agency coordination: Does the state have a plan for coordination among the state Medicaid agency, waiver program staff, and					

MAC & BAC						
		Yes	**Partially**	**No**	**Unsure**	**Notes/Comments**
any other affected state entities for creation of the MAC and BAC?						
Has the state identified any individuals or organizations to bring to the state Medicaid agency for participation on the MAC and BAC?						
Standardized Process and Practices: Does the state have standardized processes and practices for the administration of the MAC and BAC that are available for public review on the state website and include the following:						
	Bylaws for governance					
	Current list of members					
	Past meeting minutes and attendees					
	The option for BAC members to remove their name from public postings for MAC and BAC meetings					
	Process for member recruitment and selection along with selection of leadership					
	Regular meeting schedule that includes separate MAC and BAC meetings at least once per quarter (minimum of 4 meetings per year)					
	Time for members and the public (when applicable) to disclose conflicts					

MAC & BAC						
			Yes	**Partially**	**No**	**Unsure**	**Notes/Comments**
	At least two MAC meetings are open to the public with dedicated time during the meeting for public comment						
	Adequate notice of the public (at least 30 calendar days prior) of the meeting date, location and time of any open MAC and BAC (if applicable) meetings						
	A rotating, variety of meeting attendance options (in-person, virtual, hybrid)						
	An ever-present telephone dial-in option to members and the public						
	The selection of meeting times and locations to maximize member attendance						
	Facilitate participation of beneficiaries by ensuring the following:						
		Meetings are accessible to people with disabilities					
		Reasonable modifications are provided to ensure access and enable meaningful participation					
		Communication with individuals with disabilities is as effective as communication with any other member					

MAC & BAC						
			Yes	Partially	No	Unsure	Notes/Comments
		Reasonable steps are taken to provide meaningful access to individuals with Limited English Proficiency					
		Meetings comply with all regulatory requirements					
Membership: Does the member selection process include the following elements:							
	Director of the Single State Medicaid Agency selects members for a term of length determined by the state						
	There is a rotating and continuous selection process						
Does the state have policies and procedures in place to ensure members do not serve consecutive terms?							
Participation: Can MAC and BAC participants advise the Director of the Single State Medicaid Agency on matters related to the effective administration of the Medicaid program?							
Does the state Medicaid agency ensure that members, in collaboration with the state, identify the topics on which to advise the state?							
Does the state Medicaid agency ensure members can advise on all mandatory topics?							

MAC & BAC						
			Yes	Partially	No	Unsure	Notes/Comments
State Medicaid Agency Staff Assistance:							
Does the state Medicaid agency provide staff to support planning and execution of the meeting?							
Does the state staff support include the following:							
	Recruitment of members						
	Planning and execution of the meetings						
	Producing meeting minutes that include actions taken and anticipated actions taken by state in response to feedback provided during the meeting						
	Posting minutes to state's website within 30 days following each meeting						
	Providing appropriate support and preparation to MAC and BAC members who are beneficiaries to ensure meaningful participation that includes:						
		Providing staff whose responsibility is to facilitate member engagement					
		Providing financial support, if necessary, to facilitate engagement					
		Attendance by at least one staff from the Single State Medicaid					

MAC & BAC						
			Yes	Partially	No	Unsure	Notes/Comments
		Agency executive staff at all meetings					
Open Meetings: Does the state have open meeting laws or policies that would require MAC and BAC meetings to be open to the public?							

MAC						
		Yes	Partially	No	Unsure	Notes/Comments
Does MAC membership include the minimum BAC member representation requirements?						
Is there at least one MAC representative from each of the required categories?						
Does the MAC submit an annual report?						
Does the state Medicaid agency review the annual report and ensure the following:						
	Report includes a section describing activities, topics discussed and recommendations of the BAC					
	Report includes state responses to the recommendations					
	Provides MAC members with final review of the report					

MAC					
	Yes	**Partially**	**No**	**Unsure**	**Notes/Comments**
Does the state post the annual MAC report on the state website within 30 days of the report being completed?					

BAC					
	Yes	**Partially**	**No**	**Unsure**	**Notes/Comments**
Does the state intend to use an existing group to meet the BAC requirements?					
Does the state currently have a BAC-like group that meets all the BAC requirements?					
Does BAC membership include:					
Individuals who are currently or have been Medicaid beneficiaries					
Individuals with direct experience supporting Medicaid beneficiaries (family members and paid or unpaid caregivers of those enrolled in Medicaid)					
Do BAC meetings:					
Occur separately from the MAC					
Occur in advance of the MAC meetings					
Do BAC members elect for meetings to be open to the public?					

Use this section to describe any necessary modifications to your IT and data management systems.

Website Transparency

Summary of Regulation Requirements

§§ 441.313, 441.486, 441.595, and 441.750

The state must publish on its website the results of the new proposed reporting requirements under §441.311. Required information includes:

- Critical incident management systems;
- HCBS QMS;
- Timeliness of access;
- Payment adequacy;
- Small provider minimum performance level; and,
- Hardship exemption information.

The state may link to managed care organization (MCO) websites or other websites if they include the required information.

Accessibility requirements

- The state website must provide:
  - Language/translation services at no cost;
  - Auxiliary aids and services at no cost; and,
  - Information about availability of this assistance.

Compliance deadline for all provisions: 3 years (July 2027)

Self-Assessment

Website Transparency					
	Yes	Partially	No	Unsure	Notes/Comments
Does the state have a website that could host the required information?					
Does the state currently meet the website accessibility requirements:					
Use of plain language					
Provides language/translation services available at no cost					
Provides auxiliary aids and services available at no cost					
Website includes clear notice of availability of translation services and auxiliary aids					
Does the state have a process in place to check the functionality and accuracy of the website on at least a quarterly basis?					

Use this section to describe any necessary modifications to your IT and data management systems.