
SMD# 26-005

**RE: Direct Care Worker Compensation
(Home and Community-Based Services
Payment Adequacy) Reporting
Requirement**

October 9, 2026

Dear State Medicaid Director:

The Centers for Medicare & Medicaid Services (CMS) is issuing this guidance on the home and community-based services (HCBS) payment adequacy reporting requirement finalized in 2024 at 42 CFR 441.311(e), and by reference to 42 CFR 441.311, at 42 CFR 441.474(c), 441.580(i), and 441.745(a)(1)(vii). In this guidance, we generally refer to the HCBS payment adequacy reporting requirement as the “direct care worker compensation reporting” requirement to clarify its purpose. Specifically, this guidance summarizes policy clarifications provided in the 2024 final rule¹ and addresses additional questions that have been raised by states, providers, and other interested parties since the rule was finalized.

Summary of the Direct Care Worker Compensation Reporting Requirement

Under 42 CFR 441.311, states must report to CMS annually, beginning July 9, 2028, on the percentage of total Medicaid payments (not including excluded costs) for furnishing homemaker, home health aide, personal care, and habilitation services that is spent on compensation for direct care workers.² States must report separately for each service and, within each service, must report separately on services that are self-directed and services delivered in a provider-operated physical location for which facility-related costs are included in the payment rate. As discussed later in this guidance, there are exceptions to these requirements for certain self-directed services and for certain Indian Health Service and Tribal health program providers.

The reporting requirement applies to services delivered under section 1915(c), (i), (j), and (k) of the Social Security Act (the Act), as well as to section 1115(a) demonstration projects that include HCBS, and to services delivered through both fee-for-service (FFS) and managed care

¹ 89 FR 40542 (May 10, 2024), available at www.federalregister.gov/documents/2024/05/10/2024-08363/medicaid-program-ensuring-access-to-medicare-services. Policy clarifications provided in the 2024 final rule are generally denoted with a Federal Register citation indicating where the clarification was provided.

² 42 CFR 441.311(e), (f).

delivery systems.³ The reporting requirement does not apply to section 1905(a) services, such as section 1905(a) state plan personal care, home health, and case management services.

One year prior to the applicability date for the direct care worker compensation reporting requirement, states must report to CMS on their readiness to comply with the reporting requirement. See 42 CFR 441.311(e)(3). Since the reporting requirement applies beginning July 9, 2028, reporting readiness is required by July 9, 2027. This readiness reporting will allow us to identify states that may need additional support to come into compliance with the reporting requirement and to provide targeted technical assistance to states as needed.

States are responsible for ensuring compliance with the reporting requirement and collecting the necessary data. States may use existing infrastructure or tools, such as provider surveys, to collect the necessary data to comply with the reporting requirement. We anticipate that providers and managed care plans⁴ in states with managed care delivery systems will be key partners for states in meeting the reporting requirement. States are encouraged to engage with their HCBS providers and managed care plans (if applicable) as soon as possible to determine roles and responsibilities, establish benchmarks and milestones, and establish processes and procedures for collecting the necessary data to meet the reporting requirement.

A summary of the reporting requirement, including how to assess and report readiness, is provided in the Appendix.

Definitions

Below we provide definitions of specific terms used in regulatory text to enhance consistency in implementation of the reporting requirement and in states' calculations of the numerator and denominator for determining the percentage of total Medicaid payments (not including excluded costs) for furnishing homemaker, home health aide, personal care, and habilitation services that is spent on compensation for direct care workers.

Services

The reporting requirement applies to homemaker, home health aide, personal care, and habilitation services (as set forth in 42 CFR 440.180(b)(2) through (4) and (6)) delivered under section 1915(c), (i), (j), and (k) of the Act, as well as section 1115(a) demonstration projects that include HCBS.

We are aware that service definitions can vary widely within and across states. States are responsible for determining which services are included in those categories. States should review their approved state plans, waivers, and demonstration projects, as applicable, to identify the services under each authority that are subject to the reporting requirement.

³ While the reporting requirement applies to payment for services delivered under specific HCBS authorities, section 1115(a) demonstration projects, and through managed care delivery systems, we are not requiring that data be disaggregated by HCBS authority, by waiver program, or by managed care plan (<https://www.federalregister.gov/d/2024-08363/p-1454>; <https://www.federalregister.gov/d/2024-08363/p-1475>).

⁴ In this guidance, the term “managed care plans” refers to managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), and prepaid ambulatory health plans (PAHPs), as defined in 42 CFR 438.2.

We encourage states to align their service definitions for homemaker, home health aide, personal care, and habilitation services with the Core Service Definitions in the section 1915(c) waiver technical guidance and service categories and subcategories in the HCBS Taxonomy.⁵ The Core Service Definitions specify the essential scope of each service, and the HCBS Taxonomy provides a standardized category and subcategory structure to support consistent classification of services. States should also refer to descriptions of services in other CMS guidance as applicable, such as the description of personal care services in section 4480 of the State Medicaid Manual (CMS Manual Pub. #45).⁶

Direct care workers (42 CFR 441.311(e)(1)(ii))

Direct care workers include individuals who provide nursing services, assist with activities of daily living (e.g., mobility, personal hygiene, eating), or provide support with instrumental activities of daily living (e.g., cooking, grocery shopping, managing finances). Specifically, they are defined in 42 CFR 441.311(e)(1)(ii) to include:

- Registered nurses, licensed practical nurses, nurse practitioners, or clinical nurse specialists who provide nursing services to Medicaid beneficiaries receiving HCBS;
- Licensed or certified nursing assistants who provide services under the supervision of a registered nurse, licensed practical nurse, nurse practitioner, or clinical nurse specialist;
- Direct support professionals;
- Personal care attendants;
- Home health aides; and
- Other individuals who are paid to provide services to address activities of daily living or instrumental activities of daily living, behavioral supports, employment supports, or other services to promote community integration directly to Medicaid beneficiaries receiving HCBS, including nurses and other staff providing clinical supervision.

Direct care workers may be employed by, or contracted with, a Medicaid provider, state agency, or third party, or may deliver services under a self-directed services delivery model.

Administrative or supervisory staff who also deliver services directly to beneficiaries may be included as direct care workers for the time spent delivering those services. However, time spent on administrative or supervisory activities should not be included in the reporting.

▪ **Clinical supervisors⁷**

Nurses or other staff who provide clinical oversight and training for direct care workers who participate in activities directly related to beneficiary care (such as completing or reviewing documentation of care), are qualified to provide services directly to beneficiaries, and periodically interact with beneficiaries are included in the definition of direct care workers. The

⁵ The section 1915(c) waiver technical guide and HCBS Taxonomy can be accessed through the CMS Waiver Applications Portal (<https://wms-mmmdl.cms.gov/WMS/faces/portal.jsp>). In the portal on the left side panel, select “1915(c) Waiver Application and Accompanying Materials” and then open Instructions_TechnicalGuide_V3.7 2024 in the zip file to access the technical guide, or select “Taxonomy Category and Subcategory definitions” for the HCBS Taxonomy.

⁶ <https://www.cms.gov/regulations-and-guidance/guidance/manuals/paper-based-manuals-items/cms021927>

⁷ <https://www.federalregister.gov/d/2024-08363/p-1097>

definition is intended to exclude staff who provide administrative supervision (such as those who oversee business operations).

- **Direct care workers performing administrative work or other tasks unrelated to their roles as direct care workers⁸**

The definition of compensation includes all compensation paid to direct care workers for activities related to their roles as direct care workers. States should ensure providers do not include, as direct care worker compensation, amounts paid for the time that workers spend on administrative or other tasks unrelated to their roles as direct care workers. We note that administrative tasks unrelated to their roles as direct care workers should not be shifted to direct care workers as a way to inflate compensation for direct care workers. However, providers may count compensation for the time direct care workers spend on tasks, including administrative tasks such as completing timecards, that are directly related to their roles in providing services to beneficiaries.

Compensation (Numerator of the Calculation) (42 CFR 441.311(e)(1)(i))

For purposes of calculating the percentage required under 42 CFR 441.311(e), the numerator is the total amount paid to providers for compensation for direct care workers for furnishing homemaker, home health aide, personal care, and habilitation services during the measurement period, across all applicable HCBS programs. Compensation includes:

- Salary, wages, and other remuneration as defined by the Fair Labor Standards Act and implementing regulations ([29 U.S.C. 201](#) et seq., [29 CFR parts 531](#) and [778](#));
- Benefits (such as health and dental benefits, life and disability insurance, paid leave, retirement, and tuition reimbursement); and
- The employer share of payroll taxes for direct care workers delivering services authorized under section 1915(c) of the Act.

- **Overtime⁹**

Our definition of compensation includes salary, wages, “and other remuneration as defined by the Fair Labor Standards Act” and its implementing regulations. Consistent with the Fair Labor Standards Act,^{10,11,12} overtime pay is included in our definition of compensation; states should include overtime pay as compensation under 42 CFR 441.311(e)(1)(i).

- **Benefits, generally¹³**

In its glossary, the Bureau of Labor Statistics (BLS) defines “compensation” as “employer costs for wages, salaries, and employee benefits,”¹⁴ and in its definition of “benefits,” notes that the

⁸ <https://www.federalregister.gov/d/2024-08363/p-1067>

⁹ <https://www.federalregister.gov/d/2024-08363/p-1021>

¹⁰ <https://www.federalregister.gov/d/2024-08363/p-1021>

¹¹ <https://www.govinfo.gov/content/pkg/USCODE-2011-title29/pdf/USCODE-2011-title29-chap8-sec207.pdf>

¹² <https://www.dol.gov/agencies/whd/flsa>

¹³ <https://www.federalregister.gov/d/2024-08363/p-1026>

¹⁴ <https://www.bls.gov/bls/glossary.htm#C>

National Compensation Survey¹⁵ includes the following categories of employee benefits: insurance (life insurance, health benefits, short-term disability, and long-term disability insurance); paid leave (vacations, holidays, and sick leave); and retirement (defined benefit and defined contribution plans). When proposing that benefits be included in the definition of compensation, we intentionally included the phrase “such as” to indicate that the examples of benefits provided in the definition are not exhaustive. We did not attempt to list all possible benefits in the regulatory definition, as we believed that would run the risk of creating a definition that is too narrow. However, we encourage states to include as compensation all benefits identified by BLS.

- **Insurance¹⁶**

In the context of our definition, “insurance” (referring to health benefits, life insurance, etc.) should not be confused with other types of insurance that would not be considered compensation, like employers’ liability insurance. In other words, benefits must benefit the employee directly to be included in the definition of compensation.

- **Paid leave¹⁷**

“Paid leave” should be understood to cover any leave for which the employee is paid, including sick leave, holidays, and vacation leave.

- **Retirement¹⁸**

“Retirement” is a blanket term that includes different types of retirement plans or contributions on the employee’s behalf.

- **Employers’ share of payroll taxes¹⁹**

Employers’ payroll tax contributions for unemployment insurance and workers’ compensation (as well as payments required by the Federal Insurance Contributions Act²⁰) are considered compensation. While not necessarily paid directly to the workers, these expenses are paid on their behalf. We also note that, according to BLS, the National Compensation Survey includes these payroll tax contributions as part of the definition of “benefits” for the purpose of determining compensation and calls them “legally required benefits.”²¹

¹⁵ <https://www.bls.gov/bls/glossary.htm#B>

¹⁶ <https://www.federalregister.gov/d/2024-08363/p-1026>

¹⁷ <https://www.federalregister.gov/d/2024-08363/p-1026>

¹⁸ <https://www.federalregister.gov/d/2024-08363/p-1026>

¹⁹ <https://www.federalregister.gov/d/2024-08363/p-1031>

²⁰ In the 2024 final rule, we inadvertently referred to the Federal Insurance Compensation Act instead of the Federal Insurance Contributions Act.

²¹ <https://www.bls.gov/bls/glossary.htm#B>

▪ **Tuition reimbursement²²**

The term “tuition reimbursement” covers a variety of scenarios in which a provider may choose to reimburse a worker for tuition costs incurred either prior to or during their period of employment.

Excluded costs (42 CFR 441.311(e)(1)(iii))

Excluded costs are costs that are not included in the calculation of the percentage of Medicaid payments to providers that are spent on compensation for direct care workers. They are limited to:

- Costs of required trainings for direct care workers (such as costs for qualified trainers and training materials);
- Travel costs for direct care workers (such as mileage reimbursement or public transportation subsidies); and
- Costs of personal protective equipment for direct care workers.

States should ensure providers deduct these costs from their total Medicaid payments before performing the calculation.²³

▪ **Training costs versus time spent on training²⁴**

The training costs that are excluded costs are limited to those costs associated with the training itself (such as qualified trainers and materials) and are distinct from the compensation paid to a direct care worker participating in the training as part of their employment duties. The time direct care workers spend in training is included in the definition of compensation if direct care workers receive compensation for the time they spend in training.

▪ **Travel costs versus time spent traveling²⁵**

The travel costs that are excluded costs are limited to those costs associated with the travel itself (such as reimbursement for mileage or public transportation) and are distinct from the compensation paid to a direct care worker for any time spent traveling as part of their employment duties. Travel time is included in the definition of compensation if direct care workers receive compensation for the time they spend traveling as part of their employment duties.

Total Medicaid payments (Denominator of the Calculation)

For purposes of calculating the percentage required under 42 CFR 441.311(e), the denominator is the total amount of Medicaid payments made to providers for furnishing homemaker, home health aide, personal care, and habilitation services within the measurement period, across all applicable HCBS programs, not including excluded costs.

²² <https://www.federalregister.gov/d/2024-08363/p-1033>

²³ <https://www.federalregister.gov/d/2024-08363/p-1035>

²⁴ <https://www.federalregister.gov/d/2024-08363/p-1035>

²⁵ <https://www.federalregister.gov/d/2024-08363/p-1042>

We did not finalize a regulatory definition for total Medicaid payments. Total Medicaid FFS payments in the denominator of the calculation of the percentage of payments spent on compensation should include base and supplemental payments (as described in [SMD 21-006](#)). Those base and supplemental payments should only include payments actually collected, or revenue, rather than billed charges. In addition, refunded or recouped payments from current or prior years based on program financial audits, chargebacks, and bad debt should be excluded from those base and supplemental payment amounts.²⁶

For Medicaid managed care, payments refer to payments from the managed care plan to the provider, including any state directed payments as defined in 42 CFR 438.6, and not the capitation payment from the state to the managed care plan. Further, for Medicaid managed care, payments in the denominator of the calculation should include only those payments actually collected and should exclude refunded or recouped payments from current or prior years based on program financial audits, chargebacks, and bad debt.²⁷

For the purpose of calculating total Medicaid payments in the denominator under 42 CFR 441.311(e), states may determine the qualifying date (that is, the date on which a payment is considered to fall within the measurement period) for Medicaid payments, provided the methodology is applied consistently over time and is consistent with generally accepted accounting principles, as that term is defined in 2 CFR 200.1. If states require providers or managed care plans to report the data used in this calculation, those entities must apply the same methodology.

Exclusions (Payment Data Excluded From, and Providers Exempt From, the Reporting Requirements)

As described in the 2024 rulemaking, the following payment data are excluded from the reporting requirement under 42 CFR 441.311(e) and therefore are not included in either the numerator or the denominator of the calculation. Additionally, certain providers are exempt from the reporting requirement entirely.

Certain self-directed services (42 CFR 441.311(e)(2)(ii))

Payment data for homemaker, home health aide, personal care, and habilitation services that are furnished under a self-directed services delivery model in which the beneficiary directing the services sets the direct care worker's payment rate must be excluded from the reporting requirement.

Indian Health Service and Tribal health program providers (42 CFR 441.311(e)(4))

States must exclude all data from the Indian Health Service and Tribal health programs subject to the requirements at 25 U.S.C. 1641.²⁸ States must not require submission of data by, nor may they include any data from, these entities for purposes of the reporting required under 42 CFR 441.311(e)(2). Aside from the exemption of data for certain Indian Health Service and Tribal

²⁶ <https://www.federalregister.gov/d/2024-08363/p-1075>

²⁷ <https://www.federalregister.gov/d/2024-08363/p-1075>

²⁸ <https://www.govinfo.gov/link/uscode/25/1641>

program providers subject to 25 U.S.C. 1641, no other providers are exempt from the reporting requirement.²⁹

Applying the Reporting Requirement to Certain Types of Payment and Service Arrangements

Alternative payment models, pay-for-performance incentives, and value-based care arrangements

We did not exempt payments made through alternative payment models, pay-for-performance incentives, or value-based care arrangements in managed care or FFS from the reporting requirement. However, states should exclude from their reporting any portion of those payments attributable to the excluded self-directed service payment data, data from exempt Indian Health Service or Tribal health programs subject to 25 U.S.C. 1641, or excluded costs. States are encouraged to contact DCWreporting@cms.hhs.gov for technical assistance related to applying the reporting requirement to payments made through alternative payment models, pay-for-performance incentives, or value-based care arrangements, including when a portion of those payments is attributable to excluded self-directed service payment data, data from exempt Indian Health Service or Tribal health program providers, or excluded costs.

Bundled services

Some states pay for multiple services (e.g., personal care and homemaker services) through a single payment, often referred to as a “bundled” payment rate. For purposes of complying with the direct care worker compensation reporting requirement, for services bundled under a single payment rate, states may:

- Allocate the compensation costs and Medicaid payments attributable to each applicable service component and report separately for each service component;
- When one service component accounts for more than 50 percent of the single payment rate, report all data under the “predominant” service component, that is, the service component that accounts for more than 50 percent of the bundled payment rate;
- When the service components included in the single payment rate account for equal proportions of the rate, report all data under one of the service components; or
- When multiple service components but not all service components covered by a single payment rate are subject to the reporting requirement, prorate the data for the service component(s) covered by the single payment rate using the percentage of the rate accounted for by the service component(s) subject to the reporting requirement.

Below, we provide several scenarios and examples of how states may report under these options.

Scenario 1: One service component accounts for more than 50 percent of the single payment rate

When an approved HCBS program pays for multiple services subject to the reporting requirement using a single payment rate, and one service component accounts for more

²⁹ <https://www.federalregister.gov/d/2024-08363/p-1500>

than 50 percent of that rate, the state may report all of the data for the service components covered by that payment rate under the predominant service component.

Example: A state offers a residential habilitation service that includes multiple service components and has a single daily rate of \$200. The service components include habilitation, personal care, and homemaker services. The state analyzes the service components and determines that the habilitation component accounts for \$120 of the \$200 daily rate (60 percent), personal care accounts for \$50 (25 percent), and the homemaker component accounts for \$30 (15 percent). Because habilitation accounts for more than 50 percent of the rate, the state may report all data under habilitation and is not required to report separately for each service component.

Scenario 2: The service components in the single payment rate account for equal proportions of the rate

When an approved HCBS program pays for multiple services subject to the reporting requirement using a single payment rate and the service components account for equal proportions of that rate, the state may report all of the data for the service components covered by that payment rate under one of the service components rather than reporting separately for each component.

Example: A state offers “community support services” that include home health aide, homemaker, and personal care service components. All three service components are subject to the reporting requirement; however, each service component represents exactly one-third of the total payment in the state’s rate methodology. In this scenario, the state may, at its option, report all the required data for community support services under one of the service components (i.e., home health aide, homemaker, or personal care services), rather than report separately for each service component.

Scenario 3: Only some service components in the single payment rate are subject to the reporting requirement

When an approved HCBS program offers multiple services covered by a single payment rate, but not all of the service components are subject to the reporting requirement, states should only report on the service component(s) subject to the direct care worker compensation reporting requirement. For these situations, states may determine the compensation costs and amount of Medicaid payments for the service component(s) subject to the reporting requirement by prorating the total compensation costs and total Medicaid payments for the service component(s) covered by the single payment rate using the percentage of the rate accounted for by the service component(s) subject to the reporting requirement. To prorate these amounts, the state would determine the percentage of the total rate accounted for by each service component, then multiply the total compensation costs and total Medicaid payments by the percentage of the payment rate accounted for by the applicable service component(s).³⁰

³⁰ The scenarios presented in this guidance are illustrative and do not cover all possible situations that states may encounter for the purpose of the direct care worker compensation reporting requirement. In some situations, states

Example: A state offers a day program that provides day habilitation, skilled nursing, and non-medical transportation under a single payment rate. Only the day habilitation component would be subject to the reporting requirement. In this example, the state may prorate the total compensation costs and total Medicaid payments based on the percentage of the rate accounted for by habilitation. For example, if the day habilitation component accounts for 60 percent of the total payment rate for the day program, the state may multiply the total compensation costs and the total Medicaid payments for the day program by 60 percent for the purpose of reporting on the direct care worker compensation reporting requirement.

Assistive technologies, remote supports, and telehealth

We encourage states and providers to implement innovative technology solutions in their HCBS programs, including through the use of assistive technologies, remote supports, and telehealth, as these tools can support direct care workers in delivering services effectively. We recognize that the use of these technologies may increase equipment and administrative costs and, in turn, reduce the percentage of payments reported as spent on direct care worker compensation. However, services that are delivered using assistive technologies, remote supports, and telehealth are not exempt from the reporting requirement. Therefore, utilization of these service delivery mechanisms do not alter the calculation of the numerator and denominator as described above.

Key Dates

Readiness reporting

States must report on their readiness to comply with the direct care worker compensation reporting requirement for both FFS and managed care delivery systems by July 9, 2027. To comply with this requirement, states must email CMS at DCWreporting@cms.hhs.gov no later than July 9, 2027, to describe how they intend to come into compliance with the direct care worker compensation reporting requirement by the applicability date (as described below) for each service and for each HCBS authority (for example, section 1915(c), (i), (j), and (k) of the Act and section 1115 demonstrations) subject to the reporting requirement. States may, but are not required to, report separately on their readiness to comply with the direct care worker compensation reporting requirement for FFS and managed care delivery systems. States are encouraged to seek technical assistance as soon as possible with any questions on

may apply a combination of the scenarios described in this guidance to report the required data. For instance, a state may have a single payment rate for three or more service components in which more than one but not all of the service components (e.g., two of three) are subject to the reporting requirement. If the service components subject to the reporting requirement represent an *equal proportion of the rate*, the state could apply a combination of the approaches in scenarios 2 and 3 as follows: first, prorate the total compensation costs and the total Medicaid payments for the service components subject to the reporting requirement (scenario 3); then, report all of the prorated data for the relevant service components under one of the service components rather separately (scenario 2). Alternatively, if one service component accounts for *more than 50 percent of the rate*, the state could apply a combination of the approaches in scenarios 1 and 3. To do so, the state would first prorate the total compensation costs and the total Medicaid payments for the services subject to the reporting requirement (scenario 3), and then report all of the prorated data for the relevant service components under the service component that exceeds 50 percent of the rate (scenario 1).

implementation of the direct care worker compensation reporting requirement. Technical assistance may be requested by contacting DCWreporting@cms.hhs.gov.

Direct care worker compensation reporting

For FFS, the direct care worker compensation reporting requirement applies beginning July 9, 2028; for managed care, the reporting requirement applies beginning with the first rating period for contracts with the managed care plans beginning on or after July 9, 2028.^{31,32}

The measurement period is the calendar year prior to when the reporting is due. For example, for direct care worker compensation data due to CMS in 2028, states are expected to report on Medicaid payments received by providers between January 1, 2027, and December 31, 2027. Additional information, including calculation instructions, common data sources, and other technical details, are provided in the technical specifications for the reporting requirement on [Medicaid.gov](https://www.medicaid.gov).³³

We expect to make a reporting form available in the Medicaid Data Collection Tool no later than September 1, 2027, and to establish an annual reporting period beginning on or about September 1 and closing on or about December 31, beginning in 2028. We will make the reporting form available for public comment in the Federal Register through the Paperwork Reduction Act notice and comment process. We will provide states with a field in the reporting form that will allow them to describe any factors that may have affected or skewed their data.

Enhanced Federal Financial Participation (FFP) for reporting systems³⁴

States are eligible for enhanced FFP at a 90 percent match rate for the design, development, or installation of improvements of mechanized claims processing and information retrieval systems to enhance the Medicaid Management Information System (MMIS) to help meet the reporting requirement, in accordance with applicable federal requirements.³⁵ States are also eligible for enhanced FFP at a 75 percent match rate for ongoing operational and maintenance costs.³⁶

³¹ 42 CFR 441.311(f)(2)

³² <https://www.federalregister.gov/d/2024-08363/p-1148>

³³ <https://www.medicaid.gov/medicaid/access-care/downloads/tech-specs-hcbs-08102026>

³⁴ <https://www.federalregister.gov/d/2024-08363/p-1445>

³⁵ See section 1903(a)(3)(A)(i); 42 CFR 433.15(b)(3); 80 FR 75817-75843; <https://www.medicaid.gov/state-resource-center/faq-medicaid-and-chip-affordable-care-act-implementation/downloads/affordable-care-act-faq-enhanced-funding-for-medicaid.pdf>; <https://www.medicaid.gov/federal-policy-guidance/downloads/SMD16004.pdf>.

³⁶ See section 1903(a)(3)(B); 42 CFR 433.15(b)(4); 80 FR 75817-75843; <https://www.medicaid.gov/state-resource-center/faq-medicaid-and-chip-affordable-care-act-implementation/downloads/affordable-care-act-faq-enhanced-funding-for-medicaid.pdf>; <https://www.medicaid.gov/federal-policy-guidance/downloads/SMD16004.pdf>.

Closing

CMS is committed to working with states on the implementation of this HCBS reporting requirement. If you have any questions about this guidance or would like to request technical assistance, please contact DCWreporting@cms.hhs.gov.

Sincerely,

/s/

Dan Brillman
Deputy Administrator and Director
Center for Medicaid and CHIP Services

Appendix: Summary of the Direct Care Worker Compensation Reporting Requirement

Topic	Requirement
Reporting requirement	• States must report annually on the percentage of total Medicaid payments (not including excluded costs) for certain HCBS spent on compensation to direct care workers. • States must report a separate percentage for each service, and within each service, must also report separate percentages for self-directed and facility-based services that are included in the payment rate.
Applicable HCBS authorities	• Section 1915(c), (i), (j), and (k) programs • Section 1115(a) demonstration projects that include HCBS
Authorities not subject to the requirement	• Section 1905(a) of the Act
Services included in the requirement	• Homemaker • Home health aide • Personal care • Habilitation
Definition of compensation	• Salary, wages, and other remuneration as defined by the Fair Labor Standards Act and implementing regulations (29 U.S.C. 201 et seq., 29 CFR parts 531 and 778); • Benefits (such as health and dental benefits, life and disability insurance, paid leave, retirement, and tuition reimbursement); and • The employer share of payroll taxes for direct care workers delivering services authorized under section 1915(c) of the Act

Topic	Requirement
Definition of direct care worker	• Direct care worker means any of the following individuals who may be employed by or contracted with a Medicaid provider, State agency, or third party; or delivering services under a self-directed services delivery model: ○ Registered nurse, licensed practical nurse, nurse practitioner, or clinical nurse specialist who provides nursing services to Medicaid beneficiaries receiving HCBS; ○ Licensed or certified nursing assistant who provides services under the supervision of a registered nurse, licensed practical nurse, nurse practitioner, or clinical nurse specialist; ○ Direct support professional; ○ Personal care attendant; ○ Home health aide; or ○ Other individuals (for instance, supported independent living staff) who are paid to provide services to address activities of daily living or instrumental activities of daily living, behavioral supports, employment supports, or other services to promote community integration directly to Medicaid beneficiaries receiving HCBS, including nurses and other staff providing clinical supervision. • Nurses in supervisory or administrative roles who are not providing nursing services to people receiving HCBS <i>are not</i> included in the direct care worker definition.
Definition of excluded costs	• Costs of required trainings for direct care workers (such as costs for qualified trainers and training materials); • Travel costs for direct care workers (such as mileage reimbursement or public transportation subsidies); and • Costs of personal protective equipment for direct care workers.
Services excluded from the requirement	• Homemaker, home health aide, personal care, and habilitation services that are furnished <i>under a self-directed services delivery model</i> in which the beneficiary directing the services sets the direct care worker's payment rate must be excluded from the reporting requirement.
Providers exempt from the requirement	• Indian Health Service and Tribal health program providers subject to 25 U.S.C. 1641.
Applicability dates	• July 9, 2027: Readiness reporting • July 9, 2028: FFS direct care worker compensation reporting; for managed care, the reporting requirement applies beginning with the first rating period for contracts with the managed care plans beginning on or after July 9, 2028 (42 CFR 438.72(b); 441.311(f)(2)).
Annual reporting period	• Beginning on or about September 1 and closing on or about December 31 of each year, beginning in 2028.

Topic	Requirement
Measurement period	January 1–December 31 (that is, the calendar year) of the year prior to when reporting is due. For example, for reporting due to CMS in 2028, the measurement period is January 1, 2027–December 31, 2027.