Rate Setting for Medicaid Home- and Community-Based Services

Medicaid home- and community-based services (HCBS) are designed to allow people with long-term services and supports (LTSS) needs to live in their homes or a home-like setting in the community. Medicaid is the nation's largest payer of HCBS for individuals with intellectual or developmental disabilities (I/DD), older adults, and individuals with physical disabilities (MACPAC 2023). In calendar year 2021, Medicaid programs nationwide spent $82.5 billion on HCBS and served more than 2.5 million HCBS users (MACPAC 2025).

States have significant flexibility in the design of their HCBS programs. HCBS are optional benefits and all states choose to cover some HCBS. States use a wide range of pathways to authorize these services, including Medicaid state plans, Section 1915(c) waivers, and Section 1115 demonstration authorities, or some combination of these authorities (Appendix A).[1] HCBS can be delivered through fee-for-service (FFS) or managed care delivery systems. States also have considerable flexibility to set HCBS payment rates and define many other parameters of HCBS in their state, including the types of services covered, the populations served, and the criteria used to determine eligibility.

When designing HCBS benefits, states can also offer individuals an option to self-direct their care. Self-direction is a beneficiary-controlled HCBS delivery model that allows the individual to choose their service providers and have control over the amount, duration, and scope of services and supports in their person-centered service plan (42 CFR 441.740, Murray et al. 2024, ACL 2014). All states offer self-directed services through either an HCBS waiver or state plan, and over half of states offering personal care via a state plan option allow for self-direction of those services (O'Malley Watts et al. 2022). Because some self-directed programs also grant beneficiaries authority over their service budget, meaning that beneficiaries have flexibility to choose payment rates for self-directed services, state rate setting may not directly apply to rates paid within self-directed programs.

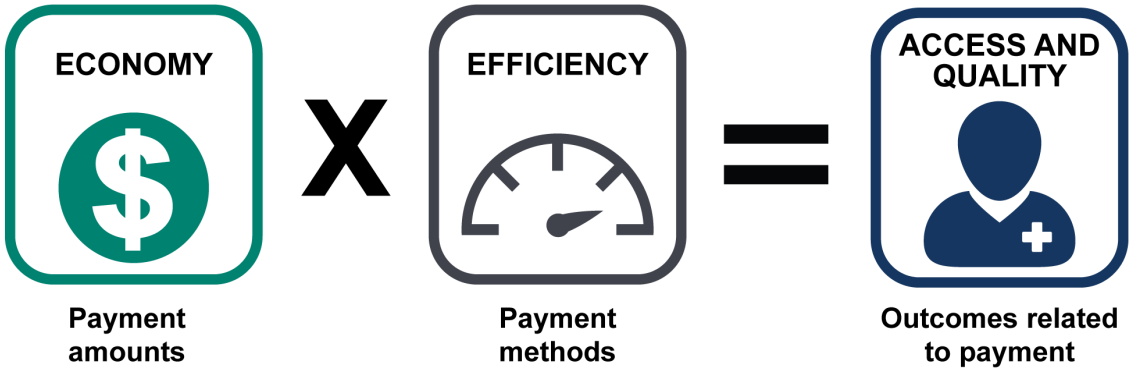
Medicaid HCBS Payment Policies

MACPAC's provider payment framework is a starting point for assessing Medicaid HCBS payment policies and their relationship to access to care. The framework describes the statutory goals of Medicaid payment policy and their relationship to each other (MACPAC 2015):

- Economy is defined as a measure of what is spent on provider payments. The most basic measure of economy is the rate that providers are paid for a particular service.
- Access and quality are defined as measures of what is obtained as a result of provider payments. Access measures include potential access (e.g., whether a provider is available), realized access (e.g., use of services), and beneficiary perceptions and experiences about their care.
- Efficiency is defined as a measure that compares what is spent (economy) to what is obtained (access and quality). To identify opportunities to improve efficiency, it is helpful to compare payment rates and outcomes across states. States with the highest payment rates and the lowest access and quality outcomes have the greatest opportunity to improve efficiency by changing payment methods to get better outcomes for the same level of spending.

To promote access and quality goals, states can improve payment rates (a measure of economy) or change payment methods and other conditions of payment to achieve more efficiency (Figure 1).

FIGURE 1. MACPAC Provider Payment Framework



Source: MACPAC 2015.

States can establish different payment methodologies for each covered Medicaid service. The payment methodologies must be set forth in the Medicaid state plan or another authority. States can set different payment rates for certain classes of providers as defined by the state (42 CFR 447.201, § 1902(a)(30)(A) of the Social Security Act (the Act)). While federal requirements may specify additional requirements for certain provider types (e.g. institutional providers or federally qualified health centers), no such standards apply to FFS methodologies for HCBS.

States must comply with certain federal public notice and transparency requirements for any changes to statewide reimbursement methods or rates (42 CFR 447.205). As part of this process, states must ensure that reductions to rates or rate restructurings do not cause access to care concerns or provide a justification if they anticipate access to care concerns ((42 CFR 447.205(c)(1) and (c)(2)). The Centers for Medicare & Medicaid Services (CMS) has the right to disapprove or take compliance action when overseeing these requirements. CMS may also discover access to care issues stemming from provider payment inadequacy and may take compliance action as a result of this discovery (42 CFR 447.205(5)).

The CMS 2024 Ensuring Access to Medicaid Services final rule creates additional requirements regarding Medicaid payment rates (HHS 2024a). The rule requires that FFS rates established by a fee schedule be published on a publicly accessible website no later than July 2026 (42 CFR 447.203). State Medicaid agencies must implement other transparency requirements within the same timeline, including a comparative payment rate analysis and disclosure (42 CFR 447.203(b)(3)). The rule additionally includes specific reporting requirements for a subset of HCBS. For Section 1915(c) waivers, states must document new measures of HCBS payment rate adequacy (42 CFR 441.302(k)) beginning in 2030.

The CMS 2024 Managed Care Access, Finance, and Quality final rule includes new requirements for a payment rate analysis for HCBS, including homemaker, home health aide, personal care, and habilitation services, effective for rating periods beginning on or after July 9, 2026 (HHS 2024b). The analysis will show the total amount each managed care plan paid for all codes billed for these services compared to what would have been paid under the state's Medicaid FFS rates (42 CFR 438.207(b)(3)(ii)).

FFS HCBS rates and rate components

Under a FFS model, the state pays providers directly for each service provided to a Medicaid beneficiary. Medicaid statute requires that all payments, including HCBS payments, are consistent with the goals of efficiency, economy, quality, and access (§1902(a)(30)(A) of the Act).

Like all other Medicaid services, states set FFS rates for HCBS. As with other services, CMS has broad authority to review rate methodologies as part of the state plan amendment process. CMS may not approve rates when the rate methodologies do not comply with the efficiency, economy, quality, and access standards required by Section 1902(a)(30)(A) of the Act. We include further detail on how states set HCBS payment rates below.

Authorities used to cover FFS HCBS are subject to different requirements, but most have requirements around public notice, public comment, and rate transparency to grant visibility into the state's rate-setting process. Section 1915(c) waiver authority requires notice of rate changes consistent with general federal payment methodology requirements but also at the time of waiver amendment or renewal (42 CFR 447.205, 42 CFR 441.304(e)). If CMS judges a state out of compliance with these requirements, it may impact CMS approval of the waiver or result in compliance action. Section 1915(i) state plan amendments similarly require a description of the reimbursement methodology in the state's submission to CMS.

CMS guidance on FFS rate setting for HCBS supports states' compliance with federal regulatory and statutory standards, and provides information on several kinds of rates, including fee schedules, negotiated market price rates, tiered rates, bundled rates, and cost reconciliation (CMS 2016). Guidance also covers prospective and retrospective payment methods. Federal language does not prescribe which kind of rate states should use.

- **Fee schedules.** Rates are set prospectively, per unit, for a specific period of time, and rates are fixed.
- **Negotiated market prices.** Rates are based on those available in a free market, and subject to negotiation between payer and provider.
- **Tiered rates.** Rates are fixed, but vary by characteristics of the individual, provider, or both.
- **Bundled rates.** Rates are set prospectively for a specific period of time for a specified group of multiple services to be delivered in tandem.
- **Cost reconciliation.** Interim rates are paid and updated according to provider cost reports.

State payment rates may be diverse to reflect the variability amongst HCBS types as well as the adjustment factors employed in rates, which may include acuity, provider costs, geographic variation, or other factors.

- **Acuity.** Rates vary based on beneficiary characteristics, such as diagnosis or service needs.
- **Provider costs.** Rates vary based on provider characteristics reported to the state, such as capital costs or other differences among providers within a class.
- **Geographic variation.** Rates vary based on urban or rural differences or along state borders to reflect differences in health care markets' costs.

Data sources and inputs

FFS payment rate setting requires robust data to generate initial rates for new programs or to update or revise payment rates. States have broad flexibility in identifying appropriate base data and setting HCBS payment rates within federal frameworks, and CMS has similarly broad authority to review and provide oversight of state rate-setting methods. HCBS payment rate development and maintenance typically involves identifying assumptions for each rate component. Rate components include:

- **worker salary and wages,** such as wage rates, direct and indirect time, supervisory time, paid time off, training time, and staff-to-client ratios; HCBS worker wages are generally the largest component of HCBS payment rates;
- **employee-related expenses,** such as employee-related taxes and fees and employee benefits such as health insurance and retirement contributions;
- **transportation and fleet vehicle expenses,** such as expenses related to ownership, maintenance, and operation of agency vehicles and mileage paid to employees for use of their own vehicles; and
- **administration, program support, and overhead,** including all other operational expenses.

Assumptions for each rate component vary significantly based on the type of service and acuity of the population. Participants in MACPAC subject matter expert interviews and a technical expert panel (TEP) cited wage data as one of the most important data inputs, both because of the significant contribution of wages to overall payment rates and because wage data themselves are composites of other costs (e.g., overtime, administrative tasks, supervision, and more). Lack of standardized baseline wage data presents a challenge for building and maintaining wage components of HCBS payment rates.

Our review of 47 state Medicaid programs' Section 1915(c) waiver applications revealed varied sources for wage assumptions when developing HCBS payment rates (MACPAC 2024; Table 1). In some cases, state waiver application language included consideration of several sources but did not specify the exact wage source used for HCBS payment rate development.

TABLE 1. Wage Data Sources Used for FFS HCBS Rate Development in Section 1915(c) Waivers

Wage data source	Home-based services		Day services		Round-the-clock services	
	States	Percent of total	States	Percent of total	States	Percent of total
Total states in analysis	**31**	**100%**	**37**	**100%**	**33**	**100%**
BLS	23	74	28	76	25	76
State wage data	9	29	8	22	9	27
Provider survey data	3	10	3	8	3	9

Notes: FFS is fee for service. HCBS is home- and community-based services. BLS is Bureau of Labor Statistics. Home-based services, day services, and round-the-clock services refer to categories that are defined in the HCBS taxonomy (CMS 2014). Some states use more than one wage source during payment rate development. States excluded from analysis do not operate FFS HCBS through Section 1915(c) waivers or did not indicate the wage source used in HCBS rate development in their Section 1915(c) waiver.

Source: Milliman 2023, analysis for MACPAC of Section 1915(c) waiver applications approved as of August 2023.

According to this analysis, the majority of states use Bureau of Labor Statistics (BLS) wage data as the foundation for the wage component of the payment rate. BLS wages are reported by Standard Occupational Classification (SOC), year, and region, state, or metropolitan area, pending availability of data. BLS data reflect national wage data for over 800 occupations in about 400 industries, and are derived from the Occupational Employment Statistics Survey, BLS Modeled Wage Estimates, or the Census Bureau's Current Population Survey (BLS 2024).

Despite their widespread use in HCBS rate setting, there is notable variability in the BLS SOC codes used during payment rate development because BLS data reflect standard labor and wage categories rather than Medicaid HCBS worker classifications. BLS, for example, does not have a single direct support professional-specific SOC (BLS 2023). Our interviews and TEP revealed that states often blend BLS SOC codes to reflect different HCBS worker roles and service-specific requirements. States use varying methodologies to blend SOC codes.

Beyond BLS, states employ other widely available sources for HCBS worker wage inputs in rate setting, including published cost indices, national survey data, or state-collected data. In waiver applications, states cited the use of a variety of price indices, including the Consumer Price Index (CPI); federal market basket indices for LTSS including nursing facilities or home health services; the Medicare Economic Index (MEI); and others. Additionally, over half of states are participating in the National Core Indicators (NCI) State of the Workforce surveys, which collect information from provider agencies about worker wages, benefits, and turnover rates among the aging and disability population as well as the I/DD population (NCI 2024a, NCI 2024b). These surveys are primarily used to monitor policy trends, and no state in our Section 1915(c) waiver reviews used the NCI survey data in their rate development efforts.

State-collected data. States may also implement or leverage other local data collection activities. States may use program data to establish tiered rate structures based on functional or clinical assessments or other data sources (CMS 2016). Some states may use state employment trend data or state compensation studies as inputs for building HCBS rates (MACPAC 2024). States also may field provider surveys to obtain data on a variety of provider costs, including administrative overhead, capital costs, or other expenses (CMS 2016).

In many cases, states require routine provider cost reporting. Cost reporting may support fee schedule reimbursement rate setting models and may be used to provide effective oversight of HCBS programs. From a federal perspective, cost reporting is not required. However, when it is in place, CMS may impose certain standards (e.g., the waiver application must describe audit protocols and standards) (CMS 2019).

Among the 47 states' Section 1915(c) waivers in our review, 10 states list cost reports as a data adjustment source in FFS HCBS rate setting. Notably, cost reporting can be perceived as onerous for both providers and states. Participants in our TEP discussed challenges with cost reporting given (1) the technical capacity of agency providers to comply with cost reporting requirements; (2) the variability in costs across different types and sizes of HCBS providers; (3) the variability in engagement from different provider types or agencies; and (4) the state agency's capacity to address these challenges and obtain consistent and accurate provider data.

Access rule. Once implemented, the 2024 access rule will provide additional data to CMS related to workforce, payment rates, and wages. Beginning in 2026, states will be required to publish average hourly FFS HCBS payment rates for homemaker, home health aide, personal care, and habilitation services. Beginning in 2028, states must report annually on the percentage of payments directed toward compensation for direct care workers for homemaker, home health aide, personal care, and habilitation services. Though states may need to calculate average wage rates for each service to satisfy the existing HCBS data reporting requirements, the access rule does not require states to report average wage rates. The access rule additionally does not require CMS to share compensation data across states or make compensation data public.

State policy inputs. Apart from historical data sources at the state or federal level, state payment rates may further reflect state policy decisions in rate components. These may include state minimum wage laws; mandatory staffing ratios included in rate models; licensure or supervisory requirements set forth in state law; licensure and

training costs; and capital investments, including health IT costs. These costs are likely reflected in other data such as historical trend data, index data, and cost reporting, but states may benchmark rates to known policies to ensure payment rates are adequate to support providers' compliance.

Federal requirements for Medicaid capitation rates and HCBS

States may cover HCBS under managed long-term services and supports (MLTSS) programs using different Medicaid managed care authorities (§§ 1932(a), 1915(a), 1915(b), 1115 of the Act). The many intersections between HCBS authorities (§§ 1915(c), 1915(i), 1915(k), 1915(j), and 1115), managed care authorities and contracts, and diverse beneficiary populations enrolled make managed care programs operating HCBS vary widely state to state. For more information on MLTSS program design characteristics, see Appendix B.

States pay Medicaid managed care plans a fixed amount, per member per month capitation payment to finance covered benefits delivered by the health plan. States' development of capitation rates is subject to federal regulatory standards and oversight. State capitation rates for managed care plans must be actuarially sound, which means that they are sufficient to cover all reasonable and appropriate costs for the services covered and according to established standards (42 CFR 438.4 and 438.5). CMS reviews states' managed care contracts and actuarial certifications for each rating period (the period for which the rates are established prospectively) (42 CFR 438.7). Managed care plans subsequently establish payment rates to providers who deliver HCBS waiver services to enrolled participants.

States may use FFS data and experience in setting capitation rates if no other acceptable base data are available (42 CFR 438.5). Base data for capitation rate setting must be drawn from the Medicaid population's actual experience or a similar population that is adjusted to be comparable to the Medicaid population. While managed care plans generally have the flexibility to negotiate their own payment rates with providers, states can require the plans to pay providers according to specific rates or methods under the directed payment option (42 CFR 438.6). For example, states can establish a minimum fee schedule (e.g., the state FFS fee schedule) and require the plans to pay at least that amount to their contracted providers.

Fiscal integrity requirements

The financial accountability assurance in the Section 1915(c) authority is one of the main federal levers CMS has for ensuring oversight of state HCBS rates and implementation. Described in 42 CFR 441.302(b), state agencies must assure financial accountability for Medicaid funds paid for waiver programs, including compliance with audit or other oversight activities undertaken by CMS.

In Section 1915(c) waiver applications and renewals, a state must specify how it makes payments for services covered by the waiver, ensures program integrity, and complies with applicable requirements concerning payments and federal financial participation. In its review of an initial waiver application or a waiver renewal, CMS applies the following review criteria (CMS 2019):

- The rate setting method used for each waiver service is described, and variation between providers of the same service is described;
- The rate setting methodology for self-directed services, if applicable, is described;
- The entity (or entities) responsible for rate determination is/are identified and oversight of the rate determination process is described;
- The year rates were set and last reviewed are provided;
- The agency's public comment process for rate determination methods is included;
- The process for making payment rate information available to waiver participants is described;

- The state's rate review methods and processes are described; and
- For concurrent HCBS-managed care authorities, the capitation rate methodology should be referenced, but is reviewed through standard capitation rate review processes at CMS.

Notably, federal policy does not universally require waiver applications or other HCBS authorities to indicate the source of wage data for building HCBS rates. Our review of 1915(c) waivers found that not all states indicated the wage data source in their waiver application despite describing the rate methodology (Table 1). CMS conducts rate-setting reviews at the time of initial and renewal applications in tandem with other financial accountability reviews and monitoring.

Methods for maintaining and updating rates

Periodic or ongoing rate reviews range from internal rate reviews, which are limited to refreshing key rate inputs within the existing rate methodology through indexing or rebasing, to comprehensive external rate evaluations, also called rate studies (Box 1).

Box 1. Definitions

Indexing. Any payment rate methods that account for changes in cost over time by linking certain trend factors to payment rates. These trend factors can include price indices, provider cost data, wage data, or minimum wage floors.

Rebasing. Periodic recalculation of payment rates according to new or updated data such as provider cost reports or more recent wage data.

Rate studies. Comprehensive external rate evaluations. Unlike indexing and rebasing, rate studies may result in changes to the underlying rate methodology.

Federal HCBS rate review requirements vary by HCBS authority; however, CMS does not prescribe a specific type of rate review for any HCBS authority. CMS technical guidance instructs states operating HCBS through Section 1915(c) waiver authority to review rates at least every five years (CMS 2019). No other HCBS authorities have a specific provision requiring a rate review or indicating a frequency for review. For more information on HCBS rate review requirements, see Appendix C.

Our analysis of Section 1915(c) waivers found that the use of formal, comprehensive rate studies for rate reviews in HCBS programs is limited. Of the 47 states that used Section 1915(c) waivers to cover HCBS, we only identified 30 states that described rate studies in their Section 1915(c) rate-setting methodology. Moreover, we also found that states' rate study methodologies and outputs were not always publicly available (MACPAC 2024). In weighing the benefits and challenges of rate studies, participants in our TEP noted that a key decision for states may be identifying the appropriate periodicity for rate studies. A strategic cadence could promote the inclusion of relevant rate assumptions and updated data without overwhelming the system with administrative or fiscal burdens.

Conclusion

States have significant flexibility in the design of their HCBS programs, and may implement a variety of payment types in their diverse HCBS offerings within and across programs. Despite these flexibilities, states must adhere to established, broad federal standards for rate-setting. States experience a shared need for appropriate, complete data in setting rates that facilitate Medicaid's statutory objectives of promoting efficient, high-quality care and access to care.

Endnotes

[1] State plan services include those services authorized under Section 1915 state plan authorities (i), (j), and (k).

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APPENDIX A: HCBS Statutory Authorities

TABLE A-1. HCBS Statutory Authorities

Type of Authority	Authority	Description
Waiver	**Section 1915(c)**	Allows states to modify Medicaid requirements to target HCBS benefits to specific populations, cap the number of beneficiaries who receive benefits, or create waiting lists for people who cannot be served under the cap.
	Section 1115	Allows states to test new delivery models and is not specific to HCBS. Allows states to target HCBS benefits to specific populations.
State plan	**Section 1905(a)(24)**	Allows states to cover personal care services but does not allow participants using self-direction to manage their individual service budgets.
	Section §1915(i)	Allows states to offer HCBS to people who need less than an institutional level of care. States can use this authority to target certain populations for HCBS.
	Section §1915(j)	Allows States to provide individuals with the option to self-direct personal assistance services, including hiring relatives. States may also provide individuals with the authority to manage their own individual service budget.
	Section §1915(k) Community First Choice Option	Provides States with a six percentage point increase in the federal medical assistance percentage (FMAP) for HCBS attendant services.

Notes: HCBS is home- and community-based services.

APPENDIX B: Managed Long-Term Services and Supports

TABLE B-1. Selected Managed Long-Term Services and Supports Program Design Characteristics

MLTSS program characteristics	Description
Managed care authorities	State options include: • Section 1115 waiver authority • A combination of Section 1915(a) and Section 1915(c) waiver authorities • A combination of Section 1915(b) and Section 1915(c) waiver authorities • A combination of Section 1932(a) state plan amendment and Section 1915(c) waiver authorities
Contract types	• Comprehensive managed care program that includes LTSS and non-LTSS benefits (some states limit enrollment to populations eligible for LTSS, others include all populations) • Plan that provides only LTSS benefits • Single comprehensive plan that covers Medicare and Medicaid benefits for individuals who are dually eligible for Medicare and Medicaid, such as those offered through the Financial Alignment Initiative
Populations covered	• Almost all state MLTSS programs cover older adults and individuals with physical disabilities • Most states exclude individuals with intellectual or developmental disabilities • Some states exclude children • Some states cover individuals with traumatic brain injuries
Mandatory or voluntary enrollment	• Many states mandate that beneficiaries in eligible populations enroll • Some states give beneficiaries the option of enrolling in an MLTSS plan or continuing to receive LTSS on an FFS basis
Geographic reach	• Statewide or only offered in certain regions

MLTSS program characteristics	Description
Inclusion of institutional coverage	• Most state MLTSS programs cover both HCBS and institutional care • A few states focus their MLTSS programs on beneficiaries currently receiving HCBS and they have delayed including current nursing facility residents or they limit their plans' risk for institutionalized beneficiaries
Number of plans participating	• State decisions on number of plans affect beneficiary choice and administrative complexity
Types of plans participating	• States can contract with for-profit, non-profit, or public entities
Payment policies	• States can make different decisions regarding payment incentives, for example, to promote HCBS
Integration with Medicare benefits	• States can align Medicaid MLTSS with Medicare Advantage dual-eligible special needs plans (D-SNPs) to integrate care for beneficiaries who are dually eligible for Medicare and Medicaid

Notes: MLTSS is managed long-term services and supports. LTSS is long-term services and supports. FFS is fee for service. HCBS is home- and community-based services.

Sources: MACPAC, 2018, analysis of Lewis et al. 2018, Dobson et al. 2017, Libersky et al. 2016, and Saucier et al. 2012.

APPENDIX C: Federal HCBS Rate Requirements

TABLE C-1. Federal Requirements for HCBS Payment Rates

HCBS authority	Description of rate methodology	Rate review	Network adequacy	Stakeholder engagement
1915(c) fee-for-service	A description of the rate-setting method used for each waiver service must be included in the waiver application, including the basis for any variation, the rate methodology for self-directed services, and the entities responsible for rate determination.	Required a minimum of every five years. States must describe their rate review process, including when rates were initially set and last reviewed, how the state measures sufficiency and compliance with §1902(a)(30)(A) of the Social Security Act, rate review methods used, and frequency of rate review activities.	Rate review must ensure that rates are adequate to maintain an ample provider base and ensure quality of services.	State must describe how the Medicaid agency solicited public comment on rate determination methodologies.
State plan	State plan language must include a description of the policy and methods used to set payment rates.	No specific provision, however state descriptions of the policy and methods used to develop payment rates must be approved by CMS.	States must: • Develop and implement a medical assistance access monitoring review plan. • Submit an access review with any State plan amendment that proposes to reduce provider payment rates or restructure provider payments in circumstances where changes could result in diminished access. • Have ongoing mechanism for beneficiary and provider input on access to care.	States must provide public notice of changes in statewide methods and standards for setting payment rates. Additional state-specific requirements may apply.

HCBS authority	Description of rate methodology	Rate review	Network adequacy	Stakeholder engagement
			• Address any access deficiencies within a predetermined time period.	
Managed care	No federal requirement for specific services.	Rate reviews for individual services are not required. Capitation rates reflecting all services included under managed care are updated annually to account for changes in program costs and utilization. MCOs negotiate payment rate changes directly with providers unless a state chooses to implement a state-directed payment arrangement.	States monitor MCO performance to ensure MCOs meet the following federal requirements: • Covered services must be accessible to MCO enrollees to the same extent that such services are accessible to other state residents with Medicaid who are not enrolled with the MCO. • MCOs must have sufficient network adequacy (sufficient number, mix, and geographic distribution of providers) to meet the expected enrollment in the service area. States may also develop state-specific performance requirements related to performance adequacy.	There are no federal requirements for the release of capitation rates for public comment. While MCOs must each have a Member Advisory Committee when states implement MLTSS, review of payment rate development under managed care is not a specific responsibility of this Committee.

Notes: HCBS is home- and community-based services. MCO is managed care organization. MLTSS is managed long-term services and supports. CMS is the Centers for Medicare & Medicaid Services.