NASDDDS
National Association of State Directors of Developmental Disabilities Services

*Proposed Access Rule State Self-Assessment

In May 2023, the Centers for Medicare and Medicaid published a Notice of Proposed Rulemaking – CMS-2442-P (available here: Federal Register:: Medicaid Program; Ensuring Access to Medicaid Services) aimed at improving access to care, quality and health outcomes, and better addressing health equity issues in Medicaid across fee-for-service and managed care, including home and community-based services (HCBS). These far-reaching regulations, as proposed, promise to impact key areas of state policy and operations, including in many aspects of HCBS. To assist states in preparing for the finalization of these regulations, we offer this self-assessment for state use that enables the state to reflect on its current policies and structures to determine the potential areas requiring effort to achieve compliance. **NASDDDS will be updating and refining this self-assessment upon regulation finalization (expected in April)**, but we wanted to provide this preliminary assessment against the NPRM for those states anxious to understand the potential implications of the regulation.

CMS will ultimately determine compliance standards. This tool is intended to provide states with an idea of the areas that might require attention.

Using the following scale, please rate how you believe your state currently measures up against the proposed provisions.
1 = The State currently does not have elements in place for this provision
2 = The State has some elements of the provision in place
3 = The State has most elements of the provision in place
4 = The State has all elements of the provision currently in place

Medicaid Advisory Committee (MAC) **Proposed Implementation: 1 Year Following Final Rule Effective Date **					
NPRM Provision/Proposed Requirement	1 None	2 Some	3 Most	4 All	Notes/Comments
Does the state have bylaws or a policy that governs the state's MAC?					
Does the state MAC policy include that someone from the Medicaid executive staff will attend all MAC meetings?					
Does the state have state staff dedicated to facilitate the MAC and BAG engagement(s)?					
Does the state MAC policy include information for recruitment and appointment					

of members (including determining the time allotted for individuals to serve)?					
Does your state have a designated space on the website for MAC meeting materials?					
Does your state website include a summary of the most recent MAC Meeting?					
Does your state website include a regular meeting schedule for the MAC?					
Does the state provide and post to its website an annual report written by the MAC to the State describing its activities, topics discussed, recommendations?					
Does the state MAC report include actions taken by the State based on the MAC recommendations?					
Does the MAC currently contain 25% composition of members meeting criteria for BAG membership?					
Does the state ensure that the MAC makes at least 2 meetings per year public, including public comment opportunities (and adequate notice)?					
Does the MAC offer a variety of in-person and virtual attendance options?					
Does the MAC provide for all accessibility considerations, ensuring meaningful access for people with disabilities and for people with limited English proficiency?					
Does the MAC provide opportunity for member recommendations on all of					

the following: additions and changes to services; coordination of care; quality of services; eligibility; beneficiary and provider communications; cultural competency; language access; health equity and disparities and others?					

Beneficiary Advisory Group (BAG)

****Proposed Implementation: 1 Year Following Final Rule Effective Date ****

NPRM Provision/Proposed Requirement	1 None	2 Some	3 Most	4 All	Notes/Comments
Does your state have a BAG?					
Does your state have bylaws or a policy on how the BAG functions?					
Does your state BAG policy identify a process for recruitment of BAG members with lived experience (defined as current or previous beneficiaries or people with direct experience supporting beneficiaries)?					
Does your state have a designated space on the website for BAG meeting materials?					
Does or will the BAG meet separately from the MAC in advance of the MAC meetings to ensure preparation and adequate input?					
Does your state website include a list of current BAG members?					
Does your state website include a summary of the most recent BAG Meeting?					
Does your state website include a regular meeting schedule for the BAG?					

Grievance System (§§ 441.301(c)(7), 441.464(d)(2)(v), 441.555(b)(2)(iv), and 441.745(a)(1)(iii)) **Proposed Implementation Deadline: 2 Years Following Final Rule Effective Date **					
NPRM Provision/Proposed Requirement	1 None	2 Some	3 Most	4 All	Notes/Comments
Does the state have a grievance policy?					
Does the state grievance policy allow beneficiaries to file grievances related to state or provider compliance with person-centered care planning requirements and the HCBS Settings Rule?					
Does the state grievance policy describe how beneficiaries can file routine and/or expedited grievances orally or in writing?					
Does the state grievance policy require that standard resolution of a grievance and notice to affected parties must occur within 90 calendar days of receipt of the grievance?					
Does the state have a grievance policy with a provision that resolution of expedited grievances will be within 14 calendar days of receipt of the grievance?					
Does the state grievance policy include language on how to request extensions of time to file?					
Does the state grievance policy have a provision that beneficiaries can request an extension for grievances if the state identifies and documents the need for more time, in which case the time frame can be extended for a further 14 calendar days?					

Does your state grievance policy allow disinterested third parties to file grievances on a beneficiary's behalf with their consent?					
Does the state grievance policy provide language accessible notice of rights and process for grievances, as well as assistance in navigating the process?					
Does the state grievance policy provide beneficiaries with notices and other information related to the grievance system, including information on their rights under the grievance system and on how to file grievance, and ensure that such information is accessible for individuals with disabilities and individuals who are limited English proficient?					
Does the state grievance process ensure that there is no retaliation against beneficiaries who file grievances?					
Does the state grievance policy include language about acknowledging receipt of grievances?					
Does the state grievance policy include a standard process for reviewing grievances?					
Does the state grievance policy include language that individuals not previously involved in related decision-making, and with appropriate expertise, can only make grievance decisions?					

Does the state grievance policy allow beneficiaries the opportunity to present evidence in writing, in person or virtually to support a grievance?					
Does the state grievance policy include language the state will supply copies of case files without charge?					
Does the state provide information on the grievance system to providers and subcontractors approved to deliver services under section 1915(c) of the Act?					
Does the state grievance policy provide beneficiaries with a reasonable opportunity, face-to-face (including through 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?					
Does the state grievance policy require the state to maintain records of grievances and is the state reviewing the information as part of their ongoing monitoring procedures?					
Does the state have a grievance policy that includes language concerning the record of each grievance must contain: a general description of the reason for the grievance, the date received, the 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.					
Does the state have an accessible record policy?					
Are state records of grievances accurately maintained and in a manner that would be available upon request?					
Incident Management Systems Assessment Requires states to provide an assurance that they operate and maintain an incident management system that identifies, reports, triages, investigates, resolves, tracks, and trends critical incidents. ****Proposed Implementation Deadline: 3 Years Following Final Rule Effective Date ****					
NPRM Provision/Proposed Requirement	**1 None**	**2 Some**	**3 Most**	**4 All**	**Notes/Comments**
Does the state have an electronic incident management system that enables electronic collection of critical incidents?					
Does the state have an electronic incident management system that tracks the status of critical incidents?					
Does the state have an electronic incident management system that tracks resolution of critical incidents?					
Does the state have an electronic incident management system that allows the trending of data on critical incidents?					
Does the state's definition of critical incident include, at a minimum: • Verbal abuse • Physical abuse • Sexual abuse • Psychological or emotional abuse • Neglect					

• Exploitation, including financial exploitation • Misuse of unauthorized use of restrictive interventions or seclusion • A medication error resulting in a telephone phone call or consultation with a poison control center, an emergency department visit, an urgent care visit, a hospitalization, or death; and • An unexplained or unanticipated death, including but not limited to a death caused by abuse or neglect?					
Does the state require providers to report to the state critical incidents that occur during the provision of authorized waiver services?					
Does the state require providers to report to the state critical incidents that are the result of the failure to provide authorized services?					
Does the state have a critical incident investigation process that assesses whether the incident was the result of abuse, neglect or exploitation?					
Does the state have a critical incident investigation process that assesses whether the incident could have been prevented?					

Does the state have a critical incident investigation process that specifies timeframes in which 90% of investigations that are initiated, completed and resolution is determined?					
Does the state have a critical incident investigation process that specifies timeframes in which 90% of investigations include completed corrective action?					
Does the state have a critical incident investigation process that separately investigates critical incidents if the investigative agency fails to report the resolution of investigation within state specified timeline?					
Does the state have a process for using claims data, Medicaid fraud control unit data, and data from others state agencies, such as APS and CPS, to the extent possible under applicable state law to identify critical incidents that occur during the delivery of waiver serves and are as a result of failure to deliver authorized services that are unreported by the provider?					
Does the state have a policy that requires SMAs and operating agencies to share data with other entities that are responsible for conducting critical incident investigations?					

Incident Management Compliance Reporting **Proposed Implementation Deadline: 3 Years Following Final Rule Effective Date**					
NPRM Provision/Proposed Requirement	1 None	2 Some	3 Most	4 All	Notes/Comments
Does the state have a process to report, every 24 months, the number and percentage of critical incidents for which an investigation was initiated within state-specified time frames? **CMS may determine reporting required every 60 months*					
Does the state have a process to report, every 24 months, the number and percentage of critical incidents for which the state determined the resolution within specified time frames? **CMS may determine reporting required every 60 months*					
Does the state have a process to report, every 24 months, the number and percentage of critical incidents for corrective action has been implemented within state specified timeframes? **CMS may determine reporting required every 60 months*					
Person Centered Planning Compliance Reporting **Proposed Implementation Deadline: 3 Years Following Final Rule Effective Date **					
NPRM Provision/Proposed Requirement	1 None	2 Some	3 Most	4 All	Notes/Comments
Does the state have a Person-Centered planning policy that states a reassessment of functional need has been completed for at least 90 percent of individuals annually?					

Does the state have a Person-Centered plan policy that states be reviewed and revised or at least 90 percent of those individuals whose reassessments indicate needed revisions annually?					
Does the state have performance measures to report these metrics annually for a statistically valid sample?					
Does the state have the data and mechanisms to track and report for a statistically valid, random sample Percent of beneficiaries continuously enrolled for at least 365 days for whom a reassessment of functional need was completed within the past 12 months?					
Does the state have the data and mechanisms to track and report for a statistically valid, random sample Percent of beneficiaries continuously enrolled for at least 365 days who had a service plan updated as a result of a re-assessment of functional need within the past 12 months?					
Does the state have the data and mechanisms to track and report the type, amount, and cost of services provided under the State plan?					

Quality Measure Set **Proposed Implementation Deadline: 3 Years Following Final Rule Effective Date**					
NPRM Provision/Proposed Requirement	1 None	2 Some	3 Most	4 All	Notes/Comments
Does the state have a process to ensure reporting on mandatory measures from the HCBS Quality Measure Set to CMS every other year?					
Does the state have a process to establish targets and report on additional measures in the HCBS Quality Measure Set? **OPTIONAL**					
Does the state have the ability to establish performance targets and describe quality improvement strategies for the HCBS Quality Measure Set?					
Does the state have the ability to stratify data based on race, ethnicity, gender, urban and rural?					
Wait List Reporting States must submit annually a description of the process they use to maintain their waiver waitlists ****Proposed Implementation Deadline: 3 Years Following Final Rule Effective Date****					
NPRM Provision/Proposed Requirement	1 None	2 Some	3 Most	4 All	Notes/Comments
Does the state have a process for reporting to CMS on an annual basis a description of their waiver waitlist including at a minimum ○ Whether the state screens individuals on the waiting list for waiver eligibility; ○ Whether the state periodically re-screens					

individuals on the waiver list for eligibility and the frequency of re-screening; ○ The number of people on the waiting list; and ○ For a statistically valid random sample, the average amount of time that individuals newly enrolled in the waiver program in the past 12 months were on the waiting list. ○ For a statistically valid random sample, the percent of authorized hours for homemaker services, home health aide services and/or personal care services?					
Payment Adequacy Reporting **Proposed Implementation Deadline: 4 Years Following Final Rule Effective Date**					
NPRM Provision/Proposed Requirement	1 None	2 Some	3 Most	4 All	Notes/Comments
Does the state have systems in place to collect data demonstrating that at least 80 percent of all Medicaid payments for homemaker, home health aide, and personal care services provided through 1915(c), (j), (k), and (i) authorities, including base payments and supplemental payments, are spent on compensation to direct care workers § 441.302(k)(1)(ii) (DCWs)? (note: these requirements do not apply to other services that include elements of the three specified services, such as various types of habilitation services)					

Can the state report separately for each service and, within each service, separately report services that are self-directed?					
Website Transparency **Proposed Implementation Deadline: 3 Years Following Final Rule Effective Date**					
NPRM Provision/Proposed Requirement	1 None	2 Some	3 Most	4 All	Notes/Comments
Does the state have a single, centralized web site that hosts or could host the information required by CMS?					
Does the website meet the availability and accessibility requirements at § 435.905, including plain language, language accessibility, and the availability of no-cost auxiliary aids and services, as well as clear notice of the availability of such services?					
Does the website include the required information regarding incident management, critical incidents, person centered planning, and service provision compliance data; data on the HCBS Quality Measure Set; access data; and payment adequacy data as consistent with the reporting requirements at § 441.311?					
Does the state have a process in place to check the functionality and accuracy of the web page on at least a quarterly basis?					

Payment Rate Publication **Proposed Implementation Deadline: 4 Years Following Final Rule Effective Date**					
NPRM Provision/Proposed Requirement	1 None	2 Some	3 Most	4 All	Notes/Comments
Does the state publish Medicaid FFS payment rates in a location easily reached from a hyperlink on the State Medicaid Agency's website?					
Does the information published for each rate include: • The date on which each rate was last updated? • The constituent components and costs of bundled rates? • Stratification by population (pediatric and adult), provider type, and geographical location, if rates vary?					
Does the state have a process in place to keep this information up to date within one month of any rate change?					
Does the state have an ongoing process in place to report average hourly payment rates for personal care, home health aide, and homemaker services provided through 1915(c), (j), (k), and (i) authorities, stratified by population (pediatric and adult), provider type, and geographical location, as applicable to CMS? (note: these requirements do not apply to other services that include elements of the three specified services, such as various types of habilitation services)					

Can the state report rates for these three services provided by individual providers and rates for providers employed by an agency?					

Policy Reference

§ 441.311 Reporting requirements.
(a) *Basis and scope.* Section 1902(a)(6) of the Act requires State Medicaid agencies to make such reports, in such form and containing such information, as the Secretary may from time to time require, and to comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports. Section 1902(a)(19) of the Act requires States to provide safeguards to assure that eligibility for Medicaid-covered care and services will be determined and provided in a manner that is consistent with simplification, simplicity of administration, and in the best interest of Medicaid beneficiaries. This section describes the reporting requirements for States for section 1915(c) waiver programs, under the authority at section 1902(a)(6) and (a)(19) of the Act.

(b) *Compliance reporting* —(1) *Incident management system.* As described in § 441.302(a)(6)—

(i) The State must report, every 24 months, according to the format and specifications provided by CMS, on the results of an incident management system assessment to demonstrate that it meets the requirements in § 441.302(a)(6).

(ii) CMS may reduce the frequency of reporting to up to once every 60 months for States with incident management systems that are determined by CMS to meet the requirements in § 441.302(a)(6).

(2) *Critical incidents,* as defined in § 441.302(a)(6)(i)(A). The State must report to CMS annually on the following, according to the format and specifications provided by CMS:

(i) Number and percent of critical incidents for which an investigation was initiated within State-specified timeframes;

(ii) Number and percent of critical incidents that are investigated and for which the State determines the resolution within State-specified timeframes;

(iii) 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.

(3) *Person-centered planning,* as described in § 441.301(c)(1) through (3).

(i) Percent of beneficiaries continuously enrolled for at least 365 days for whom a reassessment of functional need was completed within the past 12 months. The State may report this metric for a statistically valid random sample of beneficiaries.

(ii) Percent of beneficiaries continuously enrolled for at least 365 days who had a service plan updated as a result of a re-assessment of functional need within the past 12 months. The State may report this metric for a statistically valid random sample of beneficiaries.

(4) The type, amount, and cost of services provided under the State plan.

(c) *Reporting on the Home and Community-Based Services Quality Measure Set,* as described in § 441.312.

(1) *General rules.* The State—

(i) Must report every other year, according to the format and schedule prescribed by the Secretary through the process for developing and updating the measure set described in § 441.312(d), on all measures in the Home and Community-Based Services Quality Measure Set that are identified by the Secretary pursuant to § 441.312(d)(1)(ii) of this subpart.

(ii) May report on all other measures in the Home and Community-Based Services Quality Measure Set that are not described in § 441.312(d)(1)(ii) and (iii) of this subpart.

(iii) Must establish, subject to CMS review and approval, State performance targets for each of the measures in the Home and Community-Based Services Quality Measure Set that are identified by the Secretary pursuant to § 441.312(d)(1)(ii) and (iii) of this subpart and describe the quality improvement strategies that the State will pursue to achieve the performance targets.

(iv) May establish State performance targets for each of the measures in the Home and Community-Based Services Quality Measure Set that are not identified by the Secretary pursuant to § 441.312(d)(1)(ii) and (iii) of this subpart and describe the quality improvement strategies that the State will pursue to achieve the performance targets.

(2) Measures identified per § 441.312(d)(1)(iii) of this subpart will be reported by the Secretary on behalf of the State.

(3) In reporting on Home and Community-Based Services Quality Measure Set measures, the State may, but is not required to:

(i) Report on the measures identified by the Secretary pursuant to § 441.312(c) of this subpart for which reporting will be, but is not yet required (that is, reporting has not yet been phased-in).

(ii) Report on the populations identified by the Secretary pursuant to § 441.312(c) of this subpart for whom reporting will be, but is not yet required.

(d) *Access reporting.* The State must report to CMS annually on the following, according to the format and specifications provided by CMS:

(1) *Waiver waiting lists.* (i) A description of how the State maintains the list of individuals who are waiting to enroll in the waiver program, if the State has a limit on the size of the waiver program, as described in § 441.303(f)(6), and maintains a list of individuals who are waiting to enroll in the waiver program. This description must include, but is not limited to:

(A) Information on whether the State screens individuals on the list for eligibility for the waiver program;

(B) Whether the State periodically re-screens individuals on the list for eligibility; and

(C) The frequency of re-screening, if applicable.

(ii) Number of people on the list of individuals who are waiting to enroll in the waiver program, if applicable.

(iii) Average amount of time that individuals newly enrolled in the waiver program in the past 12 months were on the list of individuals waiting to enroll in the waiver program, if applicable.

(2) *Access to homemaker services, home health aide, and personal care.* (i) 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), are initially approved to when services began, for individuals newly approved to begin receiving services within the past 12 months. The State may report this metric for a statistically valid random sample of beneficiaries.

(ii) 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. The State may report this metric for a statistically valid random sample of beneficiaries.

(e) *Payment adequacy.* The State must report to CMS annually on the percent of payments for certain services, as specified in § 441.302(k)(3)(i), that are spent on compensation for direct

care workers, at the time and in the form and manner specified by CMS. The State must report separately for each service and, within each service, must separately report services that are self-directed.

(1) *Services.* The State must report on payment adequacy for the services at § 440.180(b)(2) through (4) that are authorized under section 1915(c) of the Act.

Definition of compensation

(A) Salary, wages, and other remuneration as defined by the Fair Labor Standards Act and implementing regulations;

(B) Benefits (such as health and dental benefits, sick leave, and tuition reimbursement); and

(C) The employer share of payroll taxes for direct care workers delivering services authorized under section 1915(c) of the Act.

Definition of direct care worker

(A) A registered nurse, licensed practical nurse, nurse practitioner, or clinical nurse specialist who provides nursing services to Medicaid-eligible individuals receiving home and community-based services available under this subpart;

(B) A licensed or certified nursing assistant who provides such services under the supervision of a registered nurse, licensed practical nurse, nurse practitioner, or clinical nurse specialist;

(C) A direct support professional;

(D) A personal care attendant;

(E) A home health aide; or

(F) Other individuals who are paid to provide services to address activities of daily living or instrumental activities of daily living, behavioral supports, employment supports, or other services to promote community integration directly to Medicaid-eligible individuals receiving home and community-based services available under this subpart.