HCBS Provisions of the Medicaid Access Rule: Training Series

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Webinar recording: https://cms.zoomgov.com/rec/share/9W-p-MxvZTbJiEYt_4B1SEOS-r01_I-ajikmbbr4Bzywim03EzAykTIeUKVSDJAu.7Zi5Z4CQQAlyHppZ

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>> ADRIENNE DELOZIER: For those that need closed captioning, you can use the closed caption button at the bottom of the Zoom screen. This webinar is being recorded. The recording, transcript, and slides will be available on Medicaid.gov along with the material from all of our HCBS-accessible training sessions. The direct link to that page will be provided in the chat. If you are a member of the press, please refrain from asking questions during the webinar. If you do have any questions, please email press@cms.hhs.gov. Please note that all participants are muted upon entry. For today's training, we will be displaying a series of slides throughout the call and providing an overview of the provisions. At the end of the presentation, there will be time for participants to ask questions. At that time, we encourage you to post your questions however you feel most comfortable. You may type them into the Q&A box, or you may raise a hand using the button at the bottom of the screen, and we will unmute individual lines. When the moderator says your name, please unmute yourself on your end to ask any questions. When you are finished, leader member to re-mute your line. We will do our best to get to each person. With this large number of participants, we may not have adequate time to hear from each person who raises their hand. If we do not get to you, if you have additional questions on this topic or any HCBS accessible provisions, you can submit them to the access mailbox at HCBSaccessrule@cms.hhs.gov at any time.

I will now turn the call over to Melissa Harris, the Director of the Health Programs Group who will provide some opening comments.

>> MELISSA HARRIS: Welcome to our third training. We have established this training series to focus on several key provisions of the ensuring access to Medicaid rule. To ensure all partners fully understand the provisions and have an opportunity to ask questions and provide feedback on implementation of the rule, information regarding dates of the training sessions, tentative topics for each section, and registration information for the series has been shared with you all, but it is also available on Medicaid.gov. As you have heard from Adrienne, today's training is going to focus on the quality measure set.

Among other things, the access rule established a new strategy for oversight, monitoring, quality assurance, quality improvements for Medicaid HCBS programs including by creating more consistency and standardization in measurement and reporting within and across each program. One of the ways we did this was to require states to report every other year on a standardized set

of an HCBS quality measures we refer to as the HCBS quality measure set. We will provide an overview of these requirements and open up the floor for any questions that you might have.

We feel like these requirements are really necessary for advancing Medicaid HCBS, and we thank you for your attendance and participation during today's session. I am now going to hand it over to Melanie Brown, a technical director in our group who will be walking you through the requirements of the quality measure set. Thanks.

>> MELANIE BROWN: Before we jump into the quality measures that reporting requirements under the access rule, we thought it would be good to provide a little general background around the quality measure set. CMS released the first official version of the quality measure set through a state Medicaid Directors letter in July 2022. The measure set is intended to promote more common and consistent use, both within and across states, of nationally standardized quality measures and eight HCBS programs.

Implementation of the measure set creates opportunities for CMS, state, and territories to promote health equity and reduce disparities in health outcomes.

In April 2024, CMS released two Center of Medicaid and CHIP Services informational bulletins. One focused on the specific measures and reporting requirements for money follows the person recipients. The second was focused on updating the 2022 version of the HCBS quality measure set.

In May 2024, CMS published the final rule which required all states to start reporting on the HCBS quality measure set in 2028. So, the current version of HCBS quality measure set does require heavily on measures that are derived from four Experience of Care surveys. Those surveys are the HCBS consumer assessment and healthcare provider and systems or HCBS CAHPS survey, the national core indicators-aging and disability survey, the national core indicators-intellectual and developmental disability survey, and the personal outcome measures survey.

In addition to the experience of care surveys, the measure set also includes nationally standardized measures that use assessment and case management record data as well as measures that use claims or data. Next slide, please.

From now, we are going to talk more specifically about the specific requirements under the access rule for the home and community-based service quality measures that provision.

As I said earlier, the Ensuring Access to Medicaid Services final rule was published in May 2024 and the access rule does include a number of provisions focused on HCBS, including the HCBS Quality Measure Set, which is highlighted in red below. But in addition to the HCBS Quality Measure Set reporting, the access final rule also focuses on strengthening oversight of person-centered planning in HCBS. It requires states to meet standards for monitoring HCBS programs. It requires states to establish a system and fee-for-service HCBS. It requires that states report on the percentage of payments for certain HCBS spent on compensation for direct care workers. It requires that a minimum percentage of payments for certain HCBS is spent on compensation for direct care workers, subject to certain flexibilities and exemptions. It requires states to report on

waiting lists and waiver programs and on service delivery timelines for certain HCBS. And our topic for today, it requires states to report on a standardized set of HCBS quality measures, it requires for CMS to develop and update the measure set, and it promotes public transparency related to the administration of Medicaid covered HCBS through public reporting of quality, performance, and compliance measures. Next slide, please.

So, this slide also lists all of the HCBS provisions included in the access rule. You will note that it also lists the reg citations. The key takeaway from this slide is that all of these provisions have applicability across multiple HCBS authorities. So, if you are wanting to do some light reading, the specific citations are included here. Next line, please.

So, this slide does present the timeline for the applicability date for each of the HCBS provisions. You will note that circled in red is the HCBS Quality Measure Set reporting requirement. The applicability date for that provision is in July of 2028.

Now, we are going to talk specifically about what is included in the access rule related to the HCBS Quality Measure Set reporting requirement. States are required to report on a standardized set of HCBS quality measures. It also sets the requirement for CMS to develop and update the measure set. So specifically, the final rule has set the process to develop and update no more frequently than every other year the HCBS Quality Measure Set through a process that allows for public input and comments, including for the Federal Register. And the applicability date for that part of setting the process is no later than December 31st, 2026. Next slide, please.

The final rule also requires that states report every other year on measures that are identified as mandatory by CMS in the HCBS Quality Measure Set and establish performance targets and quality improvement strategies. The final rule also allows for reporting on additional voluntary measures, and it allows for CMS to report on certain measures on the state's behalf. The applicability date for that part of the requirement is July 9, 2028.

The final rule also includes facing requirements for stratification of data for certain measures of race, ethnicity, sex, age, rural or urban status, disability, language, or other factors. By July 9, 2028, states would be stratifying 25% of the measures they are reporting. By July 9, 2030, that percentage would move to 50%. By July 9, 2032, that should be at 100%. Next slide, please.

You will notice at the end of the earlier slides where all the HCBS provisions were listed, there is a reference to a website transparency. This is a provision that actually has applicability across all of the HCBS provisions. The intent is to promote public transparency related to the administration of Medicaid-covered HCBS through public reporting of quality, performance, and compliant measures. Specifically, the final rule requires the state to operate a website either directly or by linking to a managed-care website that provides the results of the HCBS reporting requirements and also meets the availability and accessibility requirements.

In addition, the final rule also requires CMS to report on its website the results of the HCBS that states report to CMS. The applicability date is July 9 of 2027. Next slide, please.

We wanted to highlight some things that are included in the preamble that may not have been specifically referenced in the reg. CMS did indicate that we would not affect the measures set

including adding new measures or retiring existing measures more frequently than every other year. CMS does intend to retain each of the measures in the measure set for at least five years to assure the availability of longitudinal data, unless there are insurmountable technical issues such as issues with reliability or validity or excessive state burden.

CMS did also note that we will be making technical updates and corrections annually as needed. Next slide, please.

CMS also noted that for each of the measures in the HCBS Quality Measure Set that are identified as mandatory for states to report or are identified as measures for which CMS would report on behalf of the state, the state should establish and describe quality improvement strategies to achieve the performance targets for those measures.

And finally, related to the phase-in and reification requirement CMS did note that we would align with the Department of Health and Human Services data standards for stratification that are based on the 1997 OMB statistical policy directive. We do expect to update the stratification categories when there are changes to the OMB or HHS data standards. Next slide, please.

And now, we are going to talk about early reporting of the HCBS Quality Measure Set under the money follows the person demonstration.

The money follows the person demonstration is a long-standing grant and opportunity that is designed with four goals. Decreasing the use of HCBS rather than institutional long-term services and supports under Medicaid; eliminating areas or mechanisms that prevent or restrict the flexible use of Medicaid funds to enable Medicaid eligible individuals to receive support for appropriate and necessary LTSS in the settings of their choice; increase the ability of Medicaid programs and ensure that procedures are in place to provide quality assurance for eligible individuals receiving Medicaid HCBS; and to provide for continuous quality improvement of such services.

There are currently 41 states and territories that are participating in MFP. Next slide, please.

And the MFP terms and conditions do require MFP grant recipients to implement the HCBS Quality Measure Set. MFP grant recipients are required to report on the HCBS Quality Measure Set every other year for the section 1915(c), (i), and (k) programs. It must include all eligible individuals or a representative sample of eligible individuals that are receiving HCBS under those authorities. Reporting is not limited to MFP program participants receiving HCBS under those authorities. MFP grant recipients are expected to report in the aggregate across all of their programs and they are not expected to report separately for each HCBS program.

For the initial implementation of the HCBS quality measure set, MFP grant recipients are expected to report on a subset of the measures that are included in the measure set and to also develop a quality improvement plan for two measures of their choice. The first year of reporting will be 2026. CMS does expect that reporting in 2026 would not be any earlier than September 1st, 2026.

Important to note, the states and territories can include the costs associated with planning, implementation, and ongoing use of the HCBS quality measure set in their MFP budgets. Next slide, please.

In the final slide, it provides a snapshot of all of the MFP reporting requirements for 2026 in one place. What is reflected here is a mandatory requirement for MFP recipients to fill out an experience of care survey for each group in the state or territory HCBS programs. The mandatory measures for 2026 are also identified. They include LTSS one, LTSS 2, LTSS 6, LTSS7, and LTSS8. The measures that can be supported on a voluntary basis are also identified in this fight and they include LTSS4, in the MLTSS plan readmission measure.

I believe this is the last slide. Last slide, please. With that, I will turn it over to Adrienne so that we can take some questions.

>> ADRIENNE DELOZIER: Thank you so much, Melanie. Like we noted before, folks are welcome to pick the raise-hand button if they would like to ask the question verbally live. You are also welcome to use the Q&A function at the bottom of your resume screen. I was just going to take a look. We do have a question here. If a state has not used MFP, or very minimally over the last decade or more in their 1915(c), would there be allowances around. Very little added investment value added to the program.

>> MELANIE BROWN: It is not clear to me. Is this an MFP state that has a smaller MFP program? Is that the question? I don't know if it is possible for them to come off mute and sort of respond.

>> ADRIENNE DELOZIER: Mary, that was your question. If you want to raise your hand. To the moderator, do we have any hands raised?

>> We have two hands raised, but I don't see who you said. You said Mary? Mary Brogan? I see you.

>> PARTICIPANT: Very little utilization of the MFP program in the 1915c waiver. There might be more utilization in the 1115 that operates a different HCBS. Some of the reporting requirements that are so onerous in terms of the assessments, vertically the clinical assessments and think that may not add value to the program unless my understanding must be required for the entire >> For population. I wonder if there can be a discussion around -- 1915(c) population. I wonder if there can be a discussion around having used MFP or other debts make the burden of the assessments and value added or not to the program.

>> MELANIE BROWN: I think it might be -- not just for people participating in the MFP program. You are required to report on all the individuals served under those authorities, 1915(c), with HCBS. It's not limited to MFP participants. We have heard you specifically mention I think the assessment measure. I think other states have mentioned that there might be some burden associated with collecting that level of data. I think we can certainly talk more with you if you would like to reach out to us for additional technical assistance for what the specific issues would be around addressing these measures for your programs. I think we would be happy to set up some time to meet with you.

Let me just say if there were others with CMS you may have anything to add in response to that question.

>> For the early implementation of the measures that were money follows the person grant recipients, it is only a subset of the measures in the measure set. It is not all the measures in the current version. We did take that into consideration. We wanted to start with a smaller set of initial measures and also just sort of remind folks that because this is an MFP grant requirement, the cost of implementing the measure set including the cost of paying a contractor to repair that may conduct a survey, bring on additional staff, IT systems, all of that can be included in the MFP budget. And because these are generally administrative costs, we would consider them administrative costs under the grant. They are 100% federally funded under the grant so one of the states includes the cost within the budget.

>> ADRIENNE DELOZIER: All right. Do we have any other hands raised at this time?

>> Yes, we do. You are able to unmute. Sara Quist? You are able to unmute. You look unmuted. Okay. Maybe she didn't mean to put her hand up. We will go to the next person. Liz, you are able to unmute.

>> PARTICIPANT: Thanks, Jackie. This question is for Melanie. This is Liz from California. I wanted to ask about, you had mentioned the measures need to be reported in aggregate across programs. I just wanted to make sure I was hearing that correctly. We were under the impression it would still be segmented by our waivers for the measures. So, when you mentioned in aggregate, is that just across the waiver itself? Or are you saying that the measures have to be reported across waivers for each particular measure?

>> MELANIE BROWN: I think the reporting requirement is that you report in the aggregate across all of the waivers. However, and I will ask Jen to weigh in, we are working on system development. We are trying to allow there to be the capacity for the system to allow you to report by waiver, and then the system does the roll up. We have gotten that question before. States and territories have indicated it would be easier for them to report at the level of the waiver. So, we are trying to allow that capacity. Technically, the requirement is that you report in the aggregate. Jen, is there anything you would like to add to that?

>> JENNIFER BOWDOIN: Yeah. I agree with that, Melanie, we are looking at developing the capability. I think we would be interested in hearing from states if that is something they would be interested in. We have heard anecdotally that some states would like the ability to report at a more granular level even though the requirement is in the aggregate. If that is of interest, it would be helpful if you would let us know that. I will note that if you do report at the waiver level or more granular level than in the aggregate, we are probably going to have to work with you on the sampling to make sure that when it rolls up, the results all rollup, that we are getting an aggregate result that accurately reflects the state overall so that one program, for instance, isn't overweighted in the results.

>> PARTICIPANT: Sounds good. Thanks, Jennifer and Melanie.

>> ADRIENNE DELOZIER: We will take a couple of follow-up questions. Someone mentioned that early reporters would only need to report on a subset of the measures. Someone is asking if or where the subject has been published.

>> MELANIE BROWN: I can respond to that. So, the subset is essentially what I went over in terms of what the mandatory measures are. For 2026, it is LTSS 1, 2, LTSS 6, 7 and 8 are the required LTSS measures. There is also a survey for each of the major population groups that are served in your HCBS programs. You can find that exact information in the April 2024 informational bulletin. It's also available -- and I'm not sure who answered the question. There is also information on your Moodle site about that. They would be happy to shoot you the link for the CMCS informational bulletin. I think we can do that in the chat, I think.

>> ADRIENNE DELOZIER: Perfect. There was a question here, is CMS expecting states to be able to isolate MFP data from all of the others' waiver data?

>> MELANIE BROWN: That question has come up a lot. The answer is no; the requirement is that you report in the aggregate. There is not the expectation that you would do sort of separate reporting for MFP beneficiaries. We have heard I think from some states and territories that there may be benefit to doing that if they want to actually have measures that data specifically on their MFP participants. So again, that is one thing we are looking at in terms of the reporting capacity of our system. But no, that is not the requirement. You are not expected to separate out the MFP participants.

>> ADRIENNE DELOZIER: Do we have any hands raised if we want to take a question or two live?

>> JACKIE - MODERATOR: Yes. It looks like Doris, you are able to unmute.

>> PARTICIPANT: Hi. Thank you so much for inviting me to air our issues. We are a senior center, social senior center in New York. We are having a lot of issues with HCBS and compliance with the managed care plans and compliance with the community integration policies or rules. There's a lot of noncompliance, but there seems to be nothing we can do about it. So, when seniors are denied access to the community by denying access to integration, and that is an HCBS violation, we have reported it to HCBS final rule. We have reported it to HCBS -- all emails. There was no follow-up, and there is no conclusion. Is there anyone else we can talk to at CMS that is looking to make sure that the services are integrated, healthcare and social care?

>> MELANIE BROWN: I am not sure I have a response for that. Jen and others from CMS, is there someone we can direct them to address this question?

>> MELISSA HARRIS: This is Melissa Harris. I would say a couple of things. This is probably best for an off-line conversation. It is an important conversation. With any kind of expression of dissatisfaction with how a state or a provider is implementing a federal requirement, we are first going to ask you if you have had a conversation with the state because they are going to be the entity to first be more nimbly able to correct a problem on the ground.

If you have already contacted the state and want to make CMS of that, then you mentioned you have submitted an email to the HCBS settings regulation mailbox. We do monitor that mailbox. Chances are, we are having a conversation with the state that might not result in really quick, speedy action, but we do want to understand what is happening on the ground.

But why don't you send another email to us, and we will follow-up off-line. Thanks.

>> PARTICIPANT: Thank you so much.

>> ADRIENNE DELOZIER: I am going to take a quick question from the Q&A box. It says, I am a disability rights advocate, not an employee of any agencies. I want to know how these measures will benefit those with disabilities. In most cases, the more standardized measurement of a person's health, the more it discriminates unintentionally against the disabled population.

>> MELANIE BROWN: I'm going to ask my colleagues to weigh in on this. I can start. I do want to point out, while I think approximately 12 of the measures are LTSS measures, record review, the majority of the measures included in the measures that are actually experience of care survey measures. I do think there is opportunity to hear directly from the consumer about their experience of care around the home community-based services they receive. That was intentional. There is an experience of care survey that is available for each of the major LTSS population groups. Our hope is that that sort of consumer-level perspective on whether or not this care is meeting their needs, I think there is an opportunity to receive that kind of information via the HCBS Quality Measure Set. Others from CMS, anything you would add?

>> JENNIFER BOWDOIN: I will note a couple of additional things. We didn't get into too much detail in the training, but in the rule, we laid out a process for CMS to update and maintain the measures that that is required % reporting under the access rule. The measures that we have talked about so far, those are the ones required for early reporting for Money Follows the Person grant recipients. As required by the access rule, CMS actually has to go through a process that includes opportunities for public comment to be able to identify the measures that states are required to report out. We are going to go through our process. And we will be convening a process every two years.

The way, in the Rule, what we committed to was to have an opportunity for public comment for the Federal Register. We will be posting a draft version of the measures set in the Federal Register for public comment. In the rule we'll be listing a final version of the measures set in the Federal Register. That will be the first version under the access rule that states are required to report on in 28. We committed in the rule to releasing that no later than December 2026. There will be a process for people to provide comment and feedback on the measures they think are important for states to report on as part of the quality measures that requirements.

Prior to actually releasing the draft measures in the Federal Register for public comment, we are actually going through some additional processes. We had our contractor recently release a public offer measures. Unfortunately, that has closed. So, there was an opportunity to provide feedback there. We will be repeating that on an every other year basis for the public to weigh in

and make recommendations for measures to add and remove. That is a little more informal process through the posting of the Federal Register.

The other opportunity that is coming up is we have also -- our contractor is also establishing a workgroup, the HCBS Quality Measure Set workgroup. If anyone on the call is familiar with the core set workgroups, it is going to work very similar to that. This is made up of external parties, states, and advocates, people with disabilities, who have an opportunity to review the measures in the measures that, make recommendations for measures to add and remove. As part of those workgroup meetings, there will also be opportunities for public comment.

And so, I would encourage you, if you are interested in becoming involved in those, please send an email to us. Email the access rule mailbox. We can put that back in the chat. We can put it in the chat again. Send us an email, and we will make sure you are aware of it. We post a lot of stuff on Medicaid.gov. We do a lot of listserv announcements. Our contractor also makes information available through their own listserv and things like that. If you let us know that you are interested, we will try to make sure that you are up-to-date on various activities that are happening in that you have an opportunity to provide feedback on the measures and the measure set and that they are representing the types of things you would think are important for CMS to require states to report on.

>> ADRIENNE DELOZIER: Thanks, Jen. We have a couple of related questions. Will there be guidance coming from CMS on the direction of the current 1915c assurance and sub-assurance reporting requirements? And what effect the QMS will have on these. There is also a specific question about, while data is pulled for 372 reports--which is waiver specific versus the QMS in 2260 and that being aggregate reporting. I would say that CMS still does intend to release guidance on what to do during that transitional period. But Jen, I don't know if you have anything to add to that.

>> JENNIFER BOWDOIN: Sure. And just to clarify for some folks, if they haven't read the final rule and memorized it in detail, one of the things that we noted in the preamble is that there are existing requirements for 1915(c) waiver programs. There are essentially required reporting performance measures. States have to report to CMS on those and achieve an 86 performance level to be compliant with the existing requirements. There are similar requirements for 1915i as well.

Those requirements were laid out in guidance we had released in 2014. Essentially, what we said in the rule is that the reporting requirements that are currently in place or C waivers and 1915i will be replaced by those in the access rule. There are requirements and things that will remain. We will be providing some clarification on that. But all of the existing performance measures for the step assurance are essentially going to go away when the access rule requirements are going to come into place. So, we will be working with states to phaseout from those existing requirements and to move into the new requirements including the quality measures set. And we will be issuing some guidance related to that.

Anybody else want to add anything? Melanie, you want to add anything?

>> MELANIE BROWN: I don't think so. I think you covered it.

>> ADRIENNE DELOZIER: Take a break from reading questions and see if we have any hands raised.

>> JACKIE - MODERATOR: Candace, I have seen your hand the longest. You are able to unmute.

>> PARTICIPANT: Good afternoon. Can you hear me okay?

>> We can.

>> PARTICIPANT: For the LTSS 1 specifically, it lists several areas that a state would need to assess the member on. It also lists several standardized tools for each domain, each item. I wanted to know, are those examples, or is it -- this is the menu that a state must collect from?

>> MARY BOTTICELLI: Those are tools you can use as examples. It has to meet the requirements, whichever one of the core supplemental items that you are addressing. And those are indicated as examples that you can use. But if you have one in your state that meets the same requirements, then yes, you can use those.

>> PARTICIPANT: For example -- thank you. So, for example, if we are screening for alcohol use, a state can come up with their own set of questions to use to assess that rather than relying on one of the examples, one of the five or six different standardized tools that are listed? Is that right?

>> MARY BOTTICELLI: Correct. Yes.

>> PARTICIPANT: Okay. Thank you.

>> MARY BOTTICELLI: Sure.

>> ADRIENNE DELOZIER: A couple raised hands or two, Jackie?

>> JACKIE - MODERATOR: Is it lay? You are able to unmute.

>> PARTICIPANT: It is LeeAnn. You answered my question in the chat.

>> ADRIENNE DELOZIER: Jackie, anybody else?

>> JACKIE - MODERATOR: Yes. Martha? You are able to unmute.

>> PARTICIPANT: Okay. Hi there. For states that are already doing the HCBS reporting to the HR Q data, they require the data to be reported separately, like older adults, et cetera. Previously, watch another training state if I understood correctly, is by reporting it to test data HR Q, that would make the reporting requirements. It is reported, though, by separate waivers and programs. So, I just wanted to clarify if that is still the case. Like, if they will do the rollup of data? I'm not sure.

>> MELANIE BROWN: I can take that. We are still working on the process. It is correct that what we have stated to MFP requirements, if you're already reporting to West stat, to the arc

managed database, if you are using -- and reporting data to them, that you wouldn't have to duplicate reporting. To report again to CMS. We are trying to establish a process that would allow us to receive the data directly from the measures stored. Any roll up or additional calculation, we are trying to figure that out in our process. But that is correct, you would only have to report the experience of care survey data if you are using one of those three surveys. This doesn't apply to the palms survey, but we are not -- you would need to report --

>> ADRIENNE DELOZIER: Thank you. Jackie, do we want to take one more?

>> JACKIE - MODERATOR: It looks like Dr. Dwight. You are able to unmute. Dr. Dwight, I think it is Sanders? You are able to unmute. Maybe they didn't mean to raise their hands either. That is the only hand raised for now.

>> ADRIENNE DELOZIER: Okay. We will take a few questions from the Q&A box. Is the quality measures that are in the form of survey questions which will be asked to participants? In my stead, we already conduct surveys of various kinds about the quality of services, and I am wondering how or if that data can be used for any of the reporting.

>> MELANIE BROWN: There is a requirement that you use at least one of the experience of care surveys that are included in the HCBS Quality Measure Set. In order to meet the requirement, you would need to be using at least one of those experience of care surveys for each one of the LTSS populations that are served in the programs.

Just to be clear, that doesn't mean you couldn't continue to use your other surveys if they meet other needs. You could. But to make a specific requirement, you would need to be fielding the expense of care surveys included in the HCBS Quality Measure Set. For the expense of care surveys, have the specific topics been identified? I have come across in being transportation, person centeredness, community inclusion, and safety. Is that correct? And will there be more areas in the future?

>> MELANIE BROWN: We do share with the -- a draft with mandatory experience of care survey measures so you are correct, the four domains we identified were commuting inclusion, person centeredness, transportation, and safety. So, the idea is to identify specific measures across all of the four experience of care surveys that you will be required to report on. We did do that. We have not -- we are in the process of developing an official sort of guidance document to share. But that is the direction that we are going. There is not at this time a plan to introduce additional mandatory experience of care survey measures for 2026 MFP reporting. Jen, do you want to add anything to that?

>> JENNIFER BOWDOIN: Nope. Thank you.

>> ADRIENNE DELOZIER: The requirements they stated are required to complete as many surveys as necessary to cover populations groups. Do you have definitions of these population groups? We want to be sure we are defining populations in the same way as other states.

>> MELANIE BROWN: They are specifically referenced -- rather than trying to repeat it back to you off the top of my head, I am going to send you a copy which identifies the four specific LTSS subpopulation groups.

>> ADRIENNE DELOZIER: This might be a good time to note that if folks open up the chat box, Jen and I have been pasting in links. You will see actually, if you scroll up a little bit, the link to the CIB. You will see the HCBS accessible mailbox address for folks to submit if we don't get to your questions or if you have other questions of this center provisions or any of the HCBS accessible provisions. That mailbox is there. And the link that will contain the slides, the transcript, and the recording of this training also is there. Jen, you just posted something about the measures that review workgroup.

So, if you want those relevant links, go copy and paste them from the chat box now so you don't lose access to them when the call is ended today.

Let's see. Do we have any hands raised to take some live questions?

>> JACKIE - MODERATOR: Yes, it looks like Marcus. You are able to unmute. Marcus Canaday? You are able to unmute. Maybe he didn't mean to raise his hand or he had his question answered in the chat.

>> ADRIENNE DELOZIER: We will keep working our way down the Q&A box here. To elaborate on the aggravation question, are you saying for all 1915(c) waivers even across the population subgroups? They would all be aggregated together?

>> MELANIE BROWN: I didn’t hear the question. Could you repeat it one more time?

>> ADRIENNE DELOZIER: To elaborate on the aggregation question, are you saying for all spec for labor across different population subgroups, for example, IDD and HD waivers would all be aggregated together?

>> MELANIE BROWN: The aggregated reporting is across waivers. You are intended to report in the aggregate across all waivers. We are trying, we are hearing it from you all, there may be benefit or utility in you being able to perhaps report at the level of your waiver. We are trying to allow our system, the Medicaid data question tool, at the level of the waiver in the system to the aggregation. But the requirement itself is that you report in the aggregate across the waivers. Jen, do you want to add anything to clarify?

>> JENNIFER BOWDOIN: No. I think you covered it. Thanks.

>> ADRIENNE DELOZIER: Is stratification going to be expected for NCI measures? If so, is CMS expecting a statistically significant sample from a stratification group for surveys? That is a lot of alliteration.

>> MELANIE BROWN: For early reporting for 2026, there is no stratification requirement. They can elect to do so. There is no requirement. I think we are still figuring out what the specific stratification requirements will be on the 25% threshold at a certain time and 50% and 100%. Jen or Mary, anything you want to add in response to that question?

>> JENNIFER BOWDOIN: I will just note that for the access rule, the requirements around stratification are going to be set through that public comment process in the Federal Register posting. And so, whether a specific measure required stratification and exactly what is required is really going to be determined through that public comment process. I would encourage people if they have specific opinions on which measures the stratification measures are phased in over time, we would welcome feedback on what should be prioritized as part of that public comment process. You are welcome to comment on the stratification requirements. But I think we will have more to say in the future as we develop the measures set and have the specific measures identified for stratification in the future. Mary, did you want to add anything else?

>> ADRIENNE DELOZIER: Jackie, I think you said we had a couple more hands raised?

>> JACKIE - MODERATOR: It looks like Marcus raised his hand again.

>> PARTICIPANT: Okay. Can you hear me? Terrific. I have two questions. First of all, has CMS defined representative sample? In the second question is, regarding the two quality improvement projects, if I heard you correctly, we are to pick a couple of measures in which to use for this quality measures set, for those quality improvement projects. If that's right, do those two come from the five mandatory measures? Do they come from the voluntary measures in the measures set? Or can we choose them from the broader quality measures set?

>> MELANIE BROWN: Marcus, I have already forgotten your first question. I will have to ask you to repeat it. The second question was around whether or not you had to choose a mandatory measure of the quality improvement strategy. I think we determined -- and I will ask Jen to weigh in because it may have changed. I think we determined early on the states could choose any measures they are actually reporting on for the two measures to develop a quality improvement strategy. Jen, is that still your understanding?

>> JENNIFER BOWDOIN: We have been encouraging states to focus on the required measures, but what I would suggest is that you reach out to CMS. We are happy to provide technical assistance wrapped around state-specific issues and why they would want to pick a particular measure.

>> PARTICIPANT: So it could be something other than the five mandatory, pending a conversation with CMS?

>> JENNIFER BOWDOIN: Potentially. Why don't we talk further?

>> PARTICIPANT: Okay. My first question was, has CMS defined what is meant by representative sample?

>> JENNIFER BOWDOIN: I was going to suggest Mary take that. Melanie, feel free.

>> MELANIE BROWN: I would say the same, so I will defer to Mary.

>> MARY BOTTICELLI: For MFP, which is what you are referring to, the MFP requirements of the LTSS, the fee-for-service, for the assessment and care planning measures which are LTSS 1 and 2, they are related to the assessment and care plan and update. There is a minimum sample

size of 411 records. That doesn't mean it has to be 411 MFP participant records. It would be 411 folks who receive LTSS in your state and could be part of 1915(c),i, j, and k waivers.

>> MELANIE BROWN: There is a manual. I don't know if that is one of the items that has already been put in the chat. I'm not sure. If not, we can send that to you. That is really the best source if you have questions about required samples. And then for each of the experience of care surveys, the best source for information about required samples is really going to be the measure -- we can provide contact information for any specific questions.

>> PARTICIPANT: Thank you. Hi, Mary. I haven't talked to you in the longest time. The definition or representative sample is defined in the technical guide? Is that right?

>> MARY BOTTICELLI: Correct. Yes.

>> PARTICIPANT: Thank you very much.

>> MARY BOTTICELLI: Sure. I will put in the chat too.

>> ADRIENNE DELOZIER: I think we probably have time for one more live question. But before we do that, I will point everyone to the chat again. There are several links. One is about the measure set review work group. There is a link to where our slides and transcript and our recording will be posted. And most importantly, there is our HCBS access rule mailbox, question mailbox, which is HCBSaccessrule@cms.hhs.gov. If we were not able to get your questions today, we apologize. At one point, I think we had over 800 participants. We weren't able to get to everyone. If we have any more hands raised, we will take one more question. Make sure you grab the links in the chat box while we are doing that. We really want to thank everyone for their participation today. I will give it to Mary.

>> PARTICIPANT: Thank you, Jackie. See if there is more context, the public comment period for the HPS -- how does that intersect with the MFP reporting that has been established? Thank you.

>> JENNIFER BOWDOIN: Melanie, do you want o answer that?

>> MELANIE BROWN: I think so. The MFP review would be required to report from the 2024 version released in April. The public comment activity and review activity, much of that is happening and the public date for the process is December 2026. A lot of that is happening right after or during the MFP reporting period.

So, if the question is whether or not the measure set itself, the MFP recipients are required to report on would be impacted by that process, not for 2026. So, the idea is that that process would impact the 2028 version of the measure set.

>> ADRIENNE DELOZIER: Jen, anything you want to add?

>> JENNIFER BOWDOIN: No. Thanks.

>> ADRIENNE DELOZIER: Once again, I think we are right at the hour. Make sure you take a look at the links that we have sent if you are interested. We will make sure that within a few days

or so, these materials are posted on the website that we threw up in the chat box. We encourage you if there are any questions you still have about these provisions or any of the HCBS access rule provisions, please send them to the mailbox we have referenced a few times. I want to thank everybody for their participation. We will see you on our next training.