Sellers Dorsey Summary

CMS Ensuring Access to Medicaid Services Final Rule (CMS-2442-F)

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EXECUTIVE SUMMARY

On April 22, 2024, the Centers for Medicare & Medicaid Services (CMS) released for public inspection a final rule, Ensuring Access to Medicaid Services. The rule will be published in the Federal Register on May 10, 2024. In the event CMS makes changes to the published version of this rule, Sellers Dorsey will update this summary. The rule expands on CMS' previous rulemaking around access to care, transparency, and home- and community-based services (HCBS) quality of care. CMS has finalized most provisions in the rule as proposed, with minor adjustments to the beneficiary advisory and HCBS payment requirements. Effective dates for the finalized provisions vary, with states having up to six years to comply with some provisions.

The proposed rule was published in the *Federal Register* on May 3, 2023. CMS accepted public comment on the proposed rulemaking through July 3, 2023. CMS received a total of 2,123 timely comments on the proposed rule, including comments from state Medicaid agencies and managed care organizations, home health providers, and other stakeholders. In their comments, many stakeholders requested additional time, resources, and flexibility to reach compliance should the rules be finalized, while others, particularly providers, opposed the 80/20 rule related to payment for certain HCBS.

Of note, CMS simultaneously released a companion proposed rule, "Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality," addressing topics specific to managed care delivery systems, including new requirements around medical loss ratio, state-directed payments, and rate transparency. CMS also released for public inspection the final rule for this companion proposed rule; publication in the *Federal Register* is also anticipated for May 10, 2024. For the Sellers Dorsey summary of the final Medicaid managed care rule, click here.

KEY PROVISIONS IN THE PROPOSED AND FINAL RULE

MEDICAID ADVISORY COMMITTEE AND BENEFICIARY ADVISORY GROUP

PROPOSED

Re-names the Medical Care Advisory Committee (MCAC) to the Medicaid Advisory Committee (MAC) and proposes additional procedural and operational requirements including the establishment and operations of a Beneficiary Advisory Group (BAG).

Requires the MAC membership to include at least 25 percent of BAG members with lived experiences.

Requires the state to establish and publish MAC and BAG bylaws, memberships, meeting schedules, and minutes.

Requires the MAC to create an annual report for the state.

FINAL

Re-names the Medical Care Advisory Committee (MCAC) to the Medicaid Advisory Committee (MAC) and provides additional procedural and operational requirements.

Re-names Beneficiary Advisory Group to **Beneficiary Advisory Council (BAC)** and creates some additional flexibilities for states regarding the compliance timelines.

HOME- AND COMMUNITY-BASED SERVICES (HCBS)

PROPOSED

Requires states to annually reassess the functional need of the person-centered service plans of at least 90 percent of individuals continuously enrolled in the waiver for at least 365 days. Applies to both fee-for-service (FFS) and managed care delivery systems.

Implements new grievance standards for 1915(c) waivers.

Requires states to maintain an incident management system that identifies, reports,

FINAL

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Revises the 80 percent HCBS payment requirement for Direct Care Workers to create a **hardship exemption** for small providers and adds a new section specifying that it **does not apply to Indian Health Services.**

triages, investigates, resolves, tracks, and trends critical incidents.

Requires states to report every other year on measures in the mandatory measures of the HCBS Quality Measure Set or those identified by the Secretary and stratify specified measures, in addition to establishing performance targets. Requires use of this measure set in 1915(c) waiver programs and establishes a process for removing or adding measures.

Requires states that limit the size of their section 1915(c) waiver program and maintain a wait list of individuals seeking to enroll to provide a description annually on how they maintain the wait list.

Requires states to annually report on the percent of payments for homemaker, home health aide, and personal care services that are spent on compensation for direct care workers.

Establishes new requirements for Website Transparency to provide information on HCBS access, quality, and outcomes across states.

Implements new grievance standards for 1915(c) waivers but **removes provisions on expedited grievances.**

Requires states to maintain an incident management system that identifies, reports, triages, investigates, resolves, tracks, and trends critical incidents.

Requires states to report every other year on measures in the mandatory measures of the HCBS Quality Measure Set or those identified by the Secretary and stratify specified measures, in addition to establishing performance targets. Requires use of this measure set in 1915(c) waiver programs and establishes a process for removing or adding measures.

Requires states that limit the size of their section 1915(c) waiver program and maintain a wait list of individuals seeking to enroll to provide a description annually on how they maintain the wait list.

Requires states to annually report on the percentage of payments for homemaker, home health aide, **habilitation**, and personal care services that are spent on compensation for direct care workers.

Establishes new requirements for Website Transparency to provide information on HCBS access, quality, and outcomes across states.

DOCUMENTATION OF ACCESS TO CARE AND SERVICE PAYMENT RATES

PROPOSED

Repeals and replaces CMS' existing AMRP framework.

Requires states to publicly post their FFS fee schedule.

Requires states to develop and publish an analysis comparing Medicaid to Medicare

FINAL

Repeals and replaces CMS' existing AMRP framework.

Requires states to publicly post their FFS fee schedule.

Requires states to develop and publish an analysis comparing Medicaid to Medicare rates for primary

rates for primary care, OB/GYN services, and outpatient behavioral health services.

Requires states to develop and publish a rate disclosure showing the average hourly payment rate for home health aide services, homemaker services, and personal care services.

Requires states to establish an advisory committee for direct care worker payment rates.

Sets out three criteria for states to meet when proposing payment rate reductions or payment restructurings in circumstances when the changes could result in diminished access.

Requires states to conduct a more extensive access analysis for any SPA that proposes to reduce provider payment rates or restructure provider payments in circumstances when the changes could result in diminished access where the three criteria are not met.

Provides mechanisms for ensuring compliance with requirements for state analysis for rate reduction or restructuring.

care, OB/GYN services, and outpatient behavioral health services.

Requires states to develop and publish a rate disclosure showing the average hourly payment rate for home health aide services, homemaker services, **habilitation**, and personal care services.

Requires states to establish an advisory committee for direct care worker payment rates.

Sets out three criteria for states to meet when proposing payment rate reductions or payment restructurings in circumstances when the changes could result in diminished access.

Requires states to conduct a more extensive access analysis for any SPA that proposes to reduce provider payment rates or restructure provider payments in circumstances when the changes could result in diminished access where the three criteria are not met.

Provides mechanisms for ensuring compliance with requirements for state analysis for rate reduction or restructuring.

MEDICAID ADVISORY COMMITTEE AND BENEFICIARY ADVISORY COUNCIL

Regulatory Background

Section 431.12 required states to have a MCAC to advise the State Medicaid agency about health and medical care services. This regulation was intended to ensure that State Medicaid agencies have a way to receive feedback from interested parties, however, the current regulations lack specificity on how these committees can be used to ensure efficient administration of the Medicaid program. CMS revised § 431.12 to require states to establish both a Medicaid Advisory Committee (MAC) and a new Beneficiary Advisory Council (BAC).

Summary of Proposed to Final Rule and Effective Dates

Medicaid Advisory Committee (MAC) & Beneficiary Advisory Council (BAC) (§ 431.12)

Proposed Language	Final Language	Effective Date
Amends § 431.12(a) to update the name of the existing MCAC to the MAC, and to add the requirement for states to establish and operate a dedicated beneficiary advisory group comprised of Medicaid beneficiaries, the BAG.	Finalized as proposed, with minor modifications as follows: • Language modifications to change BAG to the "Beneficiary Advisory Council (BAC)."	July 9, 2025.
Amends § 431.12(b) regarding the state plan requirements, to reflect the proposed MAC and BAG and the expanded mandate proposed in this proposed rule.	Finalized as proposed, with minor modifications as follows: • Language modifications to change BAG to "BAC." • Replaces the term Medicaid Agency Director with the term, "director of the single State Agency for the Medicaid program."	July 9, 2025.
Amends § 431.12(c) to specify that committee members of the MAC and BAG be appointed by the agency	Finalized as proposed, with minor modifications as follows: • Language modifications to change BAG to "BAC."	July 9, 2025.

director or higher state authority on a rotating, continuous basis and serve for a specific amount of time, the length of which to be determined by each state and documented in its bylaws. • Requires states to make their process and bylaws for recruitment and appointment of members of the MAC and BAG public and post the list of both sets of members to be easily accessible on the state's website.	• Replaces the term agency director or higher authority with the term, "director of the single State Agency for the Medicaid program." • Replaces the word "appoint" with "select" in various places. • Adds language for MAC and BAC members' length of terms to be determined by the state, with additional conditions on consecutive terms.	
Amends § 431.12(d) to account for both committee membership and composition, and to require the MAC membership to include members from the BAG who are currently or have been Medicaid beneficiaries, and individuals with direct experience supporting Medicaid beneficiaries; as well as advocacy groups; providers or administrators of Medicaid services; representatives of managed care plans or state health plan associations representing such managed care plans; and representatives from other state agencies that serve Medicaid beneficiaries. • New § 431.12(d)(1) requires that at least 25 percent of the MAC must be individuals with lived Medicaid beneficiary experience from the BAG. BAG would be comprised of people who: (1) are currently or have been Medicaid beneficiaries and	Finalized as proposed, with minor modifications as follows: • Language modifications to change BAG to BAC; • Replaces the language at § 431.12 (d)(1) to clarify the timeframe for states to reach 25 percent of MAC members coming from the BAC. The new sentence will now read, "For the period from [insert effective date of the final rule] through July 9, 2025, 10 percent of the MAC members must come from the BAC; for the period from July 10, 2025 through July 10, 2026, 20 percent of MAC members must come from the BAC; and thereafter, 25 percent of MAC members must come from the BAC." • Language modifications to § 431.12 (d)(2)(C) to replace "managed care plan" with "MCOs, PIHPs, PAHPs, PCCM entities or PCCMs as defined in § 438.2;" and • Adds the word "non-voting" to ex-officio members at the end of § 431.12 (d)(2)(D).	For the period from the effective date of the final rule through one year after the effective date, 10 percent; for the period from year 1 plus one day through year 2 after the effective date of the final rule, 20 percent; and thereafter, 25 percent of committee members must be from the BAC.

(2) individuals with direct experience supporting Medicaid beneficiaries (family members or caregivers of those enrolled in Medicaid).		
• Replaces the language in § 431.12(e) with new requirements for states to create a dedicated BAG, which will meet separately from the MAC. • New § 431.12(e)(1) requires that the MAC members described in paragraph § 431.12 (d)(1) must also be members of the BAG. • New § 431.12 (e)(2) requires that BAG meetings occur in advance of each MAC meeting to ensure BAG member preparation for each MAC discussion.	Finalized as proposed, with minor modifications as follows: • Language modifications to reflect the new name of the BAC; • Adds language that caregivers on the BAC can be "paid or unpaid." Section 431.12(e) will now state, "…individuals who are currently or have been Medicaid beneficiaries and individuals with direct experience supporting Medicaid beneficiaries (family members and paid or unpaid caregivers of those enrolled in Medicaid) …." • Deletes the phrase "…and provide input to...." Section 431.12(e) will now state "…to advise the state regarding their experience with the Medicaid program, on matters of concern related to policy development and matters related to the effective administration of the Medicaid program."	For the period from the effective date of the final rule through one year after the effective date, 10 percent; for the period from year 1 plus one day through year 2 after the effective date of the final rule, 20 percent; and thereafter, 25 percent of committee members must be from the BAC.
Amends § 431.12(f) to create an administrative framework for the MAC and BAG to ensure transparency and a meaningful feedback loop to the public and among the members of the committee and group: • New § 431.12(f)(1) requires state agencies to develop and post publicly on their website bylaws for governance of the MAC and BAG, current lists of MAC and BAG memberships, and past meeting minutes for	Finalized as proposed, with minor modification as follows: • Language modifications to reflect the new name of the BAC. • Updates § 431.12(f)(1) to state, "States will also post publicly the past meeting minutes of the MAC and BAC meetings, including a list of meeting attendees. States will give BAC members the option to include their names in the membership list and meeting minutes that will be posted publicly." • Updates § 431.12(f)(3) to state, "Each MAC and BAC meeting	For the period from the effective date of the final rule through one year after the effective date, 10 percent; for the period from year 1 plus one day through year 2 after the effective date of the final rule, 20 percent; and thereafter, 25 percent of committee members must be from the BAC.

both the committee and group. • New § 431.12(f)(2) requires state agencies to develop and post publicly a process for MAC and BAG member recruitment and appointment, and for selection of MAC and BAG leadership. • New § 431.12(f)(3) requires state agencies to develop, publicly post, and implement a regular meeting schedule for the MAC and BAG. • New § 431.12(f)(4) requires that at least two MAC meetings per year must be opened to the public. For the MAC meetings that are open to the public, the meeting agenda must include a dedicated time for public comment to be heard by the MAC. The state must also adequately notify the public of the date, location, and time of public MAC meetings at least 30 calendar days in advance. The same requirements would apply to states whose BAG meetings were determined, by its membership, to be open to the public. • New § 431.12(f)(5) requires that states offer in-person and virtual attendance options to maximize member participation at MAC and BAG meetings. • New § 431.12(f)(6) requires that states ensure meeting times and locations for MAC and BAG meetings are selected to maximize	agenda must include a time for members and the public (if applicable) to disclose conflicts of interest." • Updates § 431.12(f)(4) to move one sentence up to be the new second sentence and the deletion of a repetitive sentence so that third sentence now reads as, "The public must be adequately notified of the date, location, and time of each public MAC meeting and any public BAC meeting at least 30 calendar days in advance of the date of the meeting." • Updates § 431.12(f)(5) to state, "Offer a rotating, variety of meeting attendance options. These meeting options are: all in-person attendance, all virtual attendance, and hybrid (in-person and virtual) attendance options. Regardless of which attendance type of meeting it is, states are required to always have at a minimum, telephone dial-in option at the MAC and BAC meetings for its members." • Updates paragraph (f)(7) to reflect additional Federal requirements (adding reference to the Title VI of the Civil Rights Act of 1964). The sentence will now state, "…that reasonable steps are taken to provide meaningful access to individuals with Limited English Proficiency, and that meetings comply with the requirements at § 435.905(b) of this chapter and applicable regulations implementing the ADA, Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act, and section 1557 of the Affordable Care Act at 28 CFR part 35 and 45 CFR parts 80, 84 and 92, respectively."	

participant attendance, which may vary by meeting. • New § 431.12(f)(7) requires state agencies to facilitate participation of beneficiaries by ensuring that meetings are accessible to people with disabilities, that reasonable modifications are provided when necessary to ensure access and enable meaningful participation, that communication with individuals with disabilities is as effective as with others, that reasonable steps are taken to provide meaningful access to individuals with Limited English Proficiency, and that meetings comply with the requirements at § 435.905(b) and applicable regulations implementing the ADA, section 504 of the Rehabilitation Act, and section 1557 of the Affordable Care Act at 28 CFR part 35 and 45 CFR parts 84 and 92.		
Amends § 431.12(g) to detail an expansion of the topics on which the MAC and BAG should provide feedback to the Medicaid agency from the prior MCAC requirements and be based on state needs and matters of policy and program development.	Finalized as proposed, with minor modifications as follows: • Language modifications to reflect the new name of the BAC. • Replaces the wording at § 431.12(g) "to participate in and provide recommendations" with "advise" to clarify the advisory role of the MAC and BAC. • Conforming edits to replacing the term State Medicaid Director at § 431.12(g) with the term, "director of the single State Agency for the Medicaid program." Language modifications to §	For the period from the effective date of the final rule through one year after the effective date, 10 percent; for the period from year 1 plus one day through year 2 after the effective date of the final rule, 20 percent; and thereafter, 25 percent of committee members must be from the BAC.

	431.12(g)(5) to replace "managed care plan" with "MCOs, PIHPs, PAHPs, PCCM entities or PCCMs as defined in §438.2." • Redesignates and finalizes proposed § 431.12(g)(7) as (g)(8) and adds a new § 431.12(g)(7), "access to services." • Replaces the word "or" with the word "and" after 431.12(g)(7), access to services.	
New § 431.12(h) expands on existing state responsibilities for managing the MAC and BAG regarding staff assistance, participation, and financial support to create meaningful beneficiary engagement and participation.	Finalized as proposed, with minor modifications as follows: • Language modifications to reflect the new name of the BAC. • Conforming edits to replace the word "State Agency" with the "single State agency for the Medicaid program" in several places across § 431.12(h). • Language modifications to § 431.12(h)(3) to state, "…MAC and BAC members who are Medicaid beneficiaries…"	For the period from the effective date of the final rule through one year after the effective date, 10 percent; for the period from year 1 plus one day through year 2 after the effective date of the final rule, 20 percent; and thereafter, 25 percent of committee members must be from the BAC.
New § 431.12(i) requires that the MAC, with support from the state and in accordance with the requirements proposed in this section, submit an annual report to the state and that the state post the published report on its website.	Finalized as proposed, with minor modifications as follows: • Language modifications to reflect the new name of the BAC. • Additional sentences at the end of § 431.12(i)(3), "States have two years from [insert the effective date of the final rule] to finalize the first annual MAC report. After the report has been finalized, states will have 30 days to post the annual report."	States have until July 9, 2026 to finalize the annual report. After finalizing, the state must post the annual report within 30 days.

Moves § 431.12(g) to § 431.12(j) and maintains current regulatory language on FFP to support committee activities.	Finalized as proposed, with minor modification as follows: • Language modification to reflect the new name of the BAC.	Not Applicable.
	Adds new paragraph § 431.12 (k) *Applicability dates*. Changed two applicability dates in the new paragraph, that except as noted in paragraphs (d)(1) and (i)(3) of this section, the requirements in paragraphs (a) through (j) are applicable July 9, 2025.	Not Applicable.

HOME- AND COMMUNITY-BASED SERVICES (HCBS)

Regulatory Background

In 2014, CMS released guidance for section 1915(c) waiver programs that included expectations for state reporting of state-developed performance measures to demonstrate both compliance with section 1915(c) of the Social Security Act and implementing regulations through six assurances (level of care, service plan, qualified providers, health and welfare, financial accountability, and administrative authority). CMS also issued State Medicaid Director Letter #22-003 that outlined the first official version of the HCBS Quality Measure Set.

The HCBS requirements in this rulemaking are intended to establish a new strategy for oversight, monitoring, quality assurance, and quality improvement for section 1915(c) waiver programs. The approach focuses on priority areas that have been identified by states, oversight entities, consumer advocacy organizations, and other interested parties and include person-centered planning, health and welfare, access, beneficiary protections, and quality improvement. CMS finalized new state assurance requirements, minimum performance requirements, and new reporting requirements for section 1915(c) waiver programs that are intended to supersede and fully replace the reporting requirements and the 86 percent performance level threshold for performance measures described in the 2014 guidance for section 1915(c) waiver programs. Additionally, most new requirements are proposed to apply similarly to section 1915(i), (j), and (k) state plan services and managed care delivery systems under sections 1915(a), 1915(b), 1932(a), and 1115(a) to the extent they include HCBS.

Commenters expressed general support for CMS' efforts to increase transparency and accountability in HCBS programs to improve access to Medicaid services, particularly related to provisions intended to support HCBS delivery systems through enhancements in data collection relating to waiting lists and service delivery, improvements to person-centered planning, calibration of critical incident investigation and grievance process requirements, and formation of distinct quality measures. Commenters' reactions to the payment adequacy minimum performance level were mixed and highlighted that the direct care worker shortage is impacting beneficiaries' abilities to access quality services. Commenters' concerns were mainly around the apparent exclusion of services and the timeframe states would be given to make the transition.

Summary of Proposed to Final Rule and Effective Dates

Person-Centered Service Plans

(§§ 42 CFR 441.301(c), 441.450(c), 441.540(c), 441.725(c))

Proposed Language	Final Language	Effective Date
Amends § 441.301(c)(3)(i) to specify a state must ensure the person-centered service plan is reviewed at least every 12 months,	Finalized as proposed.	For FFS delivery systems, July 7, 2027.

when the individual's circumstances or needs change, or at an individual's request. To ensure consistency in the administration of policies and procedures across HCBS programs, CMS proposes to apply the requirements at § 441.302(c)(3) to 1915(i), (j), and (k) state plan services via cross-reference. To ensure consistency in person-centered service plan requirements between FFS and managed care delivery systems, CMS proposes to add the requirements at § 441.301(c)(3) to 42 CFR 438.208(c).		For managed care, the first rating period beginning on or after July 7, 2027.
New § 441.301(c)(3)(ii)(A) requires states demonstrate that a reassessment of functional need was conducted at least annually for at least 90 percent of individuals continuously enrolled in the waiver for a minimum of 365 days.	Finalized as proposed with minor technical modifications.	For FFS delivery systems, July 7, 2027. For managed care, the first rating period beginning on or after July 7, 2027.
New § 441.301(c)(3)(ii)(B) requires that states demonstrate that they reviewed the person-centered service plan and revised the plan as appropriate based on the results of the required reassessment of functional need at least every 12 months for at least 90 percent of individuals	Finalized as proposed with minor technical modifications.	For FFS delivery systems, July 7, 2027. For managed care, the first rating period beginning on or after July 7, 2027.

continuously enrolled in the waiver for at least 365 days.		

Grievance System
(§§ 441.301(c)(7), 441.464(d)(2)(v), 441.555(b)(2)(iv), 441.745(a)(1)(iii))

Proposed Language	Final Language	Effective Date
New § 441.301(c)(7) requires states establish grievance procedures for Medicaid beneficiaries receiving section 1915(c) waiver program services through an FFS delivery system. • States must establish a procedure for a beneficiary to file a grievance related to the state's or a provider's compliance with the person-centered planning and service plan requirements at §§ 441.301(c)(1) through (3) and the HCBS settings requirements at §§ 441.301(c)(4) through (6).	Finalized § 441.301(c)(7)(i) and (ii) with minor modifications as follows: • Includes language specifying the state may have activities described in paragraph (c)(7) of this section performed by contractors or other government entities, provided, however, that the state retains responsibility for ensuring performance of and compliance with these provisions. Finalized § 441.301(c)(7)(i) and the definition of grievance in § 441.301(c)(7)(ii) with the following modification: • States must establish a procedure for a beneficiary to file a grievance related to the state's or a provider's performance of (rather than compliance with) the person-centered planning and service plan requirements at §§ 441.301(c)(1) through (3) and the HCBS settings requirements at §§ 441.301(c)(4) through (6). Finalized the definition of grievance system at § 441.301(c)(7)(ii) as proposed.	July 9, 2026.
New § 441.301(c)(7)(iii)(A) requires a beneficiary or authorized representative be	Finalized § 441.301(c)(7)(iii)(A) as proposed, with a minor modification as follows:	July 9, 2026.

permitted to file a grievance. Under the proposal, another individual or entity may file a grievance on a beneficiary's behalf, provided the beneficiary or authorized representative provides written consent. All references to beneficiary in the regulatory text of this section include the beneficiary's representative, if applicable.	CMS specifies another individual or entity may file a grievance on behalf of the beneficiary or provide the beneficiary with assistance or representation throughout the grievance process, with the written consent of the beneficiary or authorized representative. § 441.301(c)(7)(iii)(A)(2) is finalized as proposed.	
New § 441.301(c)(7)(iii)(B)(1) through (7) require states to: • Have written policies and procedures for their grievance processes that at a minimum meet the requirements of this proposed section and serve as the basis for the state's grievance process; • Provide beneficiaries with reasonable assistance in completing the forms and procedural steps related to grievances and to ensure that the grievance system is consistent with the availability and accessibility requirements at § 435.905(b); • Ensure that punitive action is not threatened or taken against an individual filing a grievance; • Accept grievances, requests for expedited resolution of grievances, and requests for extensions of timeframes from beneficiaries; • Provide beneficiaries with notices and other information related to the grievance system, including information on their rights under the grievance system	The process requirement at § 441.301(c)(7)(iii)(B) is finalized as proposed. § 441.301(c)(7)(iii)(B)(2) is finalized as proposed, with a modification to specify states must provide beneficiaries with reasonable assistance in ensuring that grievances are properly filed in the system and changing the language to read "individuals with Limited English Proficiency." § 441.301(c)(7)(iii)(B)(3) is modified slightly to extend protections to an individual who has had a grievance filed on their behalf. § 441.301(c)(7)(iii)(B)(4) is modified to remove the reference to expedited grievances.	July 9, 2026.

and on how to file a grievance, and ensure that such information is accessible for individuals with disabilities and individuals who are limited English proficient in accordance with § 435.905(b); • Review grievance resolutions with beneficiaries who are dissatisfied; and • Provide information on the grievance system to providers and subcontractors approved to deliver services under section 1915(c) of the Act.		
New § 441.301(c)(7)(iii)(C)(1) through (5) require that the processes for handling grievances must: • Allow beneficiaries to file a grievance either orally or in writing; • Acknowledge receipt of each grievance; • Ensure that decisions on grievances are not made by anyone previously involved in the review or decision-making related to the problem or issue for which the beneficiary has filed a grievance or a subordinate of such an individual, are made by individuals with appropriate expertise, and are made by individuals who consider all of the information submitted by the beneficiary related to the grievance; • Provide beneficiaries with a reasonable opportunity, face-to-face (including through	Finalized as proposed with minor technical and formatting modifications.	July 9, 2026.

the use of audio or video technology) and in writing, to present evidence and testimony and make legal and factual arguments related to their grievance; • Provide beneficiaries, free of charge and in advance of resolution timeframes, with their own case files and any new or additional evidence used or generated by the state related to the grievance; and • Provide beneficiaries, free of charge, with language services, including written translation and interpreter services in accordance with § 435.905(b), to support their participation in grievance processes and their use of the grievance system.		
New § 441.301(c)(7)(iv)(A) requires the beneficiary be able to file a grievance at any time.	Finalized as proposed but redesignated § 441.301(c)(7)(iv)(A) as § 441.301(c)(7)(iv).	July 9, 2026.
New § 441.301(c)(7)(iv)(B) requires beneficiaries be permitted to request expedited resolution of a grievance, whenever there is a substantial risk that resolution within standard timeframes will adversely affect the beneficiary's health, safety, or welfare.	References to the expedited resolution requirement at § 441.301(c)(7)(iv)(B) were removed.	Not applicable.
New § 441.301(c)(7)(v)(A) requires states resolve and provide notice of resolution related to each grievance as quickly as the beneficiary's health, safety, and welfare requires and within state-	Finalized as proposed, with minor modification to require that the state resolve each grievance, and provide notice, as expeditiously as the beneficiary's health condition (instead of	July 9, 2026.

established timeframes that do not exceed the standard and expedited timeframes proposed in § 441.301(c)(7)(v)(B).	health, safety, and welfare) requires.	
New § 441.301(c)(7)(v)(B)(1) requires that standard resolution of a grievance and notice to affected parties must occur within 90 calendar days of receipt of the grievance.	Redesignated § 441.301(c)(7)(v)(B)(1) as § 441.301(c)(7)(v)(B), and retitled § 441.301(c)(7)(v)(B) as "Resolution timeframes." Removed the word "standard" in § 441.301(c)(7)(v)(B)(1) since the finalized requirements do not distinguish between "standard resolution" and other types of resolutions.	July 9, 2026.
New § 441.301(c)(7)(v)(B)(2) requires that expedited resolution of a grievance and notice must occur within 14 calendar days of receipt of the grievance.	References to the expedited resolution of a grievance requirement was removed.	Not applicable.
New § 441.301(c)(7)(v)(C) permits states to extend the timeframes for the standard resolution and expedited resolution of grievances by up to 14 calendar days if the beneficiary requests the extension, or the state documents that there is need for additional information and how the delay is in the beneficiary's interest.	Finalized as proposed, with minor modification as follows: Designated (C)(1)(i) and (C)(1)(ii) as (C)(1) and (C)(2), respectively, and removes the reference to expedited grievances.	July 9, 2026.
New § 441.301(c)(7)(v)(D) requires that states make reasonable efforts to give the beneficiary prompt oral notice of the delay, give the beneficiary written notice within two calendar days of determining a need for a delay but no later than the timeframes in paragraph (c)(7)(v)(B) of the	Finalized as proposed, with minor technical modifications.	July 9, 2026.

reason for the decision to extend the timeframe, and resolve the grievance as expeditiously as the beneficiary's health condition requires and no later than the date the extension expires if the state extends the timeframe for a standard resolution or an expedited resolution.		
New § 441.301(c)(7)(vi)(A) requires that states establish a method for written notice to beneficiaries and that the method meet the availability and accessibility requirements at § 435.905(b).	Redesignated § 441.301(c)(7)(vi)(A) as § 441.301(c)(7)(vi) without substantial modification.	July 9, 2026.
New § 441.301(c)(7)(vi)(B) requires that states make reasonable efforts to provide oral notice of resolution for expedited resolutions.	References to the expedited resolution of grievances were removed.	Not applicable.
New § 441.301(c)(7)(vii)(A) requires that states maintain records of grievances and review the information as part of their ongoing monitoring procedures.	Finalized as proposed.	July 9, 2026.
New § 441.301(c)(7)(vii)(B)(*1*) through (6), require that the record of each grievance must contain the following information at a minimum: general description of the reason for the grievance, date received, date of each review or review meeting (if applicable), resolution and date of the resolution of the grievance (if applicable), and the name of the beneficiary for whom the grievance was filed.	Finalized as proposed, with minor modifications as follows: • Replaces the periods at the end of each paragraph with semi-colons, to accurately reflect that § 441.301(c)(7)(vii)(B)(1) through (6) are elements of a non-exhaustive list, not separate declarative statements. • Added the word "and" to the end of § 441.301(c)(7)(vii)(B)(5).	July 9, 2026.

New § 441.301(c)(7)(vii)(C) requires grievance records be accurately maintained and in a manner that would be available upon CMS request.	Finalized as proposed.	July 9, 2026.

Incident Management System
(§§ 441.302(a)(6), 441.464(e), 441.570(e), 441.745(a)(1)(v) and (b)(1)(i))

Proposed Language	Final Language	Effective Date
New § 441.302(a)(6) requires that states provide an assurance that they operate and maintain an incident management system that identifies, reports, triages, investigates, resolves, tracks, and trends critical incidents.	Finalized as proposed.	For FFS delivery systems, July 9, 2027. For managed care, the first rating period beginning on or after July 9, 2027. Note a different effective date for § 441.302(a)(6)(i)(B) below.
New § 441.302(a)(6)(i)(A) through (G) establish requirements for states' incident management systems: New § 441.302(a)(6)(i)(A) establishes a minimum standard definition of a critical incident to include, at a minimum, 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 visit, an urgent care visit, a hospitalization, or death; or an unexplained or unanticipated death, including but not limited to a death caused by abuse or neglect.	Finalized as proposed, with formatting modifications.	For FFS delivery systems, July 9, 2027. For managed care, the first rating period beginning on or after July 9, 2027. Note a different effective date for § 441.302(a)(6)(i)(B) below.
New § 441.302(a)(6)(i)(B) requires states have electronic critical incident systems that, at a minimum, enable electronic collection, tracking (including of the status and resolution of	Finalized as proposed, with minor modification as follows: • § 441.302(a)(6)(i)(B) with the addition of the word "enables" and striking "enables" from §	For FFS delivery systems, July 9, 2029. For managed care, beginning the first rating period on or after July 9, 2029.

investigations), and trending of data on critical incidents.	441.302(a)(6)(i)(B)(1) so that it applies to all paragraphs in § 441.302(a)(6)(i)(B).	
New § 441.302(a)(6)(i)(C) requires states to require providers to report to states any critical incidents that occur during the delivery of section 1915(c) waiver program services as specified in a waiver beneficiary's person-centered service plan, or any critical incidents that are a result of the failure to deliver authorized services.	Finalized as proposed with minor modifications as follows, highlighted in bold: • Requires providers to report to the state, within state-established timeframes and procedures, any critical incident that occurs during the delivery of services authorized under section 1915(c) of the Act and as specified in the **beneficiary's** person-centered service plan, or occurs as a result of the failure to deliver services authorized under section 1915(c) of the Act and as specified in the **beneficiary's** person-centered service plan.	For FFS delivery systems, July 9, 2029. For managed care, beginning the first rating period on or after July 9, 2029.
New § 441.302(a)(6)(i)(D) requires states use claims data, Medicaid Fraud Control Unit data, and data from other state agencies such as Adult Protective Services or Child Protective Services to the extent permissible under applicable state law to identify critical incidents that are unreported by providers and occur during the delivery of section 1915(c) waiver program services, or as a result of the failure to deliver authorized services.	Finalized as proposed, with minor modifications as follows: • Requires providers to report to the state, within state-established timeframes and procedures, any critical incident that occurs during the delivery of services authorized under section 1915(c) of the Act and as specified in the **beneficiary's** person-centered service plan, or occurs as a result of the failure to deliver services authorized under section 1915(c) of the Act and as specified in the **beneficiary's** person-centered service plan. (New language identified in bold.)	For FFS delivery systems, July 9, 2029. For managed care, beginning the first rating period on or after July 9, 2029.
New § 441.302(a)(6)(i)(E) requires states share	Finalized as proposed, with the following minor technical	For FFS delivery systems, July 9, 2029.

information, consistent with the regulations in 42 CFR part 431, subpart F, on the status and resolution of investigations.	modification to clarify that mention of critical incident in § 441.302(a)(6)(i)(E) refers to critical incidents as defined in paragraph (a)(6)(i)(A) of § 441.302).	For managed care, beginning the first rating period on or after July 9, 2029.
New § 441.302(a)(6)(i)(F) requires states to separately investigate critical incidents if the investigative agency fails to report the resolution of an investigation within state-specified timeframes.	Finalized as proposed.	For FFS delivery systems, July 9, 2029. For managed care, beginning the first rating period on or after July 9, 2029.
New § 441.302(a)(6)(i)(G) requires states meet the reporting requirements at § 441.311(b)(1) related to the performance of their incident management systems.	Finalized as proposed.	For FFS delivery systems, July 9, 2029. For managed care, beginning the first rating period on or after July 9, 2029.
New § 441.302(a)(6)(ii)(A) through (C) require states demonstrate that an investigation was initiated, within state-specified timeframes, for no less than 90 percent of critical incidents; an investigation was completed and the resolution of the investigation was determined, within state-specified timeframes, for no less than 90 percent of critical incidents; and corrective action was completed, within state-specified timeframes, for no less than 90 percent of critical incidents that require corrective action.	Finalized as proposed.	For FFS delivery systems, July 9, 2029. For managed care, beginning the first rating period on or after July 9, 2029.

Reporting
(§ 441.302(h))

Proposed Language	Final Language	Effective Date
Amends § 441.302(h) to consolidate reporting expectations in one new section at proposed § 441.311, described in the *Reporting Requirements* section below. This reporting will supersede existing reporting for section 1915(c) waivers and standardize reporting across section 1915 HCBS authorities.	Finalized as proposed.	Beginning July 9, 2027 for § 441.311(b) (compliance reporting) and § 441.311(d) (access reporting). Beginning July 9, 2028 for § 441.311(c) (reporting on the HCBS Quality Measure Set) and (e) (HCBS payment adequacy reporting).

HCBS Payment Adequacy
(§§ 441.302(k), 441.464(f), 441.570(f), 441.745(a)(1)(vi))

Proposed Language	Final Language	Effective Date
New § 441.302(k)(3)(i) requires at least 80 percent of all Medicaid payments, including but not limited to base payments and supplemental payments, with respect to homemaker services, home health aide services, and personal care services, be spent on compensation to direct care workers.	The national minimum payment level of 80 percent at § 441.302(k) is finalized with several modifications: • Revised the heading of § 441.302(k)(3) to read "Minimum performance at the provider level," and clarifies that excluded costs are not included in the calculation of the percentage of total payments to a provider that is spent on direct care worker compensation. • Revised § 441.302(k)(3)(ii) to allow states to set a separate minimum performance level for small providers.	July 9, 2030.

New § 441.302(k)(1)(i) defines compensation to include salary, wages, and other remuneration as defined by the Fair Labor Standards Act and implementing regulations, and benefits (such as health and dental benefits, sick leave, and tuition reimbursement), as well as the employer shared of the payroll taxes for direct care workers delivering services under section 1915(c) waivers.	Revised the definition of compensation at § 441.302(k)(1)(i)(B) to read "Benefits (such as health and dental benefits, life and disability insurance, paid leave, retirements, and tuition reimbursement)."	July 9, 2030.
New § 441.302(k)(1)(ii) defines direct care workers to include workers who provide nursing services, assist with activities of daily living (ADLs) or instrumental activities of daily living (IADLs), and provide behavioral supports, employment supports, or other services to promote community integration. Direct care workers include individuals employed/contracted by a Medicaid provider, state agency, or third party or delivering services under self-directed delivery models. Specifically, direct care workers include: • Nurses (registered nurses, licensed practical nurses, nurse practitioners, or clinical nurse specialists) who provide nursing services to Medicaid-eligible individuals receiving HCBS, • Licensed or certified nursing assistants, • Direct support professionals, • Personal care attendants, • Home health aides, and	• Revised the definition of compensation at § 441.302(k)(1)(i)(B) to read "Benefits (such as health and dental benefits, life and disability insurance, paid leave, retirements, and tuition reimbursement)." • Revised the definition of direct care worker proposed at § 441.301(k)(1)(ii) to clarify that clinical supervisors are included in the definition of direct care workers. • Modified to not finalize § 441.302(k)(1)(ii)(G) and instead add language proposed there to the end of § 441.302(k)(1)(ii) which clarifies that a direct care worker 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 services delivery model.	July 9, 2030.

• Other individuals who are paid to directly provide services to Medicaid beneficiaries receiving HCBS to address ADLs, IADLs, behavioral supports, employment supports, or other services to promote community integration.	• Added a definition of excluded costs at § 441.302(k)(1)(iii) to ensure certain costs (training, travel, and PPE costs) are not included in the minimum performance level calculation of the percentage of Medicaid payments to providers that is spent on compensation for direct care workers.	
New § 441.302(k)(2) requires states demonstrate that they meet the minimum performance level at § 441.302(k)(3)(i) through new Federal reporting requirements at § 441.311(e).	Finalized as proposed, with modifications as follows: Redesignated § 441.302(k)(2) as § 441.302(k)(2)(i) and made technical modifications to clarify the types of services under the payment adequacy requirement (homemaker, home health aide, and personal care services). § 441.302(k)(2)(i) was finalized with references to the reporting requirements finalized at §§ 441.302(k)(6) and 441.311(e) and the exception finalized at § 441.302(k)(2)(ii). Added a new requirement at § 441.302(k)(2)(ii) that clarifies that if the services are under a self-directed model in which the beneficiary sets the payment rate, then these are not included in the payment data.	July 9, 2030.
	Added a new provision at § 441.302(k)(4) to provide an option for states to develop reasonable, objective criteria to identify small providers to meet a small provider minimum performance level set by the state.	July 9, 2030.

	Added a new hardship exemption provision at § 441.302(k)(5) to allow states to develop reasonable, objective criteria to exempt certain providers from meeting the minimum performance level requirement.	July 9, 2030.
	Added a new provision at § 441.302(k)(6)(i) to require states that establish a small provider minimum performance level in accordance with § 441.302(k)(4) to report to CMS annually on: • Small provider criteria • The new minimum performance level • The percentage of providers that qualify for this exception, • A plan for small providers to eventually come into compliance with the 80 percent requirement. Finalized §§ 441.474(c), 441.580(i), and 441.745(a)(1)(vii) with a technical modification to clarify that the reporting requirement at § 441.302(k)(6) applies to section 1915(j), (k) and (i) authorities, respectively.	July 9, 2030.
	Added a new provision at § 441.302(k)(7) to exempt the Indian Health Service (IHS) and Tribal health programs subject to 25 U.S.C. 1641 from the HCBS payment adequacy requirements at § 441.302(k).	July 9, 2030.
New § 441.302(k)(4) applies these requirements to services delivered under FFS or managed care delivery systems.	Finalized as proposed, with minor modifications as follows: Redesignated as § 441.302(k)(8) and made minor technical edits to the language to improve	July 9, 2030.

	accuracy and alignment with common phrasing in managed care contracting policy.	
Cross reference at §§ 441.464(f), 441.570(f), and 441.745(a)(1)(vi) to apply these requirements to section 1915(j), (k), and (i) state plan services.	§§ 441.464(f), 441.570(f), and 441.745(a)(1)(vi) are finalized as proposed with a technical modification to clarify that references to person-centered service plans mean beneficiaries' person-centered service plans. Finalized as proposed, with minor modifications to clarify that § 441.302(k) applies to services delivered under these authorities, except that references to section 1915(c) of the Act are instead references to sections 1915(j), (k), or (i) of the Act, as appropriate.	July 9, 2030.

Supporting Documentation Required
(§ 441.303(f)(6))

Proposed Language	Final Language	Effective Date
Amends § 441.303(f)(6) to require states to meet the reporting requirements at § 441.311(d)(1), specifically requiring information from states on waiting lists and processes related to HCBS waiting lists to ensure CMS can adequately oversee and monitor states' use of waiting lists in their section 1915(c) waiver programs.	Finalized as proposed, with some modifications discussed in the Reporting Requirements (§§ 441.311, 441.474(c), 441.580(i), and 441.745(a)(1)(vii)) section.	For FFS delivery systems, July 9, 2027. For managed care, beginning the first rating period on or after July 9, 2027.

Reporting Requirements
(§§ 441.311, 441.474(c), 441.580(i), 441.745(a)(1)(vii))

Compliance Reporting

Incident Management System Assessment

Proposed Language	Final Language	Effective Date
New § 441.302(a)(6)(i)(A) establishes a minimum standard definition of a critical incident to include, at a minimum, 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 visit, an urgent care visit, a hospitalization, or death; or an unexplained or unanticipated death, including but not limited to a death caused by abuse or neglect.	Finalized as proposed, with minor modifications.	Beginning July 9, 2027; except for the requirement at § 441.302(a)(6)(i)(B) (electronic incident management system), which begins July 9, 2029.
New § 441.302(a)(6)(i)(B) requires that states have electronic critical incident systems that, at a minimum, enable electronic collection, tracking (including of the status and resolution of investigations), and trending of data on critical incidents.	Finalized as proposed, with minor formatting modifications.	Beginning July 9, 2027; except for the requirement at § 441.302(a)(6)(i)(B) (electronic incident management system), which begins July 9, 2029.
New § 441.302(a)(6)(i)(C) requires states to require providers to report to states any critical incidents that occur during the delivery of section	Finalized as proposed, with minor modifications to require providers to report to the state, within state-established timeframes and procedures, any	Beginning July 9, 2027; except for the requirement at § 441.302(a)(6)(i)(B) (electronic incident management system), which begins July 9, 2029.

1915(c) waiver program services as specified in a waiver beneficiary's person-centered service plan, or any critical incidents that are a result of the failure to deliver authorized services.	critical incident that occurs during the delivery of services authorized under section 1915(c) of the Act and as specified in the beneficiary's person-centered service plan, or that occurs as a result of the failure to deliver services authorized under section 1915(c) of the Act and as specified in the beneficiary's person-centered service plan.	
New § 441.302(a)(6)(i)(D) requires states use claims data, Medicaid Fraud Control Unit data, and data from other state agencies such as Adult Protective Services or Child Protective Services to the extent permissible under applicable state law to identify critical incidents that are unreported by providers and occur during the delivery of section 1915(c) waiver program services, or as a result of the failure to deliver authorized services.	Finalized as proposed, with minor modifications to require providers to report to the state, within state-established timeframes and procedures, any critical incident that occurs during the delivery of services authorized under section 1915(c) of the Act and as specified in the beneficiary's person-centered service plan, or occurs as a result of the failure to deliver services authorized under section 1915(c) of the Act and as specified in the beneficiary's person-centered service plan.	Beginning July 9, 2027; except for the requirement at § 441.302(a)(6)(i)(B) (electronic incident management system), which begins July 9, 2029.
New § 441.302(a)(6)(i)(E) requires that states share information, consistent with the regulations in 42 CFR part 431, subpart F, on the status and resolution of investigations.	Finalized as proposed, with minor formatting modifications.	Beginning July 9, 2027; except for the requirement at § 441.302(a)(6)(i)(B) (electronic incident management system), which begins July 9, 2029.
New § 441.302(a)(6)(i)(F) requires states to separately investigate critical incidents if the investigative agency fails to report the resolution of an investigation within state-specified timeframes.	Finalized as proposed.	Beginning July 9, 2027; except for the requirement at § 441.302(a)(6)(i)(B) (electronic incident management system), which begins July 9, 2029.
New § 441.302(a)(6)(i)(G) requires states meet the reporting requirements at	Finalized as proposed.	Beginning July 9, 2027; except for the requirement at § 441.302(a)(6)(i)(B) (electronic

§ 441.311(b)(1) related to the performance of their incident management systems.		incident management system), which begins July 9, 2029.
New § 441.302(a)(6)(ii)(A) through (C) require states demonstrate that an investigation was initiated, within state-specified timeframes, for no less than 90 percent of critical incidents; an investigation was completed and the resolution of the investigation was determined, within state-specified timeframes, for no less than 90 percent of critical incidents; and corrective action was completed, within state-specified timeframes, for no less than 90 percent of critical incidents that require corrective action.	Finalized as proposed.	Beginning July 9, 2027; except for the requirement at § 441.302(a)(6)(i)(B) (electronic incident management system), which begins July 9, 2029.
New § 441.311(b)(1)(i) requires states to report every 24 months the results of an incident management system assessment to demonstrate they meet requirements at § 441.302(a)(6).	Finalized as proposed, with minor modification to clarify the state must report on the results of an incident management system assessment, every 24 months, in the form and manner, and at a time, specified by CMS, rather than according to the format and specifications provided by CMS.	For FFS delivery systems, July 9, 2027. For managed care, the first rating period beginning on or after July 9, 2027.
New § 441.311(b)(1)(ii) permits CMS to reduce the frequency of required reporting to once every 60 months.	Finalized as proposed.	For FFS delivery systems, July 9, 2027. For managed care, the first rating period beginning on or after July 9, 2027.

Critical Incidents

Proposed Language	Final Language	Effective Date
New § 441.311(b)(2) requires states report annually on the: • Number and percent of critical incidents for which an investigation was initiated within state-specified timeframes, • Number and percent of critical incidents that are investigated and for which the state determines the resolution within state-specified timeframes; and • Number and percent of critical incidents requiring corrective action, as determined by the state, for which the required corrective action has been completed within state-specified timeframes.	Finalized as proposed, with minor modification to clarify that the state must report to CMS annually in the form and manner, and at a time, specified by CMS, rather than according to the format and specifications provided by CMS.	For FFS delivery systems, July 9, 2027. For managed care, the first rating period beginning on or after July 9, 2027.

Person-Centered Planning

Proposed Language	Final Language	Effective Date
New § 441.311(b)(3)(i) requires states to report on the percent of beneficiaries continuously enrolled for at least 365 days for whom a reassessment of functional need was completed within the past 12 months.	Finalized as proposed, with the minor modification noted above to specify that the state may report this metric using **statistically valid random sampling of beneficiaries**.	For FFS delivery systems, July 9, 2027. For managed care, the first rating period beginning on or after July 9, 2027.
New § 441.311(b)(3)(ii) requires states to report on the percent of beneficiaries continuously enrolled for at least 365 days who had a service plan updated	Finalized as proposed, with the minor modification noted above to specify that the state may report this metric using	For FFS delivery systems, July 9, 2027.

as a result of a reassessment of functional need within the past 12 months.	**statistically valid random sampling of beneficiaries**.	For managed care, the first rating period beginning on or after July 9, 2027.

Type, Amount, and Cost of Services

Proposed Language	Final Language	Effective Date
New § 441.311(b)(4) contains language previously at § 441.302(h)(1), requiring state reporting of the type, amount and cost of services provided.	Finalized with language from § 441.302(h) (highlighted in bold) to specify that, **annually**, the **state will provide CMS with information on the waiver's impact on** the type, amount, and cost of services provided under the state plan.	For FFS delivery systems, July 9, 2027. For managed care, the first rating period beginning on or after July 9, 2027.

Reporting on Home- and Community-Based Services (HCBS) Quality Measure Set

Proposed Language	Final Language	Effective Date
New § 441.311(c)(1)(i) requires states to report every other year on measures identified in the HCBS Quality Measure Set as mandatory measures for states to report or are identified as measures for which the Secretary will report on behalf of states, according to the form and schedule prescribed by the Secretary.	Finalized as proposed, with a minor modification that states must comply with the reporting requirement beginning four years, rather than three years, from the effective date of this final rule for the HCBS Quality Measure Set.	For FFS delivery systems, July 9, 2028. For managed care, the first rating period beginning on or after July 9, 2028.
New § 441.311(c)(1)(ii) allows states to report on measures in the HCBS Quality Measure Set that are not identified as mandatory.	Finalized as proposed.	For FFS delivery systems, July 9, 2028. For managed care, the first rating period beginning on or after July 9, 2028.
New § 441.311(c)(1)(iii) requires states to establish performance	Finalized as proposed.	For FFS delivery systems, July 9, 2028.

targets (subject to CMS review and approval) for each of the measures in the HCBS Quality Measure Set identified as mandatory or measures CMS will report on behalf of states, in addition to describing the quality improvement strategies that will be undertaken to achieve the established performance targets.		For managed care, the first rating period beginning on or after July 9, 2028.
New § 441.311(c)(1)(iv) allows states to establish performance targets for non-mandatory measures in the HCBS Quality Measure Set or measures the Secretary will report on behalf of states as well as to describe the quality improvement strategies that they will pursue to achieve the performance targets for those targets.	Finalized as proposed.	For FFS delivery systems, July 9, 2028. For managed care, the first rating period beginning on or after July 9, 2028.
New § 441.311(c)(2) obligates CMS to report, on behalf of states, on a subset of measures in the HCBS Quality Measure Set.	Finalized as proposed.	For FFS delivery systems, July 9, 2028. For managed care, the first rating period beginning on or after July 9, 2028.
New § 441.311(c)(3) permits states to report on measures that are not yet required but will be, and on populations for whom reporting is not yet required but will be phased-in in the future.	Finalized as proposed.	For FFS delivery systems, July 9, 2028. For managed care, the first rating period beginning on or after July 9, 2028.

Access Reporting

Proposed Language	Final Language	Effective Date
New § 441.311(d)(1)(i) requires states provide a description annually on how they maintain the list of individuals who are waiting to enroll in a section 1915(c) waiver program, if they have a limit on the size of the waiver program and maintain a list of individuals who are waiting to enroll in the waiver program, as described in § 441.303(f)(6). Additionally, the information must include information on whether the state screens individuals on the waiting list for eligibility in the waiver program, whether the state periodically re-screens individuals on the list, and the frequency of any re-screening.	Finalized as proposed.	For FFS delivery systems, July 9, 2027. For managed care, the first rating period beginning on or after July 9, 2027.
New § 441.311(d)(1)(ii) requires states annually report the number of people on the waiting list, if applicable.	Finalized as proposed.	For FFS delivery systems, July 9, 2027. For managed care, the first rating period beginning on or after July 9, 2027.
New § 441.311(d)(1)(iii) requires states annually report the average amount of time that individuals newly enrolled in the waiver program in the past 12 months were on the waiting list, if applicable.	Finalized as proposed.	For FFS delivery systems, July 9, 2027. For managed care, the first rating period beginning on or after July 9, 2027.
New § 441.311(d)(2)(i) requires states report annually on the average amount of time from when homemaker services, home health aide services, or personal care services, as listed in § 440.180(b)(2) through (4),	Finalized as proposed, with minor modifications to include habilitation services and specify the state may report this metric using statistically valid random sampling of beneficiaries.	For FFS delivery systems, July 9, 2027. For managed care, the first rating period beginning on or after July 9, 2027.

are initially approved to when services began, for individuals newly approved to begin receiving services within the past 12 months. Also provides for states to use a statistically valid random sample of beneficiaries.		
New § 441.311(d)(2)(ii), requires states to report annually on the percent of authorized hours for homemaker services, home health aide services, or personal care services, as listed in § 440.180(b)(2) through (4), that are provided within the past 12 months. Also provides for states to use a statistically valid random sample of beneficiaries.	Finalized as proposed, with minor modifications to include habilitation services and specify that the state may report this metric using statistically valid random sampling of beneficiaries.	For FFS delivery systems, July 9, 2027. For managed care, the first rating period beginning on or after July 9, 2027.

Payment Adequacy

Proposed Language	Final Language	Effective Date
New § 441.311(e) requires states annually report on the percent of payments for homemaker, home health aide, and personal care services (found at § 440.180(b)(2) through (4)) that are spent on compensation for direct care workers. Separate reporting would be required for each service subject to the reporting requirement, and, within each service, separately on payments for services that are self-directed.	Finalized with various modifications and the addition of new sections: Included habilitation services in the report. Redesignated paragraph (e) as (e)(2)(i) and specified at § 441.311(e)(2)(i) that the state must report to CMS annually on the percentage of total payments (**not including excluded costs**), to include habilitation services (as set forth in § 440.180(b)(6)) in the reporting, and to specify that states must report separately for services delivered in a provider-operated physical location for which facility-related costs are	For FFS delivery systems, July 9, 2028. For managed care, the first rating period beginning on or after July 9, 2028.

	included in the payment rate. Finalized a new requirement at § 441.311(e)(2)(ii) that specifies if the services are provided through a self-directed model, the state must exclude the payment data from the report. Finalized a new § 441.311(e)(3), requiring the state must report, one year prior to the applicability date for paragraph (e)(2)(i) of this section, on its readiness to comply with the reporting requirement in paragraph (e)(2)(i). Finalized a new § 441.311(e)(4) to require states to exclude data from the Indian Health Service and Tribal health programs subject to the requirements at 25 U.S.C. 1641 from the required reporting at § 441.311(e).	
New § 441.311(f) applies all the reporting requirements described in § 441.311 to services delivered under FFS and managed care delivery systems.	Finalized as proposed, with minor modifications to correct erroneous uses of the word "effective."	For FFS delivery systems, July 9, 2028. For managed care, the first rating period beginning on or after July 9, 2028.

Home- and Community-Based Services (HCBS) Quality Measure Set
(§§ 441.312, 441.474(c), 441.585(d), 441.745(b)(1)(v))

Proposed Language	Final Language	Effective Date
New § 441.312(b)(1) defines "Attribution rules" as the process states use to assign beneficiaries to a specific health care program or delivery system for the purpose of calculating the measures on the "HCBS Quality Measure Set."	Finalized as proposed, with minor formatting modifications.	The HHS Secretary will identify quality measures no later than December 31, 2026, and no more frequently than every other year. The HHS secretary will make technical updates and corrections to the Measure Set annually as appropriate.
New § 441.312(b)(2) defines "Home and Community-Based Services Quality Measure Set" to mean the Home and Community-Based Measures for Medicaid established and updated at least every other year by the Secretary through a process that allows for public input and comments, including through the Federal Register.	Finalized as proposed, with minor modifications to mean, "the Home- and Community-Based Services Quality Measures for Medicaid established and updated by the Secretary through a process that allows for public input and comment, including through the Federal Register, as described in paragraph (d) of this section."	The HHS Secretary will identify quality measures no later than December 31, 2026, and no more frequently than every other year. The HHS secretary will make technical updates and corrections to the Measure Set annually as appropriate.
New § 441.312(c)(1) obligates the Secretary to identify and update the measure set at least every other year, through a process that allows for public input and comment.	Revised the frequency for updating the measure set to no more frequently than every other year and replaced December 31, 2025, with December 31, 2026.	The HHS Secretary will identify quality measures no later than December 31, 2026, and no more frequently than every other year. The HHS secretary will make technical updates and corrections to the Measure Set annually as appropriate.
New § 441.312(c)(2) requires the Secretary to solicit comment at least every other year with states and other interested parties to establish priorities, identify measures to remove or add, and ensure measures are	Finalized a new requirement at § 441.312(c)(2) that the Secretary shall make technical updates and corrections to the HCBS Quality Measure Set **annually** as appropriate.	The HHS Secretary will identify quality measures no later than December 31, 2026, and no more frequently than every other year. The HHS secretary will make technical updates and

meaningful and feasible for reporting.	Redesignated the requirement to consult with states and other interested parties from § 441.312(c)(2) to (c)(3).	corrections to the Measure Set annually as appropriate.
New § 441.312(c)(3) obligates the Secretary, in consultation with states and other interested parties, to develop and update the measures in the HCBS Quality Measure Set, at least every other year, through a process that allows for public input and comment.	Finalized as proposed, with minor modifications as follows: Redesignated § 441.312(c)(3) as (c)(4) and a minor technical modification.	The HHS Secretary will identify quality measures no later than December 31, 2026, and no more frequently than every other year. The HHS secretary will make technical updates and corrections to the Measure Set annually as appropriate.
New § 441.312(d) defines the process for developing and updating the HCBS Quality Measure Set: • Identify all new, removed, and mandatory measures for which the Secretary will allot additional time to report. This includes measures reported on behalf of states and measures that states can choose to have the Secretary report on. • Inform states how to collect and calculate data. • Provide a standardized format and reporting schedule. • Provide procedures that states must follow in reporting the data. • Identify specific populations the states must report the measures. • Identify the subset of measures that must be stratified.	Finalized as proposed with a modification to replace "managed care plan" with MCO, PIHP or PAHP as defined in § 438.2.	The HHS Secretary will identify quality measures no later than December 31, 2026, and no more frequently than every other year. The HHS secretary will make technical updates and corrections to the Measure Set annually as appropriate.

• Describe how to establish state performance targets for each measure.		
New § 441.312(e) requires the Secretary to consider the complexity of state reporting and allow for the phase-in over a specified period of time of mandatory state reporting for some measures and of reporting for certain populations, such as older adults or people with intellectual and disabilities.	Finalized as proposed.	The HHS Secretary will identify quality measures no later than December 31, 2026, and no more frequently than every other year. The HHS Secretary will make technical updates and corrections to the Measure Set annually as appropriate.
New § 441.312(f) requires the Secretary to consider whether stratified sampling of mandatory measures can be accomplished based on valid statistical methods, without risking a violation of beneficiary privacy, and, for measures obtained from surveys, whether the original survey instrument collects the variables or factors necessary to stratify the measures.	Finalized as proposed, with a minor modification in the dates by when a certain percent of measures is to be stratified, delaying each deadline by one year.	The HHS Secretary will identify quality measures no later than December 31, 2026, and no more frequently than every other year. The HHS Secretary will make technical updates and corrections to the Measure Set annually as appropriate.
New § 441.312(f) describes the phased-in approach for reporting stratified HCBS Quality Measure Set data, such that states are required to provide stratified data for 25 percent of the measures in the HCBS Quality Measure Set for which the Secretary specifies.	Finalized as proposed, with minor modifications to require that stratification of 25 percent of the measures in the HCBS Quality Measure Set for which the Secretary has specified that reporting should be stratified by 4 years after the effective date of the regulations, 50 percent of such measures by 6 years after the effective date of the regulations, and 100 percent of measures by 8 years after the effective date of the regulations.	The HHS Secretary will identify quality measures no later than December 31, 2026, and no more frequently than every other year. The HHS secretary will make technical updates and corrections to the Measure Set annually as appropriate.

New § 441.312(g) lists the interested parties the Secretary must consult to specify and update the quality measures established in the HCBS Quality Measure Set.	Finalized as proposed.	The HHS Secretary will identify quality measures no later than December 31, 2026, and no more frequently than every other year. The HHS secretary will make technical updates and corrections to the Measure Set annually as appropriate.

Website Transparency
(§§ 441.313, 441.486, 441.595, 441.750)

Proposed Language	Final Language	Effective Date
New § 441.313(a) requires states to operate a website that meets the availability and accessibility requirements at § 435.905(b) and provides the results of the reporting requirements under newly proposed § 441.311 (specifically, incident management, critical incident, person-centered planning, and service provision compliance data; data on the HCBS Quality Measure Set; access data; and payment adequacy data).	Finalized as proposed, with minor modifications to include the additional reporting requirements to specify the state must operate a website consistent with § 435.905(b) and that provides the results of the reporting requirements specified at §§ 441.302(k)(6) and 441.311.	For FFS delivery systems, July 9, 2027. For managed care, the first rating period beginning on or after July 9, 2027.
New § 441.313(a)(1) requires the data and information states are required to report under § 441.311 be provided on one web page, either directly or by linking to the web pages of the managed care organization, prepaid ambulatory health plan, prepaid inpatient health plan, or primary care case management entity that is authorized to provide services.	Finalized as proposed, with minor modifications as follows: Required the state to include all content on one website, either directly or by linking to websites of individual MCO's, PIHP's, or PAHP's, as defined in § 438.2. Removed the word, "web page," and replace with the word, "website," and made minor formatting changes at § 441.313(a)(1).	For FFS delivery systems, July 9, 2027. For managed care, the first rating period beginning on or after July 9, 2027.

New § 441.313(a)(2) requires the website to include clear and easy-to-understand labels on documents and links.	Finalized as proposed.	For FFS delivery systems, July 9, 2027. For managed care, the first rating period beginning on or after July 9, 2027.
New § 441.313(a)(3) requires that states verify the accurate function of the website and the timeliness of the information and links at least quarterly.	Finalized as proposed.	For FFS delivery systems, July 9, 2027. For managed care, the first rating period beginning on or after July 9, 2027.
New § 441.313(a)(4) requires states to include prominent language on the website explaining that assistance in accessing the required information on the website is available at no cost and to include information on the availability of oral interpretation in all languages and written translation available in each non-English language, how to request auxiliary aids and services, and a toll-free and TTY/TDY telephone number.	Finalized as proposed.	For FFS delivery systems, July 9, 2027. For managed care, the first rating period beginning on or after July 9, 2027.
New § 441.313(b) requires CMS to report on their website the information reported by states (noted under § 441.311).	Finalized as proposed.	For FFS delivery systems, July 9, 2027. For managed care, the first rating period beginning on or after July 9, 2027.

Applicability of Proposed Requirements to Managed Care Delivery Systems

Proposed Language	Final Language	Effective Date
Applies requirements at §§ 441.301(c)(3), 441.302(a)(6), 441.302(k), 441.311, and 441.313 to both FFS and managed care delivery systems.	CMS addressed the various comments and questions about how specific provisions would be implemented in the managed care context and addressed how the provisions would apply in the specific regulatory sections.	Not applicable.
New cross-reference to the requirements in proposed § 438.72 to require states that include HCBS in their MCO, PIHP, or PAHP contracts to comply with the requirements at §§ 441.301(c)(1) through (3), 441.302(a)(6) and (k), 441.311, and 441.313. No changes will be made to the regulatory language at § 441.301(c)(1) or (2) or to § 438.208(c)(3)(ii) through this rule, but requirements in § 441.301(c)(1) or (2) continue to apply when states include HCBS in their MCO, PIHP, or PAHP contracts.	Finalized § 438.72 as proposed with some modifications by removing narrative descriptions of the requirements and retaining the regulatory text references only.	Not applicable.

DOCUMENTATION OF ACCESS TO CARE AND SERVICE PAYMENT RATES

Regulatory Background

In 2015, CMS finalized regulations to establish access monitoring review plans (AMRPs), a new process whereby states were required to analyze data related to the availability of certain Medicaid services. States were required to conduct this analysis every three years, in consultation with the Medical Care Advisory Committee, and submit the plan to CMS. States submitted the first round of AMRPs on October 1, 2016. Recognizing the administrative burden of the current AMRP requirements, the final rule repeals and replaces the regulations and updates the procedures states must follow when taking certain rate reduction actions.

Summary of Proposed to Final Rule and Effective Dates

Fully Fee-For-Service States

Note on request for public comment: *CMS requested public comment on whether additional access standards, such as those described in the proposed managed care rule, might be appropriate for states operating a fully FFS delivery system.*

Several commenters were generally supportive of timeliness standards for fully FFS states. Some commenters suggested phasing in requirements over time or by service, collecting information on geographic variations in wait times, and either applying the standards to all FFS programs or allowing exceptions for states with minimal covered services delivered through FFS. Other commenters pointed out concerns that would need to be addressed, like the need to establish protections for providers who do not have direct control over their scheduling.

Other commenters were not supportive of establishing timeliness standards, particularly given the context of implementing them simultaneously with the other provisions. Commenters also raised concerns with the financial and administrative burden of implementing a system to meet timeliness requirements and the time it would take to do so.

CMS emphasized that they plan to utilize the lessons learned from implementing the managed care timeliness standards to inform future FFS proposals on the same topic.

FFS Payment Rate Transparency
(§ 447.203(b))

Proposed Language	Final Language	Effective Date
New § 447.203(b)(1) requires states to publish all FFS payment rates on a public website. States	Finalized as proposed, with minor modifications as follows: Added language in (b)(1) to	July 1, 2026, then updated within 30 days of a payment rate change.

must make the fee schedule easy to locate and provide easy identification of the amount Medicaid would pay for a service. If rates vary by provider type, geography, or other category, the state must separately identify rates by category. States must publish their fee schedule no later than January 1, 2026, and identify the date rates were last updated. States must also update the published fee schedule no later than one month following CMS' approval of revised rates or rate methodologies, or one month following adoption of a new rate if CMS approval is not needed.	clarify what Medicaid FFS payment rates need to be published. • Deleted language that specified payment rate transparency must be developed and maintained on a state agency's site, in paragraph (b)(1). • Revised language giving the general public the ability to determine the service payment amount in (b)(1)(iii). • Revised language referring to bundled payment rates by deleting the word "similar" and adding "the state must publish the Medicaid fee-for-service bundled payment rate and, where the bundled payment rate is based on fee schedule payment rates for each constituent service, must …", in paragraph (b)(1)(iv). • Revised language on publishing the dates that payment rates were last updated, to be no later than one month following the approval of a SPA, in paragraph (b)(1)(vi).	
New § 447.203(b)(2) requires states to develop and publish an analysis comparing payment rates for primary care services, obstetrical and gynecological services, and outpatient behavioral health services. States must also publish a payment rate disclosure for personal care, home health aide, and homemaker services provided by individual providers and providers employed by an agency. The analysis must	Finalized as proposed with minor formatting and technical modifications. Added habilitation as a category of service in the payment rate disclosure at § 447.203(b)(2)(iv).	July 1, 2026, then every two years.

identify variations by category, such as geography, population, or provider type.		
New § 447.203(b)(3) establishes requirements for the comparative analysis and payment rate disclosure. New § 447.203(b)(3)(i) requires states to compare Medicaid FFS payment rates for the evaluation and management (E/M) codes applicable to primary care services, obstetrical and gynecological services, and outpatient behavioral health services to the Medicare payment rates for the same services effective during the same time period. States must conduct this analysis at the CPT/HCPCS level. The analysis must: • Be organized by category of service. • Identify the base Medicaid payment rates for each code, including any variation by category. • Identify the Medicare base payment rates for each code that corresponds to each Medicaid code, including any variation by category. • Express each Medicaid payment rate for each code as a percentage of each Medicare code. • Specify the number of Medicaid-paid claims and number of beneficiaries who received the service during a calendar year during which each payment rate is effective. • New § 447.203(b)(3)(ii) requires states to publish a payment rate disclosure for personal care, home health aide, and	Finalized as proposed, with minor modifications as follows: • Clarified the publication requirements that apply to comparative payment rate analysis and payment rate disclosures discussed in this section and (b)(4) and added "through (b)(1)(ii)" to align with the organizational structure. • Substituted "Medicaid base payment rates" with "base Medicaid fee-for-service fee schedule payment rates" in § 447.203(b)(3)(i)(B) through (E). • Substituted "Medicare non-facility payment rate" with "Medicare non-facility payment rate as established in the annual Medicare Physician Fee Schedule final rule," within § 447.203(b)(3)(i)(C) and (D). • Reworded § 447.203(b)(3)(ii)(B) to include "and whether the payment rate includes facility-related costs" to address facility-associated costs that can occur within habilitation settings. • Substituted "average hourly payment rate" with "average hourly Medicaid fee-for-service fee schedule payment rates," within § 447.203(b)(3)(ii) and (ii)(B) and (C). • Substituted "to providers employed by an agency" with "provider agencies" in §	July 1, 2026, then every two years.

homemaker services identifying the average hourly rate and identifying any variation between the rate for services provided by individual providers and providers employed by an agency. The disclosure must: • Be organized by category of service. • Identify the average hourly rate by category of service, including any variation by provider type, geography, or other category. • Specify the number of Medicaid-paid claims and number of beneficiaries who received the service during a calendar year during which each average hourly rate is effective.	447.203(b)(2)(iv), (b)(3)(ii), and (b)(3)(ii)(B) for clarity reasons.	
New § 447.203(b)(4) requires states to publish their initial comparative analysis and payment rate disclosure no later than January 1, 2026, to be based on the rates in effect on January 1, 2025. States must then publish an updated analysis and disclosure every two years thereafter and must post the analysis and disclosure to their public website.	Finalized as proposed, with minor modifications as follows: • Substituted "Medicaid payment rates" with "Medicaid fee-for-service fee schedule rates" in § 447.203(b)(4). • Updated the applicable date and effective date of Medicaid payment rates that are subject to the comparative payment rate analysis within the section from January 1, 2026, and January 1, 2025, respectively.	July 1, 2026, then every two years.
New § 447.203(b)(5) specifies CMS may reduce FFP to states failing to comply with payment rate transparency, comparative analysis, and rate disclosure requirements.	Finalized as proposed.	
New § 447.203(b)(6) requires states to establish an advisory committee related to provider	Finalized as proposed, with minor modifications as follows:	The first meeting must be held by July 9, 2026, then at least every two years.

rates where payments are made to direct care workers. The committee must be comprised of direct care workers, beneficiaries, beneficiaries' authorized representatives, and other parties as determined by the state. The committee must meet at least every two years to consider whether direct care worker rates are adequate to ensure access to care and make recommendations to the Medicaid agency about direct care worker rates. The state Medicaid agency must publish the committee's recommendations.	• Minor technical wording changes • Added habilitation as a category of service in § 447.203(b)(6)(iii)	

State Analysis Procedures for Rate Reduction or Restructuring
(§ 447.203(c))

Proposed Language	Final Language	Effective Date
New § 447.203(c) establishes analyses that states would be required to perform, document, and submit concurrently with the submission of rate reduction and rate restructuring SPAs, with additional analyses required in certain circumstances due to potentially increased access to care concerns. It also establishes a two-tiered approach for determining the level of access analysis states would be required to implement when proposing provider payment rate reductions or payment restructurings.	Finalized as proposed.	July 9, 2024.
New § 447.203(c)(1) sets out three criteria for states to meet when proposing payment rate reductions or payment	Finalized as proposed.	July 9, 2024.

restructurings in circumstances when the changes could result in diminished access. If all three of the below conditions are met, states would not be required to submit a more detailed analysis - outlined further below - establishing that the proposal meets the access requirement in section 1902(a)(30)(A) of the Act. • New § 447.203(c)(1)(i) requires states to provide a supported assurance that Medicaid payment rates in the aggregate (including base and supplemental payments) following the proposed reduction or restructuring for each benefit category affected by the proposed reduction or restructuring would be at or above 80 percent of the most recently published Medicare payment rates for the same or a comparable set of Medicare-covered services. • New § 447.203(c)(1)(ii), requires states to provide a supported assurance that the proposed reduction or restructuring, including the cumulative effect of all reductions or restructurings taken throughout the state fiscal year, would result in no more than a 4 percent reduction in aggregate FFS Medicaid expenditures for each benefit category affected by proposed reduction or restructuring within a single state fiscal year.		

• New § 447.203(c)(1)(iii) requires states to provide a supported assurance that the public processes described in § 447.203(c)(4) yielded no significant access to care concerns or yielded concerns that the state can reasonably respond to or mitigate, as appropriate, as documented in the analysis provided by the state under § 447.204(b)(3).		
New § 447.203(c)(2) requires states to conduct a more extensive access analysis for any SPA that proposes to reduce provider payment rates or restructure provider payments in circumstances when the changes could result in diminished access, where the requirements in paragraphs (c)(1)(i) through (iii) are not met. The state would be required to send specified information to CMS as part of the SPA submission as a condition of approval, in addition to the information required under paragraph (c)(1). • New § 447.203(c)(2)(i) requires states to provide a summary of the proposed payment change, including the state's reason for the proposal and a description of any policy purpose for the proposed change, including the cumulative effect of all reductions or restructurings taken throughout the current state fiscal year in aggregate FFS Medicaid expenditures for each benefit category	Finalized as proposed.	July 9, 2024.

affected by proposed reduction or restructuring. • New § 447.203(c)(2)(ii) requires states to provide Medicaid payment rates in the aggregate (including base and supplemental payments) before and after the proposed reduction or restructuring for each benefit category affected by the proposed reduction or restructuring, a comparison of each (aggregate Medicaid payment before and after the reduction or restructuring) to the most recently published Medicare payment rates for the same or a comparable set of Medicare-covered services, and a comparison to the most recently available payment rates of other healthcare payers in the state or the geographic area. • New § 447.203(c)(2)(iii) requires states to provide information about the number of actively participating providers of services in each benefit category affected by the proposed reduction or restructuring. • New § 447.203(c)(2)(iv) requires states to provide information about the number of Medicaid beneficiaries receiving services through the FFS delivery system in each benefit category affected by the proposed reduction or restructuring. • New § 447.203(c)(2)(v) requires states to provide		

information about the number of Medicaid services furnished through the FFS delivery system in each benefit category affected by the proposed reduction or restructuring. • New § 447.203(c)(2)(vi) requires states to submit a summary of, and the state's response to, any access to care concerns or complaints received from beneficiaries, providers, and other interested parties regarding the service(s) for which the payment rate reduction or restructuring is proposed as required under § 447.204(a)(2).		
New § 447.203(c)(3) offers mechanisms for ensuring compliance with requirements for state analysis for rate reduction or restructuring, as specified in proposed paragraphs (c)(1) and (c)(2), as applicable.	Finalized as proposed.	July 9, 2024.
Redesignates current § 447.203(b)(7) to proposed § 447.203(c)(4). CMS is not making any changes to the public process described in current paragraph (b)(7).	Finalized as proposed.	July 9, 2024.
Redesignates § 447.203(b)(8) to proposed § 447.203(c)(5) to better organize § 447.203 to reflect the policies in this proposed rule. CMS is not making any changes to the methods for addressing access questions and	Finalized as proposed.	July 9, 2024.

remediation of inadequate access to care, as described in current paragraph (b)(8).		
Redesignates current § 447.204(d) to proposed § 447.203(c)(6). CMS is not making any changes to defining the remedy for the identification of an unresolved access deficiency, as described in current § 447.204(d).	Finalized as proposed.	July 9, 2024.

Medicaid Provider Participation and Public Process to Inform Access to Care (§ 447.204)

Proposed changes in this section are limited to § 447.204(a)(1) and (b) and are essential for consistency with the newly proposed changes in § 447.203(b). The additional paragraphs of § 447.204 would remain unchanged.

Proposed Language	Final Language	Effective Date
Amends language in § 447.204(a)(1), which currently references § 447.203, to instead reference § 447.203(c).	Finalized as proposed.	July 9, 2024.
Amends language in § 447.204(b)(1), which refers to the state's most recent AMRP performed under current § 447.203(b)(6) for the services at issue in the state's payment rate reduction or payment restricting SPA; CMS proposes to remove this requirement to align with CMS' proposal to rescind the AMRP requirements in current § 447.203(b).	Finalized as proposed.	The first meeting must be held by July 9, 2026, then at least every two years.
Removes § 447.204(b)(2) and (3) because these current	Finalized as proposed.	July 9, 2024.

requirements are addressed in proposed § 447.203(c)(1) and (2). The objective processes proposed under § 447.203(c)(1) and (2) would be sufficient for CMS to obtain the information necessary to assess the state's proposal.		
Amends § 447.204(b) to read as follows, "[T]he state must submit to us with any such proposed state plan amendment affecting payment rates documentation of the information and analysis required under § 447.203(c) of this chapter." • States must publish their FFS fee schedules under § 447.203(b)(1) no later than January 1, 2026. • States must publish the comparative payment rate analysis and payment rate disclosure under § 447.203(b)(2)-§ 447.203(b)(4) no later than January 1, 2026.	Finalized as proposed.	July 1, 2026, then updated within 30 days of a payment rate change.
Removes and relocates § 447.204(d) since the nature of this provision is better suited to codification in § 447.203(c)(6).	Finalized as proposed.	Not Applicable.