Overview of Key Home and Community-Based Services (HCBS) Provisions in the Medicaid Access Rule[1]

David Machledt and Jennifer Lav

Background

The Medicaid Act requires that state payments for Medicaid are sufficient to provide at least equivalent access to care for Medicaid beneficiaries as the general population in any given geographic area.[2] Enforcement of this provision has always been a challenge. State Medicaid rates typically lag far behind Medicare and commercial insurance rates. For home and community-based services (HCBS), enforcement poses additional challenges, as Medicare and private markets rarely cover these services.[3] Thus, even defining what "equal access" means for HCBS can be difficult. In 2015, the Supreme Court made enforcement harder when it ruled that providers could not sue Medicaid agencies over insufficient rates, leaving enforcement largely to the Centers for Medicare & Medicaid Services (CMS).[4]

Over the years, CMS has tried to enforce payment adequacy via increased monitoring and other requirements, but these efforts have not resolved ongoing problems with insufficient Medicaid provider rates.[5] Persistent shortages of direct care workers have also hampered

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[1] This guide was produced in collaboration with the Human Services Research Institute (HSRI) with funding from the Administration for Community Living (ACL).
[2] 42 U.S.C. § 1396a(a)(30)(A).
[3] HCBS include services such as personal care aid, homemaker services, home health, and habilitation services. HCBS are critical to support disabled individuals in integrated community settings.
[4] *Armstrong v. Exceptional Child Center*, 575 U.S. 320 (2015).
[5] In 2015, CMS first issued rules requiring states to develop "Access Monitoring Review Plans," (AMRPs) and latter modified it several times. Generally, CMS has required states to outline the state's method and data analysis used to conclude that beneficiaries have sufficient access to covered services, if services were provided via "fee for service." *See* 80 Fed. Reg. 67576 (Nov. 02, 2015); 42 C.F.R.

access to essential HCBS.[6] Other analyses found that Medicaid beneficiaries have more challenges scheduling timely care than people with private insurance, particularly for specialist care.[7]

To its credit, CMS has recognized the need for more active enforcement. In April 2024, CMS finalized regulations aimed at enhancing rate transparency and improving access to quality care across Medicaid managed care and fee-for-service[8] programs.[9] If faithfully implemented, this Access Rule will increase HCBS provider availability for people with disabilities.

Below, we summarize eight key substantive changes in the Access Rule related to HCBS:

1) Medicaid Payment Rate Adequacy for HCBS Direct Care Workers
2) Public Reporting of Medicaid Payment Rates and Other Access Data
3) Public Input on HCBS Rates
4) Person-Centered Planning
5) Grievance Systems
6) Incident Management Systems
7) HCBS Core Quality Measure Set
8) Website Transparency

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§§ 447.203, .204; CMS, Access Monitoring Review Plans, https://www.medicaid.gov/medicaid/access-care/access-monitoring-review-plans/index.html, (Last visited July 5, 2024). The 2024 Access Rule rescinded requirements related to ARMPs. *See* 89 Fed. Reg. 40677.

[6] Alice Burns et al., Kaiser Family Found., *Payment Rates for Medicaid Home- and Community-Based Services: States' Responses to Workforce Challenges* (Oct. 24, 2023), https://www.kff.org/medicaid/issue-brief/payment-rates-for-medicaid-home-and-community-based-services-states-responses-to-workforce-challenges/.

[7] Walter Hsiang et al., *Medicaid Patients Have Greater Difficulty Scheduling Health Care Appointments Compared with Private Insurance Patients: A Meta-Analysis*, 56 INQUIRY 1 (2019).

[8] Fee-for-service is a payment system where Medicaid reimburses providers for each covered service they deliver.

[9] CMS, *Ensuring Access to Medicaid Services*, 89 Fed. Reg. 40542 (May 10, 2024), https://federalregister.gov/d/2024-08363 [Hereinafter "Access Rule."] A second rule focused on improving accountability and transparency in Medicaid managed care was finalized at the same time, but is not the subject of this brief. *See* CMS, *Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality*, 89 Fed. Reg. 41002 (May 10, 2024), https://www.federalregister.gov/documents/2024/05/10/2024-08085/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care-access-finance.

HCBS Provisions in the Access Rule

1. HCBS Minimum Payment Adequacy for Direct Care Workforce

Applicability Date: July 9, 2028 for § 441.311(e) (public reporting on HCBS payment percentage to direct care workers)
July 9, 2030 for § 441.302(k) (minimum performance percentage)
Citation: 42 C.F.R. §§ 441.302(k); § 441.311(e)[10]

Workforce shortages are a major factor causing access barriers to HCBS. CMS posits that paying direct care workers a fair wage for the work they do will increase recruiting and retention, decrease reliance on overtime pay, and increase care quality and access. The rule's specific mechanism to increase care worker wages will require states to ensure that at least 80% of payments to each Medicaid provider of personal care, homemaker, habilitation, and home health aide services, respectively, go directly toward compensating direct care workers.[11] To reduce potential burden on providers, CMS will allow states to adopt a separate standard for small providers and/or exempt certain small providers based on reasonable criteria. Similarly, payments for self-directed services where an HCBS recipient determines rates for their own caregivers will also be excluded from the 80% payment threshold.[12]

States have six years to fully implement this change, but Medicaid beneficiaries and advocates should start looking for ways to raise caregiver wages anytime a state updates its rates, which may happen much sooner. If the state has not updated its rates recently, call for an update. Raising caregiver wages should be the most straightforward way to address workforce shortages and high turnover in direct care work.

[10] For simplicity, all citations for the regulatory text of the Access Rule are provided as citations to amended Code of Federal Regulations as they would be applied to 1915(c) HCBS waivers. Most of the regulations apply also to 1915(i), (j), and (k) HCBS programs. Some are statewide. For specific cross references to these other HCBS programs, see Appendix A.
[11] The final rule excludes from this calculation costs related to trainings, travel and protective equipment for direct care workers. 42 C.F.R. §§ 441.302(k)(1)(iii), .311(e)(1)(iii).
[12] 42 C.F.R. § 441.302(k)(2)(ii).

2. Public Reporting of Medicaid Payment Analysis and Other Access Data

Applicability Date: July 1, 2026 for § 447.203(b)(1) – (4) (Payment analysis):
July 1, 2027 for § 441.311(b)(4) and (d) (Access reporting);

Citations: 42 C.F.R. § 447.203(b)(1) – (4); 42 C.F.R. § 441.311(b)(4) and (d)

States will be required to report state level data in the following categories:

- Waiting list information for 1915(c) waiver services, including state processes for screening individuals on the list for eligibility, the number of people on the list, and the average amount of time spent on the waiting list;[13]
- Average time to initiate delivery of newly authorized services for personal care, homemaker, home health aide, and habilitation services (e.g. how long it takes for someone to actually get the service after it is determined they are entitled to the service) and the percent of authorized hours that are actually provided;[14]
- The average state hourly payment rates for personal care, homemaker, home health aide, and habilitation services.[15] States must specify separate averages if rates vary by population, geographic location, provider type, and whether payments include facility-related costs;[16] and
- For personal care, homemaker, home health aide, and habilitation services, the number of Medicaid claims paid divided by the number of beneficiaries who receive the service in a calendar year.[17]

In addition to the specific requirements above for HCBS services, states must disclose all fee for service Medicaid payment rates on state websites and report on their Medicaid rates for various categories of services relative to comparable Medicare fee for service rates every two years.[18] In a separate rule issued at the same time as the Access Rule, CMS finalized an

[13] 42 U.S.C. § 441.311(d)(1). Section 1915(c) waiver services are the most common mechanism states use to deliver HCBS. States are permitted to cap the number of individuals who can enroll in 1915(c) waiver services, and therefore some states have waiting lists for these services.
[14] 42 C.F.R. 441.311(d)(2).
[15] 42 C.F.R. § 447.203(b)(3)(ii).
[16] *Id. See also* CMS, *Ensuring Access to Medicaid Services – A Guide for States to the Fee-For-Service Provisions of the Final Rule*, 30-31 (July 2024), https://www.medicaid.gov/medicaid/access-care/downloads/ffs-prov-final-rule-guidance.pdf.
[17] 42 C.F.R. § 447.203(b)(3)(ii)(C).
[18] 42 C.F.R. § 447.203(b)(1)-(3).

additional requirement that states using Medicaid managed care will need to submit an annual payment analysis comparing managed care plan payment rates for certain services to Medicare's payment rate.[19] This new transparency over rates and service utilization will allow for a closer evaluation of the correlation between rates and timely health care access, and could help pinpoint specific network shortages.

3. Public Input on HCBS Rates – Interested Parties Advisory Group (IPAG)

Applicability Date: First meeting before July 9, 2026, and every 2 years thereafter
Citation: 42 C.F.R. § 447.203(b)(6)

For CMS' strategy related to minimum payments for direct care workers to be successful, states must pay rates for services that are sufficient to attract and retain direct care staff and still provide for all the training, travel, supervision, billing support and all other legitimate expenses involved in running a business. That is, 80% of an inadequate rate will inevitably be inadequate. Therefore, the rule builds in mechanisms for public feedback on the adequacy of rates.

For example, the rule requires states to establish an "interested parties advisory group" (IPAG) to advise the state on provider rates for direct care workers providing personal care, home health, homemaker, and habilitation services.[20] The IPAG must include, at a minimum: 1) direct care workers, 2) beneficiaries and their authorized representatives; and 3) other interested parties, and the state is required to make public the process it uses to choose IPAG members.[21] The IPAG will meet at least every two years to make recommendations to the

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[19] CMS, *Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality*, 89 Fed. Reg. 41002 (May 10, 2024), https://www.govinfo.gov/content/pkg/FR-2024-05-10/pdf/2024-08085.pdf (codifying 42 C.F.R. § 438.207(b)(3)). In the case of specified HCBS services, which are not typically covered by Medicare, each plan's rates will be compared to the state's Medicaid fee for service rate. This payment analysis must be reported by the first rating period after July 9, 2026.

[20] 42 C.F.R. § 447.203(b)(6).

[21] *Id.* CMS guidance notes that states can use its Medicaid Advisory Committee (MAC) established pursuant to 42 C.F.R. § 431.12 as that IPAG, or create an IPAG as a subgroup of the MAC, as long as all the requisite members of an IPAG are represented. CMS, *Ensuring Access to Medicaid Services – A Guide for States to the Fee-For-Service Provisions of the Final Rule* 35-36 (July 2024), https://www.medicaid.gov/medicaid/access-care/downloads/ffs-prov-final-rule-guidance.pdf.

Medicaid agency on the sufficiency of rates for personal care, home health, homemaker, and habilitation services.[22] To ensure transparency, the Medicaid agency must publish the IPAG's recommendation. As CMS notes "it would benefit a state to provide as much context as possible to the group so that it can produce the strongest, best-informed, most useful recommendations. Because the group's recommendations must be published publicly, interested parties such as state legislators and HHS will be able to see and review any recommendations."[23]

This approach for centering beneficiary perspectives is reflected in other provisions of the Access Rule, such as the establishment of a Beneficiary Advisory Council, consisting of Medicaid enrollees, caregivers, and direct care workers, and the revamping of the mandatory Medicaid Advisory Committees (MACs) that include minimum participation of beneficiaries. For more on how to establish effective stakeholder advisory groups that promote enrollee participation and perspectives, see NHeLP's *Medicaid Advisory Committees: Best Practices for Effective Stakeholder Engagement*.[24]

4. Person-Centered Planning Compliance Reporting

Applicability Date: July 9, 2027
Citations: 42 C.F.R. § 441.311(b)(3)

During recent site visits to HCBS settings around the country, CMS observed repeated shortcomings in the application of person-centered planning practices across various states.[25] More needs to be done to instill, support, and monitor a culture of person-centered planning in

[22] 42 C.F.R. 447.203(b)(6).
[23] CMS, *Ensuring Access to Medicaid Services – A Guide for States to the Fee-For-Service Provisions of the Final Rule* 37 (July 2024), https://www.medicaid.gov/medicaid/access-care/downloads/ffs-prov-final-rule-guidance.pdf.
[24] Wayne Turner and Daniel Young, Nat'l Health Law Prog., *Medicaid Advisory Committees: Best Practices for Effective Stakeholder Engagement* (Aug. 28, 2024), https://healthlaw.org/resource/medicaid-advisory-committees-best-practices-for-effective-stakeholder-engagement/.
[25] CMS, *Themes Identified During CMS' Heightened Scrutiny Site Visits* 10 (Nov. 16, 2022), https://www.medicaid.gov/medicaid/home-community-based-services/downloads/themes-identified-during-cms.pdf. *See also* HCBS person-centered planning regulations at 42 C.F.R. § 441.301(c)(1)-(3).

Medicaid HCBS programs. Increasing publicly reported metrics on basic person-centered planning components is an important first step.

Starting in 2027, states will have to report on the share of HCBS users who receive a timely annual functional needs assessment and, separately, the proportion of people whose person-centered plan is reviewed and updated annually.[26] States have to ensure that at least 90% of people who use Medicaid HCBS are completing these basic steps to remain compliant with HCBS regulations. Realizing truly meaningful person-centered planning will require a broad-based culture change in many Medicaid HCBS providers that goes well beyond these simple measures of the service planning process. Still, advocates can use the basic measure reporting as a springboard to highlight the importance of comprehensive planning and promote the concerted, sustained advocacy necessary to achieve that culture change at all levels.

5. Grievance System

Applicability Date: July 9, 2026
Citations: 42 C.F.R. § 441.301(c)(7)

Grievances are complaints not directly related to eligibility or access to benefits. The new Access Rule requires states to maintain an individual grievance system for fee for service systems.[27] If well-designed and implemented, grievance systems can bolster state oversight of the broader HCBS program and thus inform compliance enforcement and continuous quality improvement. At the individual level, it serves to resolve specific problems with access to or quality of authorized services.

While many states have already adopted some grievance procedures in their fee for service HCBS programs, these are often piecemeal and not well utilized. The new rule details important components that should help streamline and simplify state HCBS grievance processes to increase their effectiveness:

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[26] These measures typically only track whether the assessments were done, not how well they were done. However, they do include subcomponents that ensure that each functional assessment and person-centered plan includes all the required components, such as documenting an individual's personal goals.
[27] Managed care regulations already require plans to have such systems. *See* 42 C.F.R. §§ 438.400-416.

- Beneficiaries should know their rights and how to access the grievance system. This includes notice and information on how to file a grievance, and assistance in doing so if needed;
- Beneficiaries must have protection from potential retribution.[28]
- Beneficiaries must be able to present evidence, orally or in writing. The state must make the individual's case file and other relevant records available timely and free of charge, and provide qualified, conflict-free adjudicators to resolve the grievance.
- Resolutions must be timely. The new regulations establish 90-day timeline to resolve grievances and requires states to provide timely notice of the decision to the complainant and keep records of each grievance and its outcome.

6. Incident Management System

Applicability Date: July 9, 2027, except for the electronic incident management system, must be in place by July 9, 2029.
Citation: 42 C.F.R. §§ 441.302(a)(6); .311(b)(1) & (2)

States must monitor the health and welfare of HCBS program participants. To do this effectively, states need a responsive, well-functioning system to report and respond when things go wrong. Unfortunately, standards and processes for reporting and responding to critical incidents vary widely across states and over time.[29] Differences regarding which incidents require reporting, timeframes for investigations and resolutions, monitoring processes, and even the definition of what qualifies as a critical incident make it very difficult

[28] Notably, managed care regulations do not mandate this protection.
[29] Jenna Libersky et al., Mathematica Policy Research, *Critical Incidents, Grievances, and Appeals: Data to Support Monitoring and Evaluation of Medicaid Managed Long Term Services and Supports (MLTSS) Programs* (Oct. 2019), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/1115-mltss-grievances-appeals-data.pdf; Govt. Accountability Office, *Medicaid Assisted Living Services – Improved Federal Oversight of Beneficiary Health and Welfare is Needed* (Jan. 2018), https://www.gao.gov/assets/690/689302.pdf; CMCS, *Incident Management in 1915(c) Waiver Programs: Incident Management Recommendations*, (Sept. 2020) https://www.medicaid.gov/medicaid/home-community-based-services/downloads/incident-mgmt-rec.pdf; CMS, *Critical Incident Management Assessment: Trends and Findings from a National Assessment of States' Critical Incident Management Systems in 1915(c) Waivers*, (Oct. 2023), https://www.medicaid.gov/medicaid/home-community-based-services/downloads/critical-incident-management-assessment.pdf.

to evaluate how well one critical incident system compares to another, or even how a single system performs over time.

For the first time, the Access Rule creates a federal minimum definition for critical incidents. By July 2027, state definitions must include at least the following as reportable critical incidents:

- 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 phone call or consultation with poison control, emergency department, urgent care, hospitalization, or death; and
- Unexplained or unanticipated deaths.

The rule also requires states to implement an electronic reporting system prior to July 2029 that ensures that providers report all critical incidents. State systems must also have mechanisms to use other data sources, such as claims data, to identify unreported incidents.[30] The state must separately investigate incidents if the responsible investigative entity fails to report resolving the incident within the required time frame (chosen by the state). State systems will have to share information on an investigation's status and resolution across state agencies.

Finally, CMS requires states to show timely response for at least 90% of reported incidents to:

1) initiate an investigation;
2) resolve the investigation; and
3) complete any corrective action.

CMS did not set a federal minimum time for these actions and leaves it to states to define what a timely response should be. CMS also encourages, but does not require, states to create a single electronic management system across their HCBS programs.[31] Together, these changes provide an opportunity to focus attention on and resolve situations of abuse and neglect. Advocates can also use the changes to push states to address common systemic problems, like the misuse of restraints and seclusion.

[30] States could also cross check with the Protection and Advocacy agencies or law enforcement to identify unreported incidents.
[31] 89 Fed. Reg. 40602.

7. HCBS Quality Measure Set

Applicability Date: HHS Secretary identifies quality measures by Dec. 31, 2026, and updates every other year; Money Follows the Person states must report specified HCBS quality measures by 2026, others by 2028. Stratified measure reporting phasing in 2028 through 2032.

Citations: 42 C.F.R. §§ 441.312, .311(c)

The Access Rule leans heavily on different quality measure reporting as an important compliance and performance improvement tool. The Access Rule will require states to report on the "HCBS Quality Measure Set." Through a public process the Secretary of HHS will identify which measures will be included by the end of 2026. CMS has already established a recommended HCBS core set in July 2022.[32] Some of these measures will comprise the new mandatory set, many of which will be tied to oversight of health and welfare assurances that are part of the 1915(c) waiver requirements. The 41 states with Money Follows the Person programs will begin mandatory reporting of a subset of the HCBS Quality Measure Set by the end of 2026.[33] All states will have to report all mandatory measures by July 2028.

Many of the measures in the current recommended HCBS core set derive from HCBS experience of care surveys that most states already use.[34] These tools ask beneficiaries detailed questions about their goals and activities, control of their daily schedule, ability to interact with the community, and the quality of the services they receive. Going forward, states will be required to conduct these surveys for a representative sample of each of the disability populations for which it offers HCBS.[35] States will also have to set performance targets for each required measure.

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[32] CMS, Dear State Medicaid Director (Jul. 21, 2022) (SMD #22-003) (Home and Community-Based Services Quality Measure Set), https://www.medicaid.gov/federal-policy-guidance/downloads/smd22003.pdf.
[33] CMS, *All-State Medicaid and CHIP Call Slides,* 9 (Feb. 13, 2024), https://www.medicaid.gov/resources-for-states/downloads/covid19allstatecall02132024.pdf.
[34] The HCBS core set includes measures derived from beneficiary surveys from National Core Indicators (NCI), HCBS Consumer Assessment of Healthcare Providers and Systems (CAHPS), or the Council on Quality and Leadership's Personal Outcome Measure (POM) survey.
[35] Because many of the HCBS Quality Measure Set measures derive from one of these experience of care surveys, states will have to conduct one or more surveys to report on this measure set every other year for all their HCBS populations. *See* 89 Fed. Reg. 40822-23.

CMS also aims to increase states' capacity to track and reduce health disparities and will gradually require states to report certain core measures stratified by key demographic characteristics, such as race/ethnicity, sex, age, disability, rural/urban status, language or other factors. States will have to stratify a quarter of the core measures by July 2028, and all measures CMS requires by July 2032. This is important because right now there is very little reliable data on health disparities in access to HCBS based on these important demographic characteristics. That data could greatly improve policy-making related to HCBS delivery. The HCBS Quality Measure Set will be regularly updated through a robust stakeholder process including notice and comment as well as consultation with a wide range of interested parties.[36]

8. Website transparency

Applicability Date: July 9, 2027
Citations: 42 C.F.R. § 441.313

Quality reporting for current 1915(c) waivers is rarely publicly available. The Access Rule will bring a new era of transparency, as all of the quality measures, access reporting, and incident reporting requirements will have to be posted on a single state website. CMS will report state quality data on its website as well. By July 2027, states will have to create and maintain a webpage with annual quality metrics and benchmarks for each plan. To better track health disparities, CMS will now require some metrics to show outcomes by race/ethnicity and other key demographic factors, and states will also publicly report on the core set of HCBS quality measures.

Directions for Future Advocacy

State and local advocates have an important role to play in ensuring strong implementation of the HCBS provisions of the Access Rule.

- As noted above, successful implementation of a strong "Interested Parties Advisory Group" will be essential to ensuring rate sufficiency. Self-advocates have an explicit role

[36] 42 C.F.R. § 441.312(c)(4) and (g). The frequency of this process is somewhat uncertain due to a change in the final rule that requires an update "no more frequently than every other year." Consultation with interested parties must occur "at least every other year."

to play in the IPAG, as states must include beneficiaries and their authorized representatives. Guidance from CMS also notes that IPAGs may include "beneficiary family members and advocacy organizations."[37] States must have a public process for choosing participants. Advocates can monitor this process to ensure transparency and that public participation in encouraged. Advocates should strongly consider becoming active members of this group and can also assist by recruiting knowledgeable participants.

- States will need to develop their own systems, frameworks, and in some cases standards for many of the basic requirements in this rule. For example, while CMS requires states to create a system for critical incidents, states will set their own timelines for resolution. As another example, states may also choose how often the IPAG meets, as long as it meets basic federal minimums. State and local advocates should monitor the development of these policies to ensure that the systems serve the interests of beneficiaries.

- Successful implementation of the rule will strengthen transparency and public access to information, with HCBS data published regularly on state websites. Advocates will have to evaluate the timeliness, usability, and accessibility of information posted and ensure that this data gets used to inform appropriate remediation and improvement activities.

[37] CMS, *Ensuring Access to Medicaid Services – A Guide for States to the Fee-For-Service Provisions of the Final Rule* 35 (July 2024), https://www.medicaid.gov/medicaid/access-care/downloads/ffs-prov-final-rule-guidance.pdf.

Appendix A. Crosswalk of Regulation Citations for Major HCBS Authorities[38]

Provision	Regulatory Citation (all in 42 C.F.R.)			
	1915(c)	1915(i)	1915(j)	1915(k)
HCBS Payment Adequacy for Direct Care Workforce	§ 441.302(k); § 441.311(e)	§ 441.745(a)(1)(vi), (vii)	§ 441.464(f); § 441.474(c)	§ 441.570(f)
Payment Rate Transparency and Comparative Analysis	§ 447.203(b)(1) – (4)			
HCBS Access Reporting	§ 441.311(b)(4), (d)	§ 441.745(a)(1)(vii)	§ 441.474(c)	§ 441.580(i)
Interested Parties Advisory Group	§ 447.203(b)(6)			
Person-Centered Planning Reporting	§ 441.301(c)(3); § 441.311(b)(3)	§ 441.725(c)	§ 441.450(c)	§ 441.540(c)
Grievance System	§ 441.301(c)(7);	§ 441.745(a)(1)(iii)	§ 441.464(d)(5)	§ 441.555(e)
Incident Management System	§ 441.302(a)(6); § 441.311(b)(1), (2)	§ 441.745(a)(1)(vi)	§ 441.464(e)	§ 441.570(e)
HCBS Quality Measure Set	§ 441.312; § 441.311(c)	§ 441.745(b)(1)(v)	§ 441.474(c)	§ 441.585(d)
Website Transparency	§ 441.313	§ 441.750	§ 441.486	§ 441.595

[38] All citations in the Appendix to the Code of Federal Regulations can be accessed online via the following link: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C.