Topic	Rule Requirement	Effective Date
Create a Medicaid Advisory Committee (MAC) & Beneficiary Advisory Council (BAC)	→ Renames and expands the scope of states' Medical Care Advisory Committees. The renamed Medicaid Advisory Committees (MAC) will advise states on an expanded range of issues. → Requires states to establish a Beneficiary Advisory Council (BAC) comprised of Medicaid beneficiaries, their families, and/or caregivers. → Establishes minimum requirements for MAC membership, including a requirement that 25% of the MAC members will be drawn from the BAC. → Requires states to make information about the MAC and BAC activities publicly available including bylaws, meeting schedules, agendas, minutes, and membership lists. → Requires states to make at least two MAC meetings per year open to the public. These meetings must include a public comment period. → Requires states to provide staff to support the planning and execution of the MAC and BAC activities. → Requires states to create and publicly post an annual report summarizing MAC and BAC activities.	→ Establishment of MAC and BAC: 1 year after the effective date of the final rule. → BAC crossover on MAC: For the period from the effective date of the final rule through 1 year after the effective date, 10 percent; for the period from year 1 plus one day through year 2 after the effective date of the final rule, 20 percent; and thereafter, 25 percent of committee members must be from the BAC. → Annual report: States have 2 years from the effective date of the final rule to finalize the first annual report. After the report has been finalized, States will have 30 days to post the annual report.
Person-Centered Service Plans	→ Strengthens oversight of person-centered service planning in HCBS.	→ Beginning 3 years after the effective date of the final rule.
Grievance Systems	→ Requires that states establish a grievance system for HCBS delivered through FFS.	→ Beginning 2 years after the effective date of the final rule.

Incident Management System	→ Requires that states meet nationwide incident management system standards for monitoring HCBS programs.	→ Beginning 3 years after the effective date of the final rule; except for the requirement for electronic except for the requirement and electronic incident management system, which begins 5 years after the incident management system, which begins 5 years after the effective date of the final rule.
HCBS Payment Adequacy	→ Requires that states generally ensure a minimum of 80% of Medicaid payments for homemaker, home health aide, and personal care services be spent on compensation for direct care workers furnishing these services, as opposed to administrative overhead or profit, subject to certain flexibilities and exceptions (referred to as the HCBS payment adequacy provision). → The HCBS payment adequacy provision provides states the option to establish: (1) a hardship exemption based on a transparent state process and objective criteria for providers facing extraordinary circumstances and (2) a separate performance level for small providers meeting state-defined criteria based on a transparent state process and objective criteria. The HCBS payment adequacy provision also exempts the Indian Health Service and Tribal health programs subject to 25 U.S.C. 1641 from complying with its requirements.	→ Beginning 6 years after the effective date of the final rule.
Reporting Requirements	→ Requires that states report on their readiness to collect data regarding the percentage of Medicaid payments for homemaker, home health aide, personal care, and habilitation services spent on compensation to the direct care workers furnishing these services; and in four years, states report on the percentage of Medicaid payments for homemaker, home health aide, personal care, and habilitation services spent on compensation to the direct care workers furnishing these services, subject to certain exceptions.	→ Beginning 3 years after the effective date of the final rule. → Beginning 4 years after the effective date of the final rule for reporting on the HCBS Quality Measure Set and HCBS payment adequacy reporting.

HCBS Quality Measure Set	→ Requires states to report on waiting lists in section 1915(c) waiver programs; service delivery timeliness for personal care, homemaker, home health aide, and habilitation services; and a standardized set of HCBS quality measures.	→ HHS Secretary begins identifying quality measures no later than December 31, 2026, and no more frequently than every other year. → HHS Secretary shall make technical updates and corrections to the HCBS Quality Measure Set annually as appropriate.
Website Transparency	→ Promotes public transparency related to the administration of Medicaid covered HCBS through public reporting of quality, performance, and compliance measures.	→ Beginning 3 years after the effective date of the final rule
Payment Rate Transparency Publication	→ Requires states to publish all FFS Medicaid fee schedule payment rates on a publicly available and accessible website.	→ July 1, 2026, then updated within 30 days of a payment rate change.
Comparative Payment Rate Analysis Publication	→ Requires states to compare their FFS payment rates for primary care, obstetrical and gynecological care, and outpatient mental health and substance use disorder services to Medicare rates, and publish the analysis.	→ July 1, 2026, then every 2 years.
Payment Rate Disclosure	→ Requires states to publish the average hourly rate paid for personal care, home health aide, homemaker, and habilitation services, and publish the disclosure.	→ July 1, 2026, then every 2 years.
Interested Parties Advisory Group	→ Requires states to establish an advisory group for direct care workers, beneficiaries, beneficiaries' authorized representatives, and other interested parties to meet and advise and consult on payment rates paid to direct care workers for personal care, home health aide, homemaker, and habilitation services.	→ The first meeting must be held within 2 years after effective date of the final rule (then at least every 2 years).
Rate Reduction and Restructuring SPA procedures	→ Requires states to demonstrate access sufficiency through an initial analysis when submitting a state plan amendment with a rate reduction, or restructuring in circumstances that could result in diminished access, for all services. If the state does not meet the requirements of the initial analysis, they must perform an additional, more extensive analysis.	→ Effective date of the final rule.