Home Care at Residential Services Agencies by Personal Care Aides

Health - General Article § 19-4A-11(d)

Maryland Department of Health

July 2025

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Background

HB 544/SB 600 (Chs. 673/674 of the Acts of 2022) requires the Department of Health to report on personal care aides who provide home care services at residential service agencies. The bills require, on or before October 1 each year, each residential service agency receiving Medicaid reimbursement for the provision of home care or similar services by a personal care aide to report to MDH, on a form or in an electronic manner developed by MDH, the number of personal care aides classified by the residential service agency as employees and independent contractors. Furthermore, on or before July 1 of each year, MDH shall use the information reported to create a report concerning:

1. Maryland Medicaid's reimbursement rates;

2. the cost of delivering services; and

3. aggregated employment classifications of individuals who provide personal care services.

A residential service agency (RSA), as defined in the Code of Maryland Regulations (COMAR) 10.07.05, is "an individual, partnership, firm, association, corporation, or other entity of any kind that is engaged in a nongovernmental business of employing or contracting with individuals to provide at least one home health care service for compensation to an unrelated sick or disabled individual in the residence of that individual; or an agency that employs or contracts with individuals directly for hire as home health care providers."[1]

RSAs provide a broad range of services, including home care services, durable medical equipment with and without oxygen, speech therapy, occupational therapy, physical therapy, medical social services, nutritional services, intravenous therapy, and/or ventilator services. Because of this range of services, RSAs may employ a diverse workforce that includes registered nurses, licensed practical nurses, certified nursing assistants, certified medication technicians, direct service professionals (i.e., personal care aides), therapists, and administrative staff.

RSAs are licensed by the Office of Health Care Quality (OHCQ) within the Maryland Department of Health (MDH), which issues operating licenses to new RSAs upon successful completion of the application process. OHCQ also conducts compliance surveys to ensure licensed RSAs meet state and federal care standards. In addition, OHCQ provides education and technical assistance to applicants, licensees, and other stakeholders.

RSAs contract with the Maryland Medicaid Administration (MA) within MDH through a Medicaid Provider Agreement to deliver services to Medicaid participants. RSAs provide services in accordance with regulatory and subregulatory guidance and are reimbursed for approved Medicaid claims. The Medicaid program does not employ staff to provide Medicaid services directly to its participants or serve as a joint employer as defined by the U.S. Department of Labor's Fair Labor Standards Act.

Medicaid Reimbursement Rates

Pursuant to SB 481 (Ch. 464 of the Acts of 2002), MDH established an annual process to set the

[1] Maryland Department of Health. (n.d.). *COMAR 10.07.05.02(25)(a)(i)-(ii).* Code of Maryland Regulations. https://dsd.maryland.gov/regulations/Pages/10.07.05.02.aspx

fee-for-service (FFS) reimbursement rates for Maryland Medicaid and the Maryland Children's Health Insurance Program. These rates apply to Medicaid-enrolled providers, such as RSAs that deliver HCBS. As part of this process, the Office of Long Term Services and Supports (OLTSS), the Developmental Disabilities Administration (DDA), and the Behavioral Health Administration (BHA)– which operate programs that provide HCBS– apply rate increases to their respective programs, as required through legislation and funding authority. More information on the rate-setting process can be found in the Joint Chairmen's Report on Medicaid Provider Rate Setting drafted in January 2024.[2]

A Medicaid-enrolled RSA that receives HCBS rate increases serves as the employer of record for direct care staff and determines how to allocate those increases within its organization. MDH does not regulate how an RSA applies the rate increase, nor does it currently collect data on how the RSA has implemented the increase.

The percentage increases are outlined below by provider type and funding authority.

Long Term Services and Supports (LTSS) Providers

LTSS provider rate increases are funded by the State budget, HB 295 *Maryland Minimum Wage Act of 2014* (Ch. 262 of the Acts of 2014),[3] HB 166/SB 280 *Labor and Employment – Payment of Wages – Minimum Wage (Fight for Fifteen)* (Chs. 10/11 of the Acts of 2019),[4] the Governor's Supplemental Budget,[5] American Rescue Plan Act (ARPA),[6] and SB 555 *The Fair Wage Act of 2023*.[7]

- FY 2017: 1.1% rate increase effective July 1, 2016
- FY 2018: 2% rate increase effective July 1, 2017
- FY 2019: 3% rate increase effective July 1, 2018
- FY 2020: 3% rate increase effective July 1, 2019
- FY 2021: 4% rate increase effective January 1, 2021
- FY 2022: 5.2% rate increase effective November 1, 2021
- FY 2023:
    - Temporary, one-time emergency 4% rate increase effective July 1, 2022
    - 8% rate increase effective July 1, 2022
- FY 2024:
    - 4% rate increase effective January 1, 2024
    - Temporary 4% rate increase authorized by ARPA terminated on July 1, 2023, and as such, reimbursement rates remain unchanged
    - 4% increase scheduled for FY 2025 and 4% increase scheduled for FY 2026 were

[2] Maryland Department of Health, Medicaid Administration. (2024). *2023 Joint Chairmen's Report (pp. 123-124): Report on current Medicaid rate structures, rate enhancements, and rate-setting studies*. https://health.maryland.gov/mmcp/Documents/JCRs/2023/ratestructureJCRfinal10-23.pdf
[3] Maryland General Assembly. (2014). *Chapter 262 (House Bill 295), 2014 Regular Session.* https://mgaleg.maryland.gov/2014RS/Chapters_noln/CH_262_hb0295e.pdf
[4] Maryland General Assembly. (2019). *Chapters 10 and 11 (House Bill 166 and Senate Bill 280), 2019 Regular Session.* https://mgaleg.maryland.gov/2019RS/chapters_noln/Ch_10_hb0166E.pdf
[5] State of Maryland, Office of the Governor. (2022). Supplemental Budget No. 4 *(Fiscal Year 2023)*. https://dbm.maryland.gov/budget/Documents/operbudget/2023/proposed/FY2023-Supplemental-Budget-No4.pdf
[6] For more information regarding MDH's ARPA spending plan, see the quarterly updates posted here: https://health.maryland.gov/mmcp/Pages/Public-Notices.aspx
[7] Maryland General Assembly. (2023). *Chapter 2 (Senate Bill 555), 2023 Regular Session.* https://mgaleg.maryland.gov/2023RS/chapters_noln/Ch_2_sb0555T.pdf

accelerated to provide an additional 8% rate increase effective January 1, 2024
- FY 2025: 3% rate increase effective July 1, 2024
- FY 2026: Service rates will remain unchanged and will not receive an increase.

Developmental Disabilities Administration (DDA) Providers

DDA provider rate increases are supported by funding through HB 295 *Maryland Minimum Wage Act of 2014* (Ch. 262 of the Acts of 2014), HB 166/SB 280 *Labor and Employment – Payment of Wages – Minimum Wage (Fight for Fifteen)* (Chs. 10/11 of the Acts of 2019),[4] the Governor's Supplemental Budget,[5] the 10% enhanced FMAP funding available for reinvestment as a result of ARPA,[6] and SB 555 *The Fair Wage Act of 2023*.[7]

- FY 2016: 3.5% rate increase effective July 1, 2015
- FY 2017: 3.5% rate increase effective July 1, 2016
- FY 2018: 3.5% rate increase effective July 1, 2017
- FY 2019: 3.5% rate increase effective July 1, 2018
- FY 2021:
    - 4% rate increase effective January 1, 2021
    - 5.5% rate increase effective April 1, 2021, except for targeted case management
- FY 2022:
    - 4% rate increase effective July 1, 2021
    - 5.5% increase for targeted case management providers effective November 1, 2021
    - One-time temporary emergency 10% increase for all providers from January 1, 2022, through March 31, 2022, except for targeted case management providers
- FY 2023:
    - 8% rate increase effective July 1, 2022
    - One-time temporary emergency 10% rate increase for targeted case management providers from October 1, 2022, through December 1, 2022
- FY 2024:
    - 4% rate increase effective July 1, 2023
    - An additional 8% rate increase, originally scheduled for FY 2025 and FY 2026, was made effective January 1, 2024.
- FY 2025: 3% rate increase effective July 1, 2024
- FY 2026: Service rates will remain unchanged and will not receive an increase.

Behavioral Health Administration (BHA) Providers

BHA provider rate increases are supported by funding through HB 1329/SB 967 *Heroin & Opioid Prevention Effort (HOPE) & Treatment Act of 2017* (Chs. 571/572 of the Acts of 2017),[8] HB 166/SB 280 *Labor and Employment – Payment of Wages – Minimum Wage (Fight for Fifteen)* (Chs. 10/11 of the Acts of 2019),[4] the Governor's Supplemental Budget,[5] the 10% enhanced FMAP funding available for reinvestment as a result of ARPA,[6] and SB 555 *The Fair Wage Act of 2023*.[7]

- FY 2019: 3.5% rate increase effective July 1, 2018
- FY 2020: 3.5% rate increase effective July 1, 2019
- FY 2021: 4% rate increase effective January 1, 2021
- FY 2022:

[8] Maryland General Assembly. (2017). *Chapters 571 and 572 (House Bill 1329 and Senate Bill 967), 2017 Regular Session*. https://mgaleg.maryland.gov/2017RS/chapters_noln/Ch_571_hb1329E.pdf

    - 3.5% rate increase effective July 1, 2021
    - 5.4% rate increase effective November 1, 2021
- FY 2023:
    - 3.25% rate increase effective July 1, 2022
    - 4% rate increase effective July 1, 2022
    - One-time temporary emergency 4% rate increase from July 1, 2022, through September 30, 2022, for Brain Injury Waiver providers
- FY 2024:
    - 3% rate increase effective July 1, 2023
    - An additional 8% rate increase, originally scheduled for FY 2025 and FY 2026, was made effective January 1, 2024
- FY 2025: 3% rate increase effective July 1, 2024
- FY 2026: Service rates will remain unchanged and will not receive an increase.

An upcoming change to RSA reimbursement is related to the implementation of the Homecare Worker Rights Act of 2024 (HB 39/SB 197).[9] Beginning January 1, 2026, MA may reimburse RSAs for personal assistance services (PAS) only if those services are provided by individuals classified as employees. PAS, offered under HCBS programs, includes assistance with activities of daily living, instrumental activities of daily living, and health-related tasks. These services are delivered through hands-on assistance, supervision, and/or cueing by personal care aides.

To comply with the new Medicaid reimbursement requirements for PAS, the State's data management system, LTSS*Maryland*, is undergoing enhancements to allow RSAs to self-report their workers' classification status (employee or contractor) and identify staff who require reclassification. An additional feature will also be implemented to process block payments for PAS delivered by individuals who are not listed as employees.

To prepare and assist the RSAs before the transition, MA partnered with the Maryland National Capital Homecare Association to provide information sessions from October 2024 through May 2025. The sessions provided resources, including guidance on employment law, HR experts, and representatives from the Department of Labor. Currently, MA is also exploring options to verify the self-reported classification data submitted by RSA starting January 1, 2026.

Cost of Delivering Services

Although MDH does not currently collect cost data from RSAs, it is exploring steps to implement cost collection processes to comply with the *Ensuring Access to Medicaid Services Final Rule* ("Access Rule") released by the Centers for Medicare & Medicaid Services on July 9, 2024.[10] Designed to improve access, quality of care, and health outcomes in Medicaid FFS and managed care delivery systems, the Access Rule includes provisions on payment adequacy for HCBS.

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[9] Maryland General Assembly. (2024). *Chapters 881 and 882 (House Bill 39 and Senate Bill 197), 2024 Regular Session.* https://mgaleg.maryland.gov/2024RS/chapters_noln/Ch_881_hb0039E.pdf

[10] Centers for Medicare & Medicaid Services. (2024). *Medicaid program: Ensuring access to Medicaid services (CMS-2442-F)*. U.S. Department of Health and Human Services. https://www.federalregister.gov/documents/2024/05/10/2024-08363/medicaid-program-ensuring-access-to-medicaid-services

To comply with the provision, MDH must demonstrate its readiness to report on the payment adequacy provision by July 9, 2027, and submit the required data annually thereafter (42 CFR 441.311).[11] The provision requires MDH to report the percentage of total Medicaid reimbursement (excluding certain costs) used to compensate direct care workers for homemaker, home health aide, personal care, and habilitation services. Additionally, by July 9, 2030, MDH must ensure providers comply with the minimum performance level, requiring that 80 percent of Medicaid payments be passed through to the direct care workforce, unless the provider qualifies as a small provider or has an approved hardship exemption (42 CFR 441.302).[12]

Currently, MDH's fiscal audit contractor, Myers and Stauffer, LC, collects provider cost reports from nursing facilities to support the state's cost-based reimbursement model. MDH has initiated discussions with Myers and Stauffer to develop a survey for RSAs to collect the cost data related to facility characteristics, service utilization, and costs– such as direct and indirect labor costs, equipment, supplies, and property. Once a draft is developed, the survey will be shared with RSAs for feedback on the proposed data points and the feasibility of completion.

The HCBS cost reporting process will allow MDH to report the percentage of total payments used to compensate direct care workers and ensure provider compliance with the minimum performance level. It will also help MDH determine appropriate rate increases based on the actual costs of delivering services, which are currently set solely through legislation and the Governor's annual budget. These provider-reported costs, audited and validated by Myers and Stauffer using national data sources, will inform rate setting to ensure rates are budget-conscious, sustainable, and support quality care.

Aggregated Employment Classification Data

Pursuant to HB 544/SB 600 (Chs. 673/674 of the Acts of 2022), OHCQ conducted a survey to gather information on personal care aides employed by RSAs. As of June 6, 2025, there are 2,812 licensed RSAs in Maryland, and 2,006 (71 percent) have completed RSA certification; 806 (29 percent) RSAs have not yet responded to OHCQ's notice to submit the RSA certification. Among the respondents, 711 RSAs (25 percent) receive Medicaid reimbursement. All new RSA applicants are required to submit certification at the time of application with the majority of RSAs having been licensed prior to the requirement going into effect. OHCQ is developing a plan to address the outstanding RSA certifications of the 806 that did not respond.

Of those surveyed:

- 222 RSAs reported using personal care aides classified as independent contractors,
- 489 reported not using independent contractors, and
- 138 reported a mix of employees and independent contractors.

The 711 Medicaid-enrolled RSAs reported a total of 13,597 personal care aides– 11,327 employees and 2,270 independent contractors.

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[11] Code of Federal Regulations. (2023). *42 C.F.R. § 441.311 – State plan requirements for home and community-based services under section 1915(i) of the Act.* U.S. Government Publishing Office. https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-441/subpart-J/section-441.311

[12] Code of Federal Regulations. (2023). *42 C.F.R. § 441.302 – State assurances.* U.S. Government Publishing Office. https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-441/subpart-G/section-441.302