Chapter 1:

Medicaid Payment Policies to Support the Home- and Community-Based Services Workforce

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Recommendation

1.1 The Secretary of the Department of Health and Human Services (HHS) should direct the Centers for Medicare & Medicaid Services (CMS) to amend 42 CFR 441.311(e)(2) to require states to report hourly wages paid to home- and community-based services (HCBS) workers who provide the following services: personal care, home health aide, homemaker, and habilitation. States should report descriptive statistics on hourly wages for each service as determined by HHS. For each service, these data should be disaggregated by worker characteristics determined by HHS, including but not limited to: by licensed nurses and all other direct care workers, and by rural versus urban settings. CMS should build upon planned or existing data collection activities or tools, and publish data on the CMS website.

Key Points

- Medicaid is the nation's largest payer of HCBS for individuals with intellectual or developmental disabilities, older adults, and individuals with physical disabilities.
- All states report HCBS worker shortages as the demand for HCBS outpaces growth in the HCBS workforce.
- Findings from our compendium, state interviews, and technical expert panel identified HCBS wage levels as a key driver of HCBS workforce shortages and acknowledged the important role of Medicaid payment policy in determining the wages that providers pay.
- To advance the statutory goals of efficiency, economy, quality, and access, states should adhere to the following payment principles:
  - ensure that HCBS payment rates promote an adequate workforce and efficient use of resources;
  - take a holistic approach to setting HCBS payment rates to ensure that variations across populations, programs, and geographies reflect policy priorities and beneficiary needs; and
  - review HCBS payment rates for adequacy at a regular interval using the tools available, such as rate studies, indexing, and rebasing.

CHAPTER 1: Medicaid Payment Policies to Support the Home- and Community-Based Services Workforce

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 homelike 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, accounting for about 60 percent of total HCBS spending (MACPAC 2024a, O'Malley Watts et al. 2022a).

The limited availability of HCBS workers is one of the key HCBS access challenges that the Commission highlighted in its June 2023 report to Congress (MACPAC 2023). Although many factors that affect the HCBS workforce are outside of Medicaid's purview, many states are exploring ways to use Medicaid payment policy to expand the number of HCBS workers and reduce worker turnover.

Through federal and state policy reviews, stakeholder interviews, and a technical expert panel (TEP), staff conducted analytic work to better understand the role of payment policy in addressing HCBS workforce shortages. Three payment principles surfaced through these analyses:

- HCBS payment rates should promote an adequate workforce and efficient use of resources;
- states should take a holistic approach to setting HCBS payment rates to ensure that variations across populations, programs, and geographies reflect policy priorities and beneficiary needs; and
- HCBS payment rates should be reviewed for adequacy at a regular interval using the tools available, such as rate studies, indexing, and rebasing.

Our research also determined that the rate setting principles cannot be achieved without robust HCBS payment data, which are limited. Based on these findings, the Commission recommends:

1.1 The Secretary of the Department of Health and Human Services (HHS) should direct the Centers for Medicare & Medicaid Services (CMS) to amend 42 CFR 441.311(e)(2) to require states to report hourly wages paid to home- and community-based services (HCBS) workers who provide the following services: personal care, home health aide, homemaker, and habilitation. States should report descriptive statistics on hourly wages for each service as determined by HHS. For each service, these data should be disaggregated by worker characteristics determined by HHS, including but not limited to: by licensed nurses and all other direct care workers, and by rural versus urban settings. CMS should build upon planned or existing data collection activities or tools, and publish data on the CMS website.

To provide context for this recommendation, the chapter begins with background on Medicaid HCBS and the ongoing workforce shortage. The chapter then describes current challenges in developing payment approaches that can support the HCBS workforce. The chapter concludes with a discussion of the identified payment principles, the recommendation, and supporting rationale.

Background

Medicaid is the nation's largest payer of HCBS for individuals with I/DD, older adults, and individuals with physical disabilities (MACPAC 2023). In calendar year (CY) 2021, total federal and state Medicaid spending on HCBS was $82.5 billion and financed care for more than 2.5 million individuals (MACPAC 2025a).

States have considerable flexibility in the design of their HCBS programs. Nearly all HCBS are optional benefits, and all states choose to cover some HCBS.[1] States use a wide range of pathways to authorize these services, including Medicaid state plan, Section 1915(c) waiver, and Section 1115 demonstration authorities, or some combination of these authorities (Appendix 1A).

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, how benefits are delivered, the populations served, and the criteria used to determine eligibility. As a result, variation exists in HCBS spending by state and subpopulation. In CY 2021, HCBS spending per person for individuals with I/DD ($55,339) was more than 50 percent higher than for individuals with physical disabilities who were younger than 65 ($36,605) and twice as high as for HCBS users 65 and older ($26,544) (MACPAC 2025a).[2] In fiscal year 2020, HCBS spending per state resident ranged from $151 in Alabama to $1,082 in New York (Murray et al. 2023).

HCBS Workforce

In 2023, there were approximately 3.6 million HCBS workers nationwide (PHI 2024a).[3] Different data sources define HCBS workers in varying and often overlapping ways. HCBS workers may be defined as direct care workers (DCWs), direct support professionals (DSPs), or independent providers, and these larger classifications may in turn include personal care aides, home health aides, and even nurses.

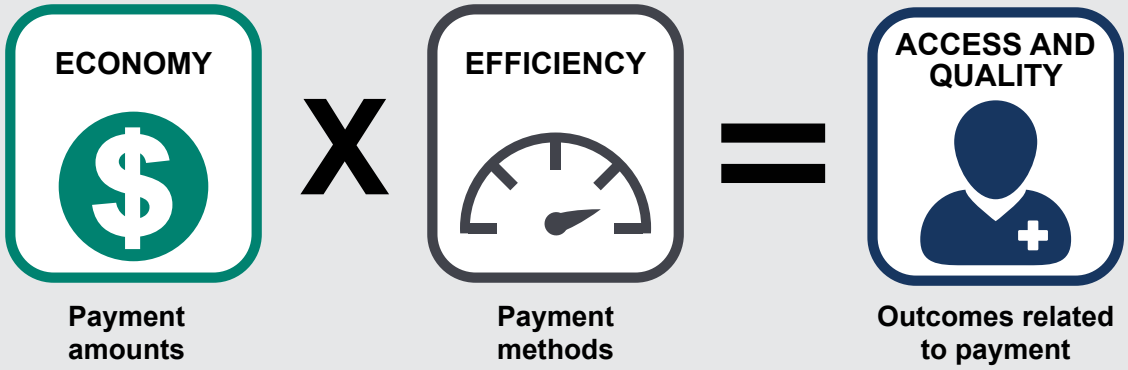
Most HCBS workers are employed by HCBS provider agencies, but approximately 1.2 million HCBS workers (42 percent) were employed as independent providers through Medicaid-funded self-direction programs (PHI 2024a). According to the 2021 American Community Survey, HCBS workers are predominantly female (84 percent) and Black or Hispanic (53 percent), and more than half of HCBS workers (58 percent) receive some kind of public assistance (PHI 2024a).

All states report HCBS worker shortages as growth in demand for HCBS outpaces growth in the HCBS workforce (Burns et al. 2023). Although the number of HCBS workers grew by an average of 4 percent per year between 2008 and 2020, the number of Medicaid HCBS participants grew by an average of 10 percent per year during that period. The ratio of home care workers to Medicaid HCBS participants began declining in 2013, and preliminary estimates suggest further declines occurred in 2020 (Kreider and Werner 2023). In addition to challenges in recruiting HCBS workers, states also face challenges retaining them. HCBS workers have a high turnover rate of approximately 40 to 60 percent each year (PHI 2023).

The COVID-19 public health emergency (PHE) further exacerbated HCBS workforce capacity challenges, making it difficult for states to maintain access to services. For example, a 2022 survey found that nearly all states reported workforce shortages in one or more HCBS settings (O'Malley Watts et al. 2022b). In addition, two-thirds of the 41 states that responded to a similar survey in 2021 reported a permanent closure of at least one Medicaid HCBS provider during the pandemic (O'Malley Watts et al. 2021). A 2021 survey of providers of community-based I/DD services found that 77 percent turned away new referrals, 58 percent discontinued certain programs or services, and 84 percent delayed programs due to staffing shortages (ANCOR 2021).

The American Rescue Plan Act of 2021 (ARPA, P.L. 117-2), in response to the PHE, introduced a new source of federal funding through a temporary increase in the federal medical assistance percentage (FMAP) specific to states' HCBS spending. Workforce initiatives were among the most common uses of the one-time infusion of federal funding (CMS 2023); all states and the District of Columbia submitted spending plans to the Centers for Medicare & Medicaid Services (CMS) indicating intentions to use enhanced funding under ARPA to support workforce recruitment and retention activities. Many state spending plans also indicated intentions to use ARPA funding to support workforce training initiatives (CMS 2023). States generally had until March 31, 2025 to spend their ARPA funding (CMS 2023), although CMS granted additional extensions to about half of states through as late as September 30, 2026 (MACPAC 2025b). According to a 2023 survey conducted by the National Academy for State Health Policy, at least 22 states planned to sustain increased Medicaid payment rates for DCWs. However, states had to identify state funding to maintain payment rate increases or other workforce enhancement strategies (Teshale et al. 2023).

FIGURE 1-1. MACPAC Provider Payment Framework



Source: MACPAC 2015.

HCBS Payment Policies

MACPAC's provider payment framework is the starting point for assessing how Medicaid payment policies can be used to address HCBS workforce challenges. 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 1-1).

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)), and although federal requirements may specify additional requirements for certain provider types (e.g., institutional providers or federally qualified health centers (FQHCs)), no such standards apply to fee-for-service (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 447.203(c)(1) and (c)(2)). CMS oversees these requirements and may take compliance action as a result of this discovery (42 CFR 447.203(c)(5) and (6)).

The CMS 2024 Ensuring Access to Medicaid Services final rule (often referred to as the "access rule") created additional Medicaid payment requirements (CMS 2024a). The rule requires that FFS rates paid by 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) and 42 CFR 441.311(e)) beginning in 2028. These require that states report to CMS annually on the proportion of Medicaid payments for furnishing homemaker services, home health aide services, personal care, and habilitation services spent on compensation for direct care workers. Compensation, as described in the regulation, includes worker wages as well as other forms of compensation, such as personnel benefits. Beginning in 2030, states must also ensure that this proportion as reported is at or above 80 percent of total payments for homemaker, home health aide, and personal care services (42 CFR 441.302(k)(3)).

The CMS 2024 Managed Care Access, Finance, and Quality final rule (often referred to as the "managed care rule") includes new requirements for a payment rate analysis for certain HCBS (homemaker, home health aide, personal care, and habilitation services), effective for rating periods beginning on or after July 9, 2026 (CMS 2024b). The analysis must 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)).

HCBS payment rates and rate components

HCBS can be delivered through FFS or managed care. Under an FFS model, the state pays providers directly for each service provided to a Medicaid beneficiary. In FFS, Medicaid HCBS payments must be consistent with the statutory goals of efficiency, economy, quality, and access (§ 1902(a)(30)(A) of the Act). Under a managed care model, the state pays a fixed amount (usually per member per month), to the managed care plan to provide the HCBS and other services specified in the plan's contract with the state. Managed care plans generally have the flexibility to negotiate payment rates with providers, unless a specific amount is required (e.g., under a state directed payment that requires use of a minimum fee schedule).

Like for all other Medicaid services, states set applicable FFS rates for HCBS. As with other services, CMS has broad authority to review rate methodologies as part of the state plan amendment or waiver application 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.

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 waiver amendment or renewal (42 CFR 447.205, 42 CFR 441.304(e)). If CMS finds a state out of compliance with these requirements, it may result in compliance action or disapproval of the waiver. Section 1915(i) state plan amendments similarly require a description of the payment 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, and for a specific period of time, and rates are fixed.
- **Negotiated market prices.** Rates are based on those available in a free market and are subject to negotiation between payer and provider.
- **Tiered rates.** Rates are fixed and 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 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 among 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.

Managed care. States may cover HCBS under managed LTSS (MLTSS) programs using different Medicaid managed care authorities (§§ 1932(a), 1915(a), 1915(b), 1115 of the Act). The many intersections between HCBS authorities (§§ 1905(a), 1915(c), 1915(i), 1915(j), 1915(k), and 1115 of the Act), managed care authorities and contracts, and diverse beneficiary populations make managed care programs operating HCBS vary widely state to state (Appendix 1B).

States pay Medicaid managed care plans per member per month capitation payments to provide all covered benefits required in their contract. Federal regulatory standards and oversight govern states' development of capitation rates. State capitation rates for managed care plans must be actuarially sound, which means that they are sufficient to cover all reasonable, appropriate, and attainable 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, or 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, including comparable populations. Although 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(c)). For example, states can establish a minimum fee schedule (e.g., a state's FFS fee schedule) and require their plans to pay at least that amount to their contracted providers.

Data sources and inputs

FFS payment rate setting requires robust data to generate initial rates for new programs and 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, generally the largest component of HCBS payment rates;
- **Employee-related expenses**, such as employee-related taxes, 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.

TABLE 1-1. Wage Data Sources Used for Fee-for-Service Home- and Community-Based Services Rate Development in Section 1915(c) Waivers

Wage data source	Home-based services		Day services		Round-the-clock services	
	States	Percentage of total	States	Percentage of total	States	Percentage 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: BLS is Bureau of Labor Statistics. Home-based services, day services, and round-the-clock services refer to home- and community-based services (HCBS) taxonomy categories. Some states use more than one wage source during payment rate development. States excluded from analysis do not operate fee-for-service 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.

Assumptions for each rate component vary considerably based on the type of service and acuity of the population. Participants in our interviews and TEP cited wage data as one of the most important data inputs, both because of the substantial 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).

Our review of 47 state Medicaid programs' Section 1915(c) waivers revealed varied sources for wage assumptions when developing HCBS payment rates (Table 1-1) (MACPAC 2024b). 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.

According to an analysis of states' Section 1915(c) waiver applications, the majority of states use Bureau of Labor Statistics (BLS) wage data as the foundation for building the wage component of the 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 more than 800 occupations in about 400 industries and are derived from the Occupational Employment Statistics Survey, BLS Modeled Wage Estimates, or the U.S. Census Bureau's Current Population Survey (BLS 2024a).

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

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; federal market basket indices for LTSS, including nursing facilities or home health services; the Medicare Economic Index; and others. Additionally, more than half of states are participating in the National Core Indicators 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-AD 2024, NCI-IDD 2024). However, no state in our Section 1915(c) waiver reviews reported the use of National Core Indicators survey data in their rate-development efforts.

State data. States 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 2024b). 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 some cases, states require routine provider cost reporting. Cost reporting may support multiple types of rate 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 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 capacity level to address these challenges and obtain consistent and accurate provider data.

Access rule. Once implemented, the 2024 access rule will provide CMS additional data related to workforce, payment rates, and wages. Beginning in 2028, states must report annually on the percentage of payments directed toward compensation for DCWs for homemaker, home health aide, personal care, and habilitation services. States will be required to publish average hourly FFS HCBS payment rates for those services beginning in 2026. 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 to CMS. 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 information technology 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.

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 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.

Federal policy does not require waiver applications or other HCBS authorities to indicate the source of wage data. CMS conducts reviews of rate determination methods at the time of initial and renewal applications in tandem with other financial accountability reviews and monitoring.

Methods for maintaining and updating rates

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 1-1).

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 (Appendix 1C).

Current Challenges

Findings from our compendium, state interviews, and TEP identified wage levels as a key driver of workforce shortages and acknowledged the important role of Medicaid payment policy in determining the wages that providers pay. Wages for HCBS workers typically lag behind other industries, such as fast food or retail, that employ workers with similar training and can often pay similar or higher wages for less demanding work (PHI 2024b, ASPE 2024). Because many HCBS providers rely on Medicaid funding, the wages they pay are linked to the wage assumptions used to develop Medicaid payment rates. As a result, rate setting is a primary tool that states use to promote an adequate workforce and efficient use of resources.

Our analyses also identified aligned rate assumptions and regular rate reviews as key payment policy levers that can be used to address HCBS workforce challenges. However, lack of consistent HCBS wage data presents a barrier to developing, monitoring, and maintaining appropriate rates and underlying wage components.

Variations in HCBS rates influence workforce participation

There is substantial variation in service definitions and associated rates across HCBS models and programs. The MACPAC compendium on Medicaid payment policies for HCBS provided under Section 1915(c) waiver authority found 253 unique, state-defined services that fit into three major HCBS service categories (MACPAC 2024b). Findings from our

BOX 1-1. Rate- Review 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.

interviews and TEP indicate that variation in rates, and how the rate ultimately relates to wages, may lead HCBS workers to participate in delivery models or programs that offer the highest wage, which in turn may affect beneficiary access.

Some variations in rates between similar services may reflect differences in patient acuity and the scope of services provided to one population versus another. For example, individuals with I/DD receiving habilitation services may require more specialized care than older adults receiving personal care services. Rate variations may also reflect administrative complexity. States typically cover HCBS through multiple authorities, which can include multiple Section 1915(c) waiver programs, state plan authorities, and concurrent managed care authorities. These programs may offer similar, but distinct, types of services to different populations through different provider types in unique combinations or scope. Ultimately, this may lead to variance in workforce, service descriptions, or service requirements across programs, which creates challenges in aligning rates across them where appropriate. Additionally, states generally develop and expand or alter their HCBS programs over time, which means that the authorities used to provide services may not be on the same renewal schedule. States may update rates for one program without making corresponding adjustments to other waivers or HCBS authorities.

Rate variations may also reflect the landscape of competing provider and beneficiary advocate groups. A single association typically does not represent all HCBS providers, nor does an organization advocate for all beneficiaries receiving HCBS in a state. As a result, influential associations and advocacy groups may secure rate increases with state legislatures that are specific to the providers or beneficiaries they represent.

Variations in payment rates or wage components may skew workforce participation in ways that may undermine statewide access goals. For example, in one state we interviewed, comparably low rates for independent workers caused HCBS workers to switch from self-direction to agency employment to obtain higher wages, which in turn led to disruptions in beneficiary care. In another state, higher rates for services provided to I/DD populations drew workers from other agencies and made it more difficult for older adults with physical disabilities to access care. Variations in county or state minimum wage laws also led workers to cross borders to secure higher wages.

States may encourage workforce participation according to population need or policy goals. For example, we heard from one state that employed consistent wage assumptions for setting rates for similar types of work across different services. Other states have adopted strategic rate variations across the LTSS system more broadly by reducing rates for residential placement to encourage community integration and rebalance care. Across our interviews and TEP, we heard the importance of considering how rate variations across LTSS and the commercial market may influence HCBS workforce participation. States may also consider opportunities to reduce wage competition across state geographies, such as imposing locality adjustments to HCBS rates.

Rate studies, rebasing, and indexing offer opportunities to review and improve rates

FFS rates for HCBS, like all other Medicaid services, are set by the state, and CMS has the authority to review rate methodologies as part of the process required to approve new state authorities and policies (42 CFR Parts 430 and 447). Federal requirements governing HCBS rate reviews vary by HCBS authority. For most HCBS authorities, no federal provision requires a rate review or indicates a specific frequency for review. CMS technical guidance instructs states operating HCBS through Section 1915(c) waiver authority to review rates at least every five years, and there is considerable flexibility to determine how to do this review (CMS 2019). As a result, Section 1915(c) rate review approaches vary.

Of the 47 states and the District of Columbia included in our review of Section 1915(c) rate methodologies, 33 states (69 percent) conducted rate studies that reviewed all components of an HCBS rate (MACPAC 2024b).[4] In 10 states (21 percent), no rate study was identified, but the states regularly rebased or indexed components of the rate. Moreover, we also found that rate study methodology and outputs were not always publicly available (MACPAC 2024b). Federal policy does not require waiver applications or other

HCBS authorities to indicate the source of wage data for building HCBS rates, and in our review, we found that not all states indicated the wage data source in their waiver application even if they described the rate methodology (Table 1-1).

Our interviews and TEP indicated the value of rate reviews in ensuring that rates account for a changing policy and financial environment. In particular, experts identified rate studies as an important tool in establishing rates that promote an adequate workforce. As discussed above, rate studies offer a comprehensive and global opportunity to evaluate HCBS rate methodologies within the context of HCBS authorities, the Medicaid payment environment, and the health care ecosystem as a whole.

Using detailed cost, wage, and service delivery information in rate studies also provides a benchmark for state legislators, providers, consumer advocates, and other stakeholders to understand the cost of services and funding needs, which can support efforts to right-size variation across services and programs. Our review of Section 1915(c) rate methodologies found substantial variability in the public documentation of rate study processes and results. Of the 33 states that conducted rate studies for one or more Section 1915(c) waivers, we identified public documentation of rate studies for 27 states. In many states, the publicly available rate study documentation was limited to a PowerPoint presentation or other similar documentation that did not include details about specific rate assumptions.

Rate studies additionally provide an opportunity to ensure that rates and their underlying wage components are comprehensive and reflect the full range of worker inputs necessary to provide care. Some inputs that may not be reflected in rates include but are not limited to the range of professional skills and responsibilities associated with the various HCBS worker types and needed to deliver a given service as well as the time HCBS workers spend conducting critical program support and supervisory tasks beyond delivering services to participants. Rate reviews may also consider language, cultural, and geographic dynamics associated with providing HCBS. For example, language and translation services, travel, and culturally appropriate meals may increase the costs of delivering care.

Compensation for indirect non-billable activities can be built into HCBS rates through productivity or other rate adjustments. Productivity adjustments refer to the practice of covering hours when staff must perform non-billable activities that prevent them from performing direct services.[5] Employers can calculate the number of productive hours spent on non-billable tasks and apply an adjustment rate to an HCBS worker's hourly base wage (CMS 2016). States may also use local payment rate adjustments or code modifiers to reflect additional indirect costs.

Rate studies require considerable time and resources to complete and implement across a variety of stakeholders, including Medicaid agency staff, state legislatures, and health care stakeholders. For example, providers completing related cost surveys often require training and technical assistance because these reports are not routinely collected by Medicare or other payers. Additionally, when rate studies are conducted, fiscal barriers such as state budget constraints may prevent the resulting rate recommendations from being implemented. These could include the timing of state budgeting processes or legislative reluctance to provide repeated rate increases. Budget constraints can be especially acute in the FFS context. Research participants indicated that legislatures are often more amenable to approving rate increases for managed care organizations (MCOs) than for FFS due to the requirement in federal law mandating actuarial soundness in MCO rates. FFS payment rates have no such federal regulatory requirement. However, implementing rate study recommendations may also create unintended effects. For example, to ensure that a rate increase identified by a rate study can be funded without exceeding their budgets, states may implement utilization limits or program waiting lists.

Our interviews and TEP identified indexing and rebasing as less-intensive mechanisms for updating rates. In our interviews, we heard about state efforts to index or regularly inflate key rate components (e.g., wages). We also learned about instances in which rebasing allowed a state to adapt rates to evolving provider costs, including increasing workforce costs. One state shared that they make automatic rate updates based on a review of state and federal wages and inflation data, biennial wage components and inflation updates, and regional variance factor updates every six years.

The state also recently added a new "competitive workforce factor" to help close the gap between assumed wages for HCBS workers and competing non-HCBS workforce sectors.

Our TEP highlighted that established inflationary adjustments or rebasing processes create predictability for providers and other stakeholders, particularly default inflationary adjustments that require no further legislative or policy action. For example, a state plan may describe a standard inflationary adjustment that can be frozen or avoided only through a subsequent state plan amendment. This approach allows stakeholders to count on the increase unless additional action is taken.

A standard and predictable inflationary or rebasing adjustment aligns HCBS payment structures with other Medicaid rate-setting models. Annual increases are common for other Medicaid payment rates, such as state-mandated inflationary adjustments for institutional providers like hospitals and nursing facilities. In a similar vein, federal regulations require annual actuarial certifications for Medicaid managed care programs. Incorporating inflationary adjustment or rebasing processes into the payment rate through legislative or Medicaid agency action makes the basis for payment rate changes more visible and transparent to stakeholders.

Automated indexing or rebasing adjustments remain subject to states' fiscal climates and may rely on scarce budget resources. Additionally, indexing can have the unanticipated effect of putting rate structures on autopilot and can stifle the system's ability to evolve over time, as this process does not require states to reevaluate payment rates or address system issues. State stakeholders flagged that applying a trend factor without periodically re-examining underlying rate assumptions can also exacerbate disparities across service types. Additionally, depending on how tightly rate development is linked to cost reporting, inflationary increases could create a compounding effect of progressively larger increases. Our findings ultimately emphasized that indexing and rebasing are effective interim rate review options, but because the policy and program environment continues to evolve, they do not substitute for periodic comprehensive assessments of rate structures and reimbursement policy. 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 and other means of adjusting rates. A strategic cadence of rate reviews could promote the inclusion of relevant rate assumptions and updated data without overwhelming the system with administrative or fiscal burdens.

Robust wage data are the foundation for payment rates that promote an adequate HCBS workforce

Based on our research, we found consistent evidence that robust wage data are a necessary input in states' formulation of effective HCBS payment rates. Wage data are a critical input to rate development because of the substantial contribution of wages to overall payment rates and because wage data themselves are composites of other costs (e.g., overtime, administrative tasks, supervision). Historical wage data alone are not sufficient to develop payment rates that address workforce shortages, as these wage levels reflect existing workforce structures and budget constraints. However, accurate, current, and robust wage data provide states with a critical starting point for HCBS rates that promote adequate workforce participation at the time of initial rate model development and in periodic rate reviews to reevaluate payment rates. Despite this need, key gaps exist in available wage data. Addressing these gaps could provide states with another important tool in implementing payment rates that facilitate access to Medicaid HCBS.

States often lack the wage data needed to build appropriate payment rates. Unlike other areas of health care, where consistent, robust data on wages are readily available, the same is not true for HCBS wage data. As described above, our review of payment policies used in Section 1915(c) waivers found that most states use wage data from the BLS to develop Medicaid wage assumptions (Table 1-1).[6] However, the BLS does not offer a single reliable data source for HCBS worker wages. BLS SOC wage data reflect the workforce serving individuals in the health care system, without regard to whether those wages are ultimately paid through the Medicaid program or another payer. Thus, wage data reflect a multi-payer market across all designated fields, rather than one specific to Medicaid. Industries are grouped according to an established hierarchy of sectors, subsectors,

and industry designations. This approach necessarily includes non-Medicaid workers in Medicaid-relevant job classifications and subsumes Medicaid-majority fields (e.g., residential facilities for individuals with IDD) into larger groupings. For example, although the BLS provides data on some HCBS worker types, including personal care aides, home health aides, and a variety of nursing and medical support professionals, no SOC code exists for DSPs (BLS 2023a). In the absence of an appropriate SOC, states often blend different occupational codes that approximate HCBS worker roles and service-specific requirements (Table 1-2).

Other sources of wage data include state-level wage data, average wages from provider surveys, provider cost reports, minimum wage levels, market rates, and stakeholder feedback. States may use provider-submitted cost reports or provider surveys to support rate development or rate reviews. However, there are several challenges associated with state cost reporting as described above, including the technical capacity of providers to comply, variability in costs across providers, the level of effort to engage stakeholders to produce complete and accurate cost data, and the required oversight of cost reporting at the state agency.

Findings from our TEP reflect the lack of necessary historical wage data and the importance of accessing such data in the future. Multiple state participants noted that granular data are a tool that states could wield to set payment rates reflecting accurate wages. Recognizing that state budgets may constrain rate updates, state and federal representatives additionally noted the value of wage data in demonstrating the need for rate adjustments to key stakeholders, including state legislatures and CMS.

New data are not sufficient. The 2024 access rule includes several provisions to create more consistency and transparency in HCBS wage data (CMS 2024a). Beginning in July 2026, states will be required to publish the average FFS hourly payment rate for personal care, home health aide, homemaker, and habilitation services on a publicly available and accessible website every two years. Additionally, beginning in July 2028, states will be required to collect and report to CMS data regarding the percentage of Medicaid payments for certain HCBS—personal care, home health aide, homemaker, and habilitation—spent on compensation for DCWs. CMS selected homemaker, home health aide, and personal care services because they are services for which CMS asserts that the vast majority of payments should be composed of compensation for DCWs.

Although the access rule provisions offer the potential for increased availability of wage and payment information, they do not require states to report the wage data needed to build adequate payment rates. Additionally, although the data collected through the access rule will allow CMS to compare payment rates and wage-to-payment ratios across state Medicaid programs, the compensation data are not required to be shared among states or made public. Furthermore, the access rules' broad definition of DCWs—which includes diverse job classes like DSPs and nurses—creates the potential for confounded data that conflate diverse worker wages.

Wage data reporting is not required. The access rule requires states to produce data on hourly HCBS rates for each of the specific services listed above and data on the proportion of HCBS rates for the same set of services that account for DCW compensation. To calculate the ratio of compensation to overall payment required by the access rule, states will need to collect and aggregate data on worker wages across each service. However, states are not required to report or publish data on wage levels. States having access to these average wage data across various job classes and service categories would support their building of appropriate rates.

Wage data are not available across labor markets. States can benefit from wage data from other states and across labor markets. HCBS rate and wage information sharing is particularly relevant for states that may compete with one another for HCBS workers—for example, in markets along a border. Robust state-specific wage data could help states identify instances in which rates are set in such a way that provides incentives for HCBS workers to travel across state lines to receive higher payments for the same or similar services. States may then work to adjust rates to reduce workforce shortfalls. The access rule, however, does not require CMS to share worker compensation data publicly. In response to concerns about lack of public reporting, CMS noted that certain BLS wage data are already publicly available and that states are not limited to the reporting requirements finalized in the access rule.

TABLE 1-2. Home- and Community-Based Services–Related Standard Occupational Classifications Reported in Bureau of Labor Statistics Wage Data

SOC	Job description	Example industries	Entry-level education requirement	2023 mean annual wage
Home health aides and personal care aides	Support individuals who are elderly or who have disabilities or chronic conditions, including by assisting with activities of daily living. Home health aides and personal care aides may provide medication or collect vital signs under supervision of a nurse or another practitioner.	Home health care services, residential facilities, continuing care retirement communities, and assisted living facilities for the elderly	High school diploma or equivalent	$33,530
Licensed practical nurses or licensed vocational nurses	Provide basic medical care to people who are ill, injured, or convalescing or who have disabilities. Duties may vary by setting (e.g., in the home versus a hospital), and scopes of practice may vary by jurisdiction.	Home health care services	Non-degree postsecondary training	$59,730
Nursing assistants	Provide or assist with basic care or support under the direction of onsite nursing supervision. May provide activities of daily living assistance or monitor health status.	Continuing care retirement communities and assisted living facilities for the elderly, home health care services	Non-degree postsecondary training	$39,610
Occupational therapy aides and assistants	Help occupational therapists provide treatment or perform procedures or fulfill support tasks such as preparing treatment rooms.	Home health care services	High school diploma or associate's degree	$65,450

Notes: SOC is Standard Occupational Classification, which is a standard used by federal agencies to classify workers into 1 of 867 detailed occupational groups. Example industries reflect the home- and community-based services–related Bureau of Labor Statistics–classified industries with the highest levels of employment of that SOC.

Sources: BLS 2024b and 2023b.

Job definitions are broad. States rely on wage data from each HCBS job class to build appropriate payment rates. As described above, our review of 1915(c) waiver documents found 253 distinct services for which states must set effective payment rates. The access rule, however, does not disaggregate wage data according to job class. The rule requires states to report for each service type for all DCWs. Additionally, CMS defines DCWs broadly, inclusive of all of the following job classifications (CMS 2024a):

- nurses (including registered nurses, licensed practical nurses, nurse practitioners, or clinical nurse specialists);
- licensed nursing assistants providing HCBS under the supervision of a nurse;
- DSPs;
- personal care attendants and home health aides; and
- any other individuals providing "services to address activities of daily living or instrumental activities of daily living, behavioral supports, employment supports, or other services to promote community integration."

As a result of this broad definition of DCWs, access rule data will not account for the vast wage variations that may occur across different HCBS job classes (Table 1-2). For example, average wages for nurses, who receive a high level of training and are responsible for a clinical scope of practice, may differ considerably from average wages for other HCBS job classes that fall under CMS's DCW definition that require less training. In 2023, the mean annual wage for home health aides and personal care aides was $33,530 compared to $59,730 for licensed practical nurses or licensed vocational nurses (Table 1-2). Including wages across all of these job classes may produce results that misrepresent the wage experience of the majority of HCBS workers. In its response to comments on the notice of proposed rulemaking, CMS acknowledged the concern that higher-wage job classes (such as nurses) might overshadow other job classes in the data (CMS 2024a). CMS indicated that states interested in examining workforce issues at a more granular level may choose to disaggregate data for state use, but the access rule does not explicitly require them to do so.

Payment Principles

For Medicaid to achieve its potential, it is important for policymakers to design payment policies that advance the statutory goals of efficiency, economy, quality, and access. MACPAC has developed an overarching provider payment framework for assessing whether payments are consistent with these goals, which has guided the Commission's development of principles for HCBS payment policy (MACPAC 2015). MACPAC's analysis demonstrates the importance of setting rates at a level that accounts for patient and workforce needs (economy) and ensuring that rates reflect the broader payment and wage context (efficiency). The following payment principles reflect these findings and offer a conceptual framework for states to use to improve their HCBS workforce.

HCBS payment rates should promote an adequate workforce and efficient use of resources. Though by no means the only factor, MACPAC's research finds that wage levels are a key driver of workforce levels, and Medicaid payment policy plays a key role in determining the wages that providers pay. States should leverage HCBS payment policy to address HCBS workforce shortages.

States should take a holistic approach to setting HCBS payment rates to ensure that variations across populations, programs, and geographies reflect policy priorities and beneficiary needs. MACPAC's research suggests that variation in HCBS rates, and subsequently in HCBS wages, may lead HCBS workers to participate in delivery models or programs that offer the highest wage. This may in turn affect beneficiary access. For example, in one state we interviewed, comparably low rates for independent workers caused HCBS workers to switch to agency employment to obtain higher wages, which created disruptions in beneficiary care.

Our analysis found substantial variation in service definitions and associated rates across HCBS models and programs. The MACPAC compendium on Medicaid payment policies for HCBS provided under Section 1915(c) waiver authority found 253 unique, state-defined services that fit into three major HCBS service categories (MACPAC 2024b). Although rate variations may reflect differences in patient acuity and the scope of services provided to one population

versus another, rate variations may also reflect administrative complexities. As noted above, states typically cover HCBS through multiple authorities often on different renewal timelines, which may lead to programs with varying service descriptions, provider requirements, provider types, or populations. This can create challenges in aligning rates across programs. Furthermore, because CMS reviews HCBS rates for each program individually, states may update rates for one Section 1915(c) waiver without making corresponding adjustments to other waivers or HCBS authorities.

HCBS payment rates should be reviewed for adequacy at a regular interval using the tools available, such as rate studies, indexing, and rebasing. Rate reviews are an important tool to help ensure that payment rates are adequate and account for a changing policy and financial environment. Rate studies, in particular, offer a comprehensive and global opportunity to evaluate HCBS rate methodologies within the context of HCBS authorities, the Medicaid payment environment, and the health care ecosystem as a whole. However, rate studies require substantial time and resources to complete and implement across a variety of stakeholders, including Medicaid agency staff, state legislatures, and health care stakeholders.

Other, less-intensive mechanisms for reviewing and updating rates include but are not limited to indexing and rebasing. Our analysis surfaced state efforts to index or regularly inflate key rate components such as wages as well as instances in which states have used rebasing to adapt rates to increasing workforce costs. Generally, established inflationary adjustments or rebasing processes create predictability for providers and other stakeholders.

States should identify the appropriate periodicity and mechanism for rate reviews to ensure that data and rate assumptions are updated regularly without creating undue administrative or fiscal burdens. States may also choose to align rate reviews across HCBS programs to promote consistency in rate setting or stagger rate reviews across programs to minimize system burden.

Commission Recommendation

The lack of consistent HCBS payment data presents a barrier to states looking to apply the payment principles listed above. The Commission therefore recommends that HHS improve the data available to help policymakers to identify payment rates and underlying wage levels that address the HCBS workforce shortage and support increased access to HCBS services.

Recommendation 1.1

The Secretary of the Department of Health and Human Services (HHS) should direct the Centers for Medicare & Medicaid Services (CMS) to amend 42 CFR 441.311(e)(2) to require states to report hourly wages paid to home- and community-based services (HCBS) workers who provide the following services: personal care, home health aide, homemaker, and habilitation. States should report descriptive statistics on hourly wages for each service as determined by HHS. For each service, these data should be disaggregated by worker characteristics determined by HHS, including but not limited to: by licensed nurses and all other direct care workers, and by rural versus urban settings. CMS should build upon planned or existing data collection activities or tools, and publish data on the CMS website.

Rationale

Section 1902(a)(30)(A) of the Act requires states to set sufficient payment rates that are consistent with efficiency, economy, and quality of care. Section 2402(a)(3)(B)(iii) of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) requires states to allocate resources for HCBS in a manner that is responsive to the changing needs and choices of beneficiaries receiving HCBS. Additionally, Section 2402(a)(3)(B)(iii) of the ACA requires states to oversee and monitor HCBS system functions to assure a sufficient number of qualified direct care workers to provide self-directed personal assistance services (CMS 2024a). Substantial and growing workforce shortages threaten states' ability to comply with these requirements.

Our findings indicate that a key tool for promoting an adequate workforce are payment rates that reflect appropriate wage components. Developing appropriate wage components for rates requires that states have access to robust and current wage data. Existing wage data are often piecemeal and do not provide a clear baseline for states to build upon to establish HCBS payment rates that promote workforce participation and retention. As the most robust and commonly used wage data source, state-specific BLS wage data provide a federal resource on HCBS wages. Yet BLS data are simultaneously broader and narrower than what states need to effectively set HCBS payment rates. BLS wage data reflect the entire workforce serving individuals in the home and community. As a result, BLS wage data include information beyond wages paid to Medicaid HCBS workers alone. Although this can provide valuable information to states looking to understand broader market wages, states still lack the data needed to assess the workforce in the Medicaid context specifically. BLS's broad lens also results in the exclusion of some Medicaid-specific service types and worker classifications that are rarely found outside the Medicaid HCBS sector, such as DSPs. BLS's limitations therefore introduce challenges in state rate setting, as we heard from states and other interview and TEP participants.

The provisions finalized in the 2024 access rule offer the potential to improve transparency and data availability in HCBS payment. The access rule clarifies the importance of payment transparency for HCBS and justifies the inclusion of "special considerations for LTSS, specifically HCBS" given the substantial workforce shortage in this industry and its strong tie to beneficiary access issues (CMS 2024a). Consistent with prior practice, CMS should release a reporting template, which would promote further standardization among the data reported by states.

However, the provisions included in the access rule do not sufficiently fill identified gaps in wage data that states need for rate setting. First, the provisions require states to report average hourly HCBS payment rates and the percentage of the rate that accounts for DCW compensation but not the average wage paid to the worker. As discussed above, historical wage data are a crucial input to developing appropriate HCBS rates, and these data are not readily available today. Second, although the HCBS workforce at all levels can benefit from additional payment transparency, CMS's broad definition of DCWs that includes nurses and other clinical staff types may confound the payment and wage reporting data that the access rule produces. The consolidation of compensation data for nurses and licensed nursing assistants alongside DSPs, personal care attendants, and home health aides in particular may produce results that misrepresent the average wage experience of many HCBS workers. Average wages for nurses, for example, may differ substantially from average wages for other HCBS job classes that fall under CMS's DCW definition.

Promoting state reporting of wage data helps ensure that the HCBS payment reporting requirements included within the access rule fill gaps in the existing data available to states to build appropriate HCBS rates. The recommendation would direct CMS to require that states disaggregate compensation to also report average wage base data by meaningful subclassifications, such as distinct workforce categories and geographic subcategories. Disaggregating the data in this manner will improve the data's accuracy and usability. The access rule requires that all data be disaggregated by service type, aligned by regulatory service definitions referenced in the access rule. CMS, in consultation with states, may leverage guidance or templates to ensure that comparable services and workers are classified and reported in a similar way under these requirements.

To further ease the burden on states, data collection and reporting methodology should align with and build upon existing reporting requirements where possible, most notably the aforementioned provisions of the access rule. To calculate the ratio of compensation to overall payment for each service already required by the access rule, states will need to collect and aggregate data on wages across all worker categories and geographies. With advance planning, and in consultation with states, CMS can implement this proposed requirement through templates or operational guidance intended to minimize additional state burden. The wage data included in our recommendation align closely with existing reporting requirements in current regulation and slated to begin

in 2028. Additionally, CMS should require states to report descriptive statistics for each service to reflect the breadth and variation in wages due to seniority, raises, bonuses, or other factors. CMS could include the proposed data reporting requirements in its access rule reporting template and provide guidance and definitions for state reporting.

Both our TEP participants and CMS indicated the importance of more granular data. Responding to comments requesting further data disaggregation in the access rule, CMS noted, "We agree that some of the granular data elements suggested by commenters could provide States with valuable insights into their own programs and workforce needs" (CMS 2024a). CMS encouraged states to consider additional data collection activities as useful. Although it is important to note that budget constraints often make rate adjustments challenging, TEP participants stressed that improved data offer state legislatures and CMS more clarity regarding how states can comply with their statutory requirement to set sufficient rates (§ 1902(a)(30)(A) of the Act).

In CMS's response to comments on the proposed rule, the agency cited transparency as a key objective of the proposed and final provisions: "Gathering and sharing data about the amount of Medicaid dollars that are going to the compensation of workers is a critical step in understanding the ways we can enact policies that support the direct care workforce and thereby help advance access to high quality care for Medicaid beneficiaries" (CMS 2024a). The importance of wage transparency is especially relevant given that states compete with one another for HCBS workers. However, the access rule does not require that the wage data collected be made public (CMS 2024a). The recommendation directs CMS to make wage data public to ensure that all state Medicaid agencies and relevant stakeholders can access the same information pertinent to HCBS payment rates.

Implications

Federal spending. The Congressional Budget Office anticipates no impact on federal spending attributable to the recommendation.

States. As a result of this recommendation, state Medicaid agencies will be equipped with granular wage data and the ability to compare wage rates across states and other HCBS marketplaces. These data can support states to identify payment rates that address HCBS workforce shortages and adjust rates as feasible. States can also use these data to justify rates to state legislatures. Although this recommendation would require states to conduct additional data reporting activities, it should not require substantial state effort beyond that required for compliance with the regulatory provisions effected by the access rule. Additionally, to the extent that states are already engaging in piecemeal and laborious data collection efforts to determine historical HCBS wages, such as through cost reports, this change could reduce existing administrative burden by potentially eliminating the need for those ad hoc activities.

Beneficiaries. This policy would not have a direct effect on beneficiaries. However, the goal of this recommendation is to support states to set payment rates in a manner that addresses workforce shortages and increases beneficiary access to HCBS. Over time, state efforts to adjust payment rates in a manner that attracts more HCBS workers may result in increased access to HCBS among beneficiaries.

Plans. This policy would not have a direct effect on managed care plans. However, any changes that states make to HCBS payment rates could affect the rates that managed care plans pay to HCBS providers, particularly if a state requires plans to pay at least the state plan rate through a directed payment arrangement. Ultimately, any payment changes should be reflected in the capitation rate that the plans receive.

Providers. This recommendation is expected to have a marginal effect on providers. Providers will need to report wage information under the current access rule provisions. In some states, providers may report more granular data under this recommendation than under the access rule alone; however, the data would already be collected, and the marginal level of effort to report at a disaggregated level should be minimized. Furthermore, as a result of increased availability of

historical wage data, state Medicaid agencies may choose to adjust payment rates to achieve a more robust HCBS workforce. Over time, payment rate adjustments and resulting wage changes would impact providers in diverse ways. Wage changes could impact the level of provider participation in the HCBS market and frequency of provider turnover as well as shift provider participation from one service area, region, or state to another. At the agency level, wage changes could allow HCBS providers to adjust the amount of the payment rate used to cover patient care versus administrative and operational needs.

Endnotes

[1] States are required to cover home health services under Section 1905(a)(7) of the Social Security Act; all other HCBS are optional for states.

[2] Section 1915(c) waivers are the most commonly used authority for HCBS and accounted for 43 percent of HCBS spending in fiscal year 2021 (Murray et al. 2023).

[3] The 458,590 nursing assistants who provide care to individuals in nursing homes are excluded from this analysis. Additionally, due to data inconsistencies across states, the Paraprofessional Healthcare Institute analysis likely excludes many independent providers (PHI 2024a).

[4] Four states (Arizona, New Jersey, Rhode Island, and Vermont) were excluded from our review of Section 1915(c) waiver rate-setting methodologies because HCBS in these states is authorized though Section 1115 demonstration authority instead.

[5] Activities that may be eligible for productivity adjustments include but are not limited to conducting beneficiary assessments, transporting beneficiaries, traveling between clients, recordkeeping, and program development.

[6] BLS is an agency of the U.S. Department of Labor that provides a wide range of data and analyses in the field of labor economics and statistics, including wage data by occupational category. The BLS reports wages according to the SOC system, which classifies workers into nearly 900 occupational categories for collecting, calculating, or disseminating data. These categories reflect occupations with similar job duties and in some cases similar skills, education, or training.

References

American Network of Community Options and Resources (ANCOR). 2021. *The state of America's direct support workforce 2021*. Alexandria, VA: ANCOR. https://www.ancor.org/sites/default/files/the_state_of_americas_direct_support_workforce_crisis_2021.pdf.

Burns, A., M. Mohammed, and M. O'Malley Watts. 2023. *Payment rates for Medicaid home- and community-based services: States' responses to workforce challenges.* Washington, DC: KFF. https://www.kff.org/medicaid/issue-brief/payment-rates-for-medicaid-home-and-community-based-services-states-responses-to-workforce-challenges/.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services (HHS). 2024a. Medicaid program; ensuring access to Medicaid services. Final rule. *Federal Register* 89, no. 92 (May 10): 40542–40874. https://www.federalregister.gov/documents/2024/05/10/2024-08363/medicaid-program-ensuring-access-to-medicaid-services.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services (HHS). 2024b. Medicaid program; Medicaid and Children's Health Insurance Program (CHIP) managed care access, finance, and quality. Final rule. *Federal Register* 89, no. 92 (May 10): 41002–41285. https://www.federalregister.gov/documents/2024/05/10/2024-08085/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care-access-finance.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2023. *Overview of state spending under American Rescue Plan Act of 2023 (ARP) Section 9817, as of the quarter ending December 31, 2022.* Baltimore, MD: CMS. https://www.medicaid.gov/sites/default/files/2023-12/arp-sec9817-overview-infographic_0.pdf?eType=EmailBlastContent&eId=cb9e0846-f3a3-4d49-b339-b5b879e574b4.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2019. *Instructions, technical guide and review criteria.* Baltimore, MD: CMS. https://wms-mmdl.cms.gov/WMS/help/35/Instructions_TechnicalGuide_V3.6.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2016. *Fee schedule HCBS rate setting: Developing a rate for direct service workers.* Baltimore, MD: CMS. https://www.medicaid.gov/medicaid/home-community-based-services/downloads/hcbs-1a-ffs-rate-setting.pdf.

Dobson, C., S. Gibbs, A. Mosey, and L. Smith. 2017. *Demonstrating the value of Medicaid MLTSS programs.* Washington, DC: National Association of States United for Aging and Disabilities and Center for Health Care Strategies. https://www.chcs.org/media/FINAL-Demonstrating-the-Value-of-MLTSS-5-12-17.pdf.

Kreider, A.R., and R.M. Werner. 2023. The home care workforce has not kept pace with growth in home and community-based services. *Health Affairs* 42, no 5: 650–657. https://www.healthaffairs.org/doi/10.1377/hlthaff.2022.01351?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub++0pubmed.

Lewis, E., S. Eiken, A. Amos, and P. Saucier. 2018. *The growth of managed long-term services and supports programs: 2017 update.* Baltimore, MD: Centers for Medicare & Medicaid Services. https://www.medicaid.gov/medicaid/downloads/mltssp-inventory-update-2017.pdf.

Libersky, J., C. Stepanczuk, R. Lester, et al. 2016. *Medicaid managed long-term services and supports: Themes from site visits to five states.* Princeton, NJ: Mathematica Policy Research.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2025a. *Spending and utilization for Medicaid home- and community-based services.* Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2025/07/Spending-and-Utilization-for-Medicaid-Home-and-Community-Based-Services.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2025b. *Implementation of Increased Federal Medical Assistance Percentage for Home and Community-Based Services under the American Rescue Plan Act: Key Takeaways.* Washington, DC: MACPAC. https://www.macpac.gov/publication/implementation-of-increased-federal-medical-assistance-percentage-for-home-and-community-based-services-under-the-american-rescue-plan-act-key-takeaways/.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2024a. *Exhibit 3: National health expenditures by type and payer.* Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2024/12/MACSTATS_Dec2024_WEB-508.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2024b. *Policy in brief: Compendium of Medicaid payment policies for home- and community-based services in Section 1915(c) waivers.* Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2024/01/Policy-in-Brief-Compendium-Final.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2023. Chapter 4: Access to home- and community-based services. In *Report to Congress on Medicaid and CHIP*. June 2023. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2023/06/Chapter-4-Access-to-Home-and-Community-Based-Services.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2018. Chapter 1: Streamlining Medicaid managed care authority. In *Report to Congress on Medicaid and CHIP*. March 2018. Washington, DC: MACPAC. https://www.macpac.gov/wp-content/uploads/2018/03/Streamlining-Medicaid-Managed-Care-Authority.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). 2015. Chapter 7: A framework for evaluating Medicaid provider payment policy. In *Report to Congress on Medicaid and CHIP.* March 2015. Washington, DC: MACPAC. https://www.macpac.gov/publication/a-framework-for-evaluating-medicaid-provider-payment-policy/.

Milliman. 2023. Analysis of Section 1915(c) waiver applications approved as of August 2023.

Murray, C., M. Eckstein, D. Lipson, and A. Wysocki. 2023. *Medicaid long term services and supports annual expenditures report: Federal fiscal year 2020*. Chicago, IL: Mathematica. https://www.medicaid.gov/media/164316.

National Core Indicators Aging and Disabilities (NCI-AD). 2024. *State of the workforce in 2022 survey report*. NCI. https://nci-ad.org/upload/reports/ACCESSIBLE_2022NCIADStateoftheWorkforceReport.pdf.

National Core Indicators Intellectual and Developmental Disabilities (NCI-IDD). 2024. *NCI state of the workforce 2023 survey report*. NCI. https://idd.nationalcoreindicators.org/wp-content/uploads/2024/11/2023-NCI-IDD-SoTW_241126_FINAL.pdf.

Office of the Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health and Human Services. 2024. *State efforts to improve direct care workforce wages: State case studies report.* Washington, DC: ASPE. https://aspe.hhs.gov/sites/default/files/documents/ba806f15767b42593752744aab3e17ba/dcw-wages-state-case-studies.pdf.

O'Malley Watts, M., M. Musumeci, and M. Ammula. 2022a. *Medicaid home & community-based services: People served and spending during COVID-19.* Washington, DC: KFF. https://www.kff.org/report-section/medicaid-home-community-based-services-people-served-and-spending-during-covid-19-issue-brief/.

O'Malley Watts, M., A. Burns, and M. Ammula. 2022b. *Ongoing impacts of the pandemic on Medicaid home & community-based services (HCBS) programs: Findings from a 50-State survey*. Washington, DC: KFF. https://www.kff.org/medicaid/issue-brief/ongoing-impacts-of-the-pandemic-on-medicaid-home-community-based-services-hcbs-programs-findings-from-a-50-state-survey/.

O'Malley Watts, M., M. Musumeci, and M. Ammula. 2021. *State Medicaid home & community-based services (HCBS) programs respond to COVID-19: Early findings from a 50-state survey*. Washington, DC: KFF. https://www.kff.org/coronavirus-covid-19/issue-brief/state-medicaid-home-community-based-services-hcbs-programs-respond-to-covid-19-early-findings-from-a-50-state-survey/.

Paraprofessional Healthcare Institute (PHI). 2024a. *Direct care workers in the United States: Key facts 2024*. New York, NY: PHI. https://www.phinational.org/resource/direct-care-workers-in-the-united-states-key-facts-2024/.

Paraprofessional Healthcare Institute (PHI). 2024b. *Competitive disadvantage: Direct care wages are lagging behind—2024 update*. New York, NY: PHI. https://www.phinational.org/resource/competitive-disadvantage-direct-care-wages-are-lagging-behind-2024-update/?xd_co_f=YjVmYTg5MGQtNThmMS00NzY4LWJjMzQtOGU3ZDE1Y2FlMzYx#.

Paraprofessional Healthcare Institute (PHI). 2023. *Direct care workers in the United States: Key facts 2023*. New York, NY: PHI. https://www.phinational.org/resource/direct-care-workers-in-the-united-states-key-facts-2023/.

Saucier, P., J. Kasten, B. Burwell, and L. Gold. 2012. *The growth of managed long-term services and supports (MLTSS) programs: A 2012 update.* Ann Arbor, MI: Truven Analytics. https://www.medicaid.gov/medicaid/downloads/mltssp_white_paper_combined.pdf

Teshale, S., N. Kaye, and W. Fox-Grage. 2023. *Most states plan to continue Medicaid home and community-based flexibilities implemented during the public health emergency.* Washington, DC: National Academy for State Health Plans. https://nashp.org/most-states-plan-to-continue-medicaid-home-and-community-based-flexibilities-they-implemented-during-the-public-health-emergency/.

U.S. Bureau of Labor Statistics (BLS), U.S. Department of Labor. 2024a. *Overview of BLS wage data by area and occupation*. Washington, DC: BLS. https://www.bls.gov/bls/blswage.htm.

U.S. Bureau of Labor Statistics (BLS), U.S. Department of Labor. 2024b. *Occupational Outlook Handbook: Home health and personal care aides*. Washington, DC: BLS. https://www.bls.gov/ooh/healthcare/home-health-aides-and-personal-care-aides.htm.

U.S. Bureau of Labor Statistics (BLS), U.S. Department of Labor. 2023a. *Standard Occupational Classification.* Washington, DC: BLS. https://www.bls.gov/soc/.

U.S. Bureau of Labor Statistics (BLS), U.S. Department of Labor. 2023b. *Occupational employment and wage statistics*. Washington, DC: BLS. https://www.bls.gov/oes/current/oes_stru.htm#31-0000.

APPENDIX 1A: Home- and Community-Based Services Statutory Authorities

TABLE 1A-1. Home- and Community-Based Services 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	Broad authority that 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 6 percentage point increase in the federal medical assistance percentage (FMAP) for HCBS attendant services.

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

Sources: Sections 1115, 1905(a)(7), 1905(a)(24), 1915(c), 1915(i), 1915(j), and 1915(k) of the Social Security Act; 42 CFR 440.70(b).

APPENDIX 1B: Managed Long-Term Services and Supports

TABLE 1B-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 fully integrated dual eligible special needs plans.
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 a fee-for-service basis.
Geographic reach	Statewide or only offered in certain regions.
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.

TABLE 1B-1. (continued)

MLTSS program characteristics	Description
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 home- and community-based services.
Integration with Medicare benefits	States can align Medicaid MLTSS with Medicare Advantage dual-eligible special needs plans to integrate care for beneficiaries who are dually eligible for Medicare and Medicaid.

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

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

APPENDIX 1C: Managed Long-Term Services and Supports

TABLE 1C-1. Federal Requirements for Home- and Community-Based Services 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 Section 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 the Centers for Medicare & Medicaid Services.	States must do the following: • 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 in which 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.

TABLE 1C-1. (continued)

HCBS authority	Description of rate methodology	Rate review	Network adequacy	Stakeholder engagement
State plan (continued)			• 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. Although MCOs must each have a member advisory committee when states implement managed care long-term services and supports, 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.

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

Commission Vote on Recommendation

In its authorizing language in the Social Security Act (42 USC 1396), Congress requires MACPAC to review Medicaid and CHIP program policies and make recommendations related to those policies to Congress, the Secretary of the U.S. Department of Health and Human Services, and the states in its reports to Congress, which are due by March 15 and June 15 of each year. Each Commissioner must vote on each recommendation, and the votes for each recommendation must be published in the reports. The recommendation included in this report, and the corresponding voting record below, fulfill this mandate.

Per the Commission's policies regarding conflicts of interest, the Commission's conflict of interest committee convened prior to the vote to review and discuss whether any conflicts existed relevant to the recommendation. It determined that, under the particularly, directly, predictably, and significantly standard that governs its deliberations, no Commissioner has an interest that presents a potential or actual conflict of interest.

The Commission voted on this recommendation on January 30, 2026.

Medicaid Payment Policies to Support the Home- and Community-Based Services Workforce

1.1 The Secretary of the Department of Health and Human Services (HHS) should direct the Centers for Medicare & Medicaid Services (CMS) to amend 42 CFR 441.311(e)(2) to require states to report hourly wages paid to home- and community-based services (HCBS) workers who provide the following services: personal care, home health aide, homemaker, and habilitation. States should report descriptive statistics on hourly wages for each service as determined by HHS. For each service, these data should be disaggregated by worker characteristics determined by HHS, including but not limited to: by licensed nurses and all other direct care workers, and by rural versus urban settings. CMS should build upon planned or existing data collection activities or tools, and publish data on the CMS website.

1.1 voting result	#	Commissioner
Yes	15	Allen, Bjork, Brown, Duncan, Gerstorff, Giardino, Hartman, Heaphy, Hill, Johnson, Karl, Killingsworth, McFadden, Nardone, Snyder
No	2	Ingram, McCarthy