

Direct Care Worker Compensation (Home and Community-Based Services Payment Adequacy) Reporting Technical Specifications

Version 1.0
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Center for Medicaid and CHIP Services
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services



Version Control

Version	Date	Summary of Changes
1.0	October 2026	Not applicable

Background

States are required at 42 CFR 441.311(e) to report annually, beginning in 2028, on the percentage of Medicaid payments for homemaker, home health aide, personal care, and habilitation services spent on compensation to direct care workers, subject to certain exceptions. This regulatory requirement is currently referred to as the home and community-based services (HCBS) payment adequacy reporting requirement.

In this document, we generally refer to the HCBS payment adequacy reporting requirement as the “direct care worker compensation” reporting requirement to better reflect the purpose of the reporting requirement at § 441.311(e).

This document provides the technical specifications for the direct care worker compensation reporting requirement. The specifications include a description of the reporting requirement, calculation instructions, common data sources, and other relevant information.

Technical Specifications

Percentage of Medicaid Payments for Homemaker, Home Health Aide, Personal Care, and Habilitation Services Spent on Compensation for Direct Care Workers

a. Description

The percentage of total Medicaid payments (not including excluded costs) to providers for homemaker, home health aide, personal care, and habilitation services spent on compensation for direct care workers. The reporting requirement applies to services furnished to individuals in an applicable HCBS program authorized under sections 1915(c), 1915(i), 1915(j), 1915(k), or 1115(a) of the Social Security Act (the Act).

States should report separately for each service type. For each service type, states should report:

1. An overall aggregated state-level percentage;
2. An aggregate state-level percentage for services that are not self-directed;

3. An aggregate state-level percentage for self-directed services, excluding self-directed services in which the beneficiary directing the services sets the direct care worker's payment rate;
4. An aggregate state-level percentage for services not delivered in a provider-operated physical location for which facility-related costs are included in the payment rate; and
5. An aggregate state-level percentage for services delivered in a provider-operated physical location for which facility-related costs are included in the payment rate.

Specifications	
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.
Qualifying date(s)	By December 31 of the measurement period. ¹
Numerator	The total amount of compensation for direct care workers for homemaker, home health aide, personal care, and habilitation services for which payment was made to providers within the measurement period, across all applicable HCBS programs.
Denominator	The total amount of Medicaid payments made to providers for homemaker, home health aide, personal care, and habilitation services within the measurement period, across all applicable HCBS programs, not including excluded costs.
Calculation	Divide the total compensation for direct care workers in the numerator by the total Medicaid payments to providers (not including excluded costs) in the denominator and then multiply by 100. Calculate an overall aggregated state-level percentage separately for each service type: homemaker, home health aide, personal care, and habilitation services. Within each service type, also calculate separate percentages for: • Services that are <u>not</u> self-directed;

¹ For the purpose of calculating total Medicaid payments in the denominator under 42 CFR § 441.311(e), states may determine the qualifying date 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.

Specifications

Calculation (cont)	• Self-directed services, excluding self-directed services in which the beneficiary directing the services sets the direct care worker's payment rate; • Services <u>not</u> delivered in a provider-operated physical location for which facility-related costs are included in the payment rate; • Services delivered in a provider-operated physical location for which facility-related costs are included in the payment rate.
Minimum performance level	Not applicable
Exclusions	• Services 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. • All data from Indian Health Service and Tribal health program providers subject to 25 U.S.C. 1641 must be excluded from the reporting. • Excluded costs should not be included in the numerator or denominator. Excluded costs are costs that are not included in the calculation of the percentage of Medicaid payments to providers that is spent on compensation for direct care workers. Such costs, defined at 42 CFR 441.311(e)(1)(iii), 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.

Specifications	
Common state data source(s)	• For direct care worker compensation: data collected directly from providers (such as through provider surveys) and/or managed care plans. • For Medicaid payments: Medicaid Management Information System (MMIS) claims or encounter records, or data collected directly from providers (such as through provider surveys) and/or managed care plans.
Sampling	Not allowed.
Applicable statutory authorities	• Sections 1915(c), 1915(i), 1915(j), and 1915(k) HCBS programs. • Section 1115(a) demonstration projects that include HCBS.
Delivery system applicability	• Fee-for-service. • Managed care delivery systems under the authority of sections 1915(a), 1915(b), 1932(a), or 1115(a) of the Act and include HCBS in the managed care plan's contract.

b. Additional Notes

For more information on the reporting requirement, see State Medicaid Director Letter #26-005.² For questions or technical assistance related to these technical specifications, contact DCWreporting@cms.hhs.gov.

² <https://www.medicaid.gov/federal-policy-guidance>