



Medicaid Home and Community-Based Services – Payment Rate Sufficiency and Access to Care

Evaluation by the Interested Parties Advisory Group

Health General Article § 15-1205

September 2026



Wes Moore, Governor · Aruna Miller, Lt. Governor · Meena Seshamani, M.D., Ph.D., Secretary

October 8, 2026

The Honorable Pamela Beidle
Chair, Senate Finance Committee
3 East Miller Senate Office Building
Annapolis, MD 21401-1991

The Honorable Heather Bagnall
Chair, Health Committee
240 Taylor House Office Building
Annapolis, MD 21401-1991

Re: Health General Article §15-1205 (HB 1142/Ch. 754, 2025) -Medicaid Home and Community-Based Services – Payment Rate Sufficiency and Access to Care-Evaluation by the Interested Parties Advisory Group (MSAR # 16638)

Dear Chair Beidle and Chair Bagnall:

The Maryland Department of Health (MDH) respectfully submits this report on the sufficiency of Medicaid payment rates for applicable service categories and challenges to accessing care for Medicaid home and community-based services (HCBS) based on the Interested Parties Advisory Group (IPAG) activities as required by HB 1142 (Ch. 754 of the Acts of 2025). The bills require, by September 1 of each year, starting in 2026, the reporting of the Group's activities and recommendations to the Governor and the General Assembly, in accordance with § 2-1257 of the State Government Article.

If you have any questions or require additional information, please contact Meghan Lynch, Director of Governmental Affairs, at meghan.lynch@maryland.gov.

Sincerely,

Meena Seshamani, M.D., Ph.D.
Secretary

cc: Perrie Briskin, M.B.A., M.P.H., Deputy Secretary, Health Care Financing and Medicaid
Rayva Virginkar, Medicaid Deputy Director
Jamie Smith, Director, Office of Long Term Services and Supports
Meghan Lynch, Director, Office of Governmental Affairs
Sarah Albert, Department of Legislative Services (5 copies)

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I. Introduction

Pursuant to House Bill (HB) 1142 (2025), the Maryland Department of Health (“the Department”) is required to submit an annual report by September 1, beginning in 2026, on the activities of the Interested Parties Advisory Group (IPAG). As part of this mandate, the report details IPAG's efforts to evaluate the sufficiency of Medicaid payment rates and identify challenges to accessing care for Medicaid home and community-based services (HCBS).¹

This legislation was introduced following the Centers for Medicare & Medicaid Services (CMS) release of the Ensuring Access to Medicaid Services Final Rule (“Access Rule”) on July 9, 2024, which mandated the establishment of the IPAG.² HB 1142 expands upon these federal regulations by detailing guidelines for IPAG implementation and introducing broader state data reporting mandates, including this annual report on IPAG activities.¹

II. Background

Effective July 9, 2024, CMS released the Access Rule to improve care quality, access, and health outcomes for Medicaid participants across fee-for-service (FFS) and managed care delivery systems, including HCBS.

Under 42 CFR § 447.203(b)(6), states are mandated to establish an advisory group to consult on provider rates for agency-based or self-directed personal care, home health aide, homemaker, and habilitation services that require payments to direct care workers. This applies across the Medicaid State Plan, 1915(c) waivers, and demonstration programs. The rule further requires that current and proposed payment rates, HCBS payment adequacy data, and access-to-care metrics be provided to the advisory group. This data allows the group to evaluate whether Medicaid payment rates are sufficient to ensure beneficiary access and maintain adequate direct care workforce capacity.³

During the 2025 legislative session, Maryland passed HB 1142 to accelerate the implementation date of IPAG from July 9, 2026, to November 1, 2025, and increase its meeting frequency from biennial to annual.

The bill mandated a 15-member group composition consisting of:

- Deputy Secretary of Health Care Financing (or designee)
- Secretary of Labor (or designee)
- Three (3) Medicaid beneficiaries (or their authorized representatives)
- Two (2) representatives of consumer organizations
- Three (3) representatives of provider organizations (two (2) from Residential Service Agencies and one (1) from an employer trade organization)

¹ Public Health – Maryland Interested Parties Advisory Group – Establishment, Md. H.B. 1142 (2025). <https://mgaleg.maryland.gov/2025RS/bills/hb/hb1142e.pdf>

² Ensuring Access to Medicaid Services Final Rule (CMS-2442-F), Centers for Medicare & Medicaid Services (2024). <https://www.cms.gov/newsroom/fact-sheets/ensuring-access-medicare-services-final-rule-cms-2442-f>

³ Payments for Services – Documentation of Access to Care and Service Payment Rates, 42 C.F.R. § 447.203 (2024). [https://www.ecfr.gov/current/title-42/part-447/subpart-B#p-447.203\(b\)\(6\)](https://www.ecfr.gov/current/title-42/part-447/subpart-B#p-447.203(b)(6))

- Two (2) representatives of worker organizations
- Three (3) direct care workers

The Department received 46 applications for IPAG membership between July 1, 2025, and August 15, 2025, and members were appointed before October 1, 2025. The inaugural IPAG meeting, which was closed to members only, was held on December 3, 2025. The second annual meeting, which was open to the public, was conducted on June 29, 2026.

HB 1142 also required the establishment of standardized procedures for administering the group and a dedicated page on the Department's website. The draft group charter was shared during the first meeting, with feedback accepted through April 3, 2026. At the June 2026 meeting, the charter was revised to specify that the IPAG will meet 'at least annually but more frequently as needed.' Following formal approval at that meeting and the collection of all member signatures, the finalized charter was published on the dedicated website.

As required by HB 1142, the dedicated website includes:^{1,4}

- A list of current advisory group members, application processes, and selection criteria
- Meeting information and relevant data posted 30 calendar days in advance of scheduled meetings
- Virtual attendance instructions and guidelines detailing opportunities for public testimony
- Accessibility procedures to ensure meaningful participation for individuals with disabilities and limited English proficiency

III. Data reported to IPAG

This section details the data reporting requirements mandated by both the CMS Access Rule and HB 1142. Certain datasets required for the IPAG are tied to other provisions within the federal Access Rule that have compliance deadlines extending past the IPAG's implementation date. Consequently, these specific data elements were marked as currently unavailable, and plans to prepare those data, along with updates on data collection and development efforts, were provided instead. The reported data and related documentation are available on the dedicated IPAG website.³

Data required by the Access Rule

1. Current and proposed payment rates

The data on current rates were available on the provider transmittal website.⁵ Proposed payment rates will be communicated to members for any upcoming rate updates. The federal compliance deadline for reporting this data to the IPAG was July 9, 2026.

2. Payment adequacy reports

⁴ Link to the dedicated website

<https://health.maryland.gov/mmcp/longtermcare/Pages/Interested-Parties-Advisory-Group.aspx>

⁵ Maryland Department of Health. (n.d.). *Provider transmittals*.

<https://health.maryland.gov/mmcp/provider/Pages/transmittals.aspx>

This reporting element is required under the Payment Adequacy provision as outlined in 42 CFR 441.311(e). Under this provision, Maryland must report the percentage of total Medicaid payments for homemaker, home health aide, personal care, and habilitation services that is spent on compensation for direct care workers. The federal compliance deadline for this data reporting is July 9, 2028, with a readiness deadline of July 9, 2027.⁶

To meet these requirements, the Department– in partnership with Myers and Stauffer LC⁷ and the Hilltop Institute (“Hilltop”)⁸– developed the HCBS Cost Survey. This initiative establishes a process for annually reporting provider cost, utilization, and workforce data across all HCBS, expanding beyond the federally mandated service categories. The Developmental Disabilities Administration (DDA) also conducts its own annual provider cost survey using a standardized General Ledger data collection tool, with DDA rates informed by the Rate Review Advisory Group (RRAG) process.⁹

The HCBS Cost Survey complements these existing efforts, rather than overlapping with them, by establishing a consistent, Department-wide approach to collecting cost and workforce information across HCBS programs. This new survey not only tracks the percentage of total Medicaid payments spent on direct care worker compensation but also provides comprehensive insights into payment rates across the entire array of Maryland’s HCBS. This broader data collection will support Maryland's future transition to a data-driven HCBS rate-setting methodology, enable robust evaluation of provider rates, and strengthen long-term HCBS program sustainability.

To inform this effort, Maryland Medicaid convened a provider workgroup representing a diverse range of organization sizes and service types to assist with survey design and feasibility. A separate pilot group of providers was subsequently formed to complete and test the HCBS Cost Survey tool. The developing tool was also presented to the IPAG for feedback on January 14, 2026.

The first iteration of the HCBS Cost Survey was successfully launched on July 1, 2026. It requires all Medicaid-enrolled providers who billed for delivering non-DDA HCBS in FY 2026 (from July 1, 2025, to June 30, 2026) to complete the survey in its entirety.¹⁰ While providers were initially required to submit their cost data by September 30, 2026, the deadline was extended to December 31, 2026, in response to provider requests.¹¹ To support providers in

⁶ Services: Requirements and Limits Applicable to Specific Services – Reporting Requirements, 42 C.F.R. § 441.311 (2024). [https://www.ecfr.gov/current/title-42/part-441/section-441.311#p-441.311\(e\)](https://www.ecfr.gov/current/title-42/part-441/section-441.311#p-441.311(e))

⁷ Myers and Stauffer LC is a professional accounting firm specializing in government health care programs.

⁸ The Hilltop Institute is a nonpartisan research organization at the University of Maryland, Baltimore County (UMBC) dedicated to improving the health and wellbeing of people and communities.

⁹ Maryland Department of Health. (n.d.). *GL Data Collection Tool*. Developmental Disabilities Administration. <https://health.maryland.gov/dda/Pages/LTSSMaryland/RRAG/GL-Data-Collection-Tool.aspx>

¹⁰ Maryland Department of Health. (2026, June 22). *Implementation of home and community-based services cost survey*. Maryland Medicaid.

https://health.maryland.gov/mmcp/provider/Documents/transmittals/PT95-26_Implementation_of_Home_and_Community-Based_Services_Cost_Survey.pdf

¹¹ Maryland Department of Health. (2026, August 10). *Updates for the home and community-based services cost survey*. Maryland Medicaid.

https://health.maryland.gov/mmcp/provider/Documents/transmittals/PT16-27_Updates_for_the_Home_and_Community-Based_Services_Cost_Survey.pdf

complying with this new mandate, the Department communicated the requirement via mail, email, and provider transmittals. Additionally, recorded training modules, live question-and-answer sessions and their recordings, and frequently asked questions were made available on a dedicated website.¹² Providers who fail to submit the annual cost survey will be subject to payment withholdings beginning January 1, 2027, until the reporting requirement is satisfied.

While this data was not yet available for the initial IPAG meetings, the findings collected from this year's survey are expected to be shared with members during the third annual IPAG meeting in 2027.

3. Access to care metrics

This data reporting is a component of the broader access to care requirements mandated by the Access Rule under 42 CFR § 441.311(d)(2). Under this provision, Maryland is required to report two (2) specific metrics to CMS by July 9, 2027.¹³

Average wait time for new beneficiaries

This metric requires the Department to report the average time elapsed from initial service approval to the actual start of services for new enrollees who entered the program within the past 12 months. This data was not available at the time of the initial IPAG meetings. The Department is currently working with Hilltop to develop and prepare this dataset ahead of the July 9, 2027 compliance deadline.

Percentage of authorized service hours delivered

This metric requires reporting the percentage of authorized hours for applicable services that were actually provided within the past 12 months. This data was also unavailable during the initial IPAG meetings. While the Department is preparing the necessary data with Hilltop to meet the federal compliance deadline, it is also partnering with the research team at the Roger and Flo Lipitz Center to Advance Policy in Aging and Disability at the Johns Hopkins Bloomberg School of Public Health to identify and address potential unmet needs. This partnership aims to investigate the underlying gaps between approved and received service hours, as well as the causes for unused service hours.

Data required by HB 1142

HB 1142 expands data reporting beyond the federal mandates of the Access Rule by introducing several additional requirements.

1. HCBS payment transparency reports

¹² Maryland Department of Health. (n.d.). *HCBS cost survey*. Maryland Medicaid. <https://health.maryland.gov/mmcp/provider/Pages/hcbs-cost-survey.aspx>

¹³ Services: Requirements and Limits Applicable to Specific Services – Reporting Requirements, 42 C.F.R. § 441.311 (2024). [https://www.ecfr.gov/current/title-42/part-441/section-441.311#p-441.311\(d\)](https://www.ecfr.gov/current/title-42/part-441/section-441.311#p-441.311(d))

This provision is tied to the Payment Rate Transparency provision in the federal Access Rule under 42 CFR § 447.203(b)(1), which establishes a compliance deadline of July 1, 2026, for the initial publication of Medicaid FFS payment rates.¹⁴ The Department meets this requirement by communicating Medicaid FFS payment rates directly to Medicaid-enrolled providers and the general public via formal provider transmittals. These transmittals are distributed to stakeholders and published on the official Medicaid provider transmittal website.¹⁵ Because the existing platform stores all Medicaid FFS fee schedule payment rates for public access, the Department fully satisfies the transparency mandate.

2. Bureau of Labor Statistics (BLS) wage data and workforce data

Based on the service codes within the applicable categories, Hilltop identified occupational codes defined by the Bureau of Labor Statistics (BLS) to analyze wage data for providers delivering home health aide, personal care, and habilitation services.¹⁵ While 14 unique BLS occupational codes were initially identified for the December 2025 inaugural meeting, two (2) additional codes were added ahead of the June 2026 meeting to align with the 2018 BLS code updates, bringing the total to 16 codes.

To report wage data, median hourly compensation data for Maryland providers were sourced from the BLS May 2024 State Occupational Employment and Wage Estimates. For regional context, the same data was compiled for Washington D.C., Delaware, Pennsylvania, Virginia, and West Virginia to support a comprehensive wage comparison.¹⁶ This identical dataset was utilized for both meetings because the May 2024 release remained the most recent data available at the time of the analysis.

For the December 2025 meeting, the location quotient was reported to assess labor market and workforce density. This metric measures employment density by comparing the concentration of a specific occupation within the state to the national average. Sourced from the BLS May 2024 State Occupational Employment and Wage Estimates, Maryland's location quotient data was presented alongside data from neighboring states for regional comparison.

For the June 2026 meeting, this metric was updated to report the ratio of providers per 1,000 residents to better represent Maryland's specific labor market and workforce landscape. By demonstrating per capita workforce capacity, this revised metric illustrates the demand and available supply for occupations providing applicable HCBS. The ratio was calculated using BLS employment population data combined with U.S. Census Bureau state population data. Data from surrounding states was again included to provide a regional comparison.

3. Benchmarking and rate studies for HCBS conducted by the Department

Due to the tight implementation timeline, the previous rate study required by HB 1696 (Chapter 798 of the Acts of 2018) was utilized to present the Department's historical HCBS benchmarking

¹⁴ Payments for Services: General Provisions – Documentation of Access to Care and Adequate Payment Rates, 42 C.F.R. § 447.203 (2024). [https://www.ecfr.gov/current/title-42/part-447/section-447.203#p-447.203\(b\)\(1\)](https://www.ecfr.gov/current/title-42/part-447/section-447.203#p-447.203(b)(1))

¹⁵ While homemaker services were included as one (1) of four (4) service categories in legislation, no applicable homemaker services exist in current waivers or programs in Maryland

¹⁶ Occupational Employment and Wage Statistics Tables, U.S. Bureau of Labor Statistics (n.d.). <https://www.bls.gov/oes/tables.htm>

and rate analysis.¹⁷ This study evaluated the gap between FY 2019 reimbursement rates for HCBS and the estimated cost to providers, using publicly available sources to calculate the difference between estimated actual costs and the reimbursement rates. The study indicated that for all but one (1) service, the estimated actual cost of providing the service exceeded the reimbursement rate.

Maryland Medicaid significantly increased reimbursement rates between FY 2019 and FY 2025, resulting in a cumulative compounded rate increase of 50.4 percent. Specific provider rate increases for Long Term Services and Supports (LTSS) providers and their funding sources are listed in Appendix 3. Because an updated rate study had not yet been conducted to reflect these subsequent rate adjustments, the historical study does not accurately depict the current difference between actual service delivery costs and reimbursement amounts.

To effectively address ongoing HCBS rate disparities, the Department will utilize the HCBS Cost Survey launched in July 2026 to comply with the federal Payment Adequacy provision. This approach aligns with the existing cost data collection process used for DDA providers, which calculates cost-based rates to ensure providers are adequately supported and services meet participant needs. The survey will comprehensively capture actual provider expenditures by collecting data on employment-related expenses, direct care worker wages and benefits, facility costs, general and administrative expenses, and more.

The Department remains committed to conducting a new, representative HCBS rate study and presenting those updated findings at a future IPAG meeting ahead of the federal compliance deadline of July 9, 2027.

4. Rate information from neighboring or similarly situated States

During the December 2025 meeting, the initial analysis identified 11 services across neighboring states that were directly comparable to Maryland's offerings. To provide a more comprehensive overview, a broader comparison method was employed for the June 2026 meeting. This expanded approach involved reviewing active waiver applications and State Plans to identify services with overlapping functionalities, allowing for the inclusion of similar services even if they were not identical.

For these comparable services, rates were retrieved from Fiscal Year (FY) 2025 or the most recent fee schedules available on the respective state department websites. Then, these rates were converted into hourly equivalents and presented as ranges, consolidating similar services across different state programs. State-specific minimum wage data were also included to provide a baseline reference point.

Despite these adjustments in methodology, significant limitations remain because the services are ultimately not identical. Direct cross-state comparisons of HCBS or their reimbursement rates are inherently inconsistent due to several systemic factors. Primarily, wide variations exist across states regarding core service definitions and the specific types of support provided under a given

¹⁷ Task Force to Study Access to Home Health Care for Children and Adults with Medical Disabilities and Report on Home- and Community-Based Services, Md. Laws ch. 798 (2018).
https://mgaleg.maryland.gov/2018RS/chapters_noln/Ch_798_hb1696T.pdf

category. Additionally, individual states utilize differing licensing and reimbursement frameworks, meaning that providers are reimbursed at entirely different rates for the same service depending on the exact license they hold. This difference is compounded by differences in structural design, including divergent acuity tiers, geographical adjustments, and varying unit billing structures. Finally, ongoing programmatic modifications— such as constant administrative updates to state waiver applications and different rate update schedules— further obscure the data, making a standardized national baseline for comparison difficult to establish. Consequently, the cross-state data primarily demonstrates that similar service categories are covered across Maryland and its neighboring states rather than providing an exact rate comparison.

While these operational variances prevent a precise service-to-service comparison, the upcoming HCBS cost report data required under the federal Payment Adequacy provision will offer a much more reliable baseline. By evaluating programs through the uniform lens of workforce compensation rather than different service definitions, this framework will provide a clearer picture of rate sufficiency.

Furthermore, as other states implement their own Payment Adequacy provisions, these standardized cost reports will enable a more accurate, nationwide comparison of direct care worker compensation. Ultimately, this standardized data will help the Department determine if Medicaid payment rates are sufficient to maintain beneficiary access and support long-term workforce capacity.

5. Access to care metrics

The data reporting for these metrics is distinct from the access to care requirements mandated by the federal Access Rule and was uniquely required under Maryland HB 1142. The following metrics were analyzed and reported using claims data from the Medicaid Management Information Systems (MMIS2).

Number of beneficiaries receiving applicable services

The unduplicated number of beneficiaries who received applicable services was reported for FY 2021 through FY 2025. These recently updated figures diverge from previously reported data due to key methodology refinements and the inclusion of newly added service codes. Additionally, because FFS claims are subject to a 12-month runout period, the data for FY 2025 remains preliminary.

Number of utilization hours for applicable service categories

Utilization data was evaluated by tracking both billed hours and billed units of service from FY 2021 through FY 2025. Billed hours and units were reported separately to ensure comprehensive utilization tracking across all applicable services, regardless of their varying unit structures. Similar to the beneficiary count, these updated utilization metrics diverge from historical data due to methodology refinements and new service code additions. The FY 2025 utilization figures are also considered preliminary due to the standard 12-month FFS claims runout period.

Other data

This section details supplementary data sets presented to the IPAG that were not explicitly mandated by the federal Access Rule or HB 1142. These materials were published on the official IPAG website alongside the required disclosures to satisfy separate Access Rule provisions and address specific information requests from IPAG members.

1. Comparative Rate Analysis

While not an explicit requirement for IPAG, the Comparative Rate Analysis was published to satisfy the broader Comparative Rate Analysis and Payment Rate Disclosure provision within the Access Rule. To meet these federal transparency standards, the analysis presents all applicable service rates as of July 1, 2025, converted into hourly equivalents to ensure cross-program comparability. Additionally, the analysis includes the total volume of Medicaid-paid claims and the unduplicated count of Medicaid-enrolled beneficiaries who received each respective service during calendar year 2025.

2. Residential Service Agency (RSA) 2025 Annual Report

Pursuant to the Homecare Workers Employment Act of 2024 (HB 189/Health–Gen. § 15-156), the Maryland Department of Labor conducted its inaugural annual survey to collect wage data on personal care aides who provide HCBS.¹⁸ In response to requests from IPAG members to access this information, the raw survey responses from the 2025 Residential Service Agency Annual Report on Personal Care Aides were published on the IPAG website.

The dataset consists of 231 anonymous responses. Because these responses are entirely self-attested by the participating agencies, they have not been independently verified by the state. Future iterations of this annual survey will continue to be shared with the IPAG as they become available.

IV. Recommendations from the IPAG

Following the June 29, 2026 meeting, IPAG members were invited to submit written contributions for this report by July 17, 2026, to capture stakeholder insights and activities. Despite the varying perspectives, the contributions presented a shared consensus that persistent workforce shortages and low retention rates are the primary barriers to care for vulnerable Maryland residents. They noted that inadequate funding prevents providers from competing in the labor market, directly causing staffing shortages in the direct care workforce that lead to delayed care and understaffed authorized hours. To stabilize the workforce, the group agreed on the necessity of increasing Medicaid reimbursement rates for personal care services to enhance recruitment, improve retention, and ensure beneficiaries receive their approved care.

Beyond this consensus, individual members provided specific recommendations to address these challenges. These include proposals to establish a mandatory wage floor and guarantee comprehensive benefits, such as paid sick leave, for direct care workers. Additionally, some

¹⁸ Maryland Medical Assistance Program – Personal Care Aides – Wage Reports, Md. H.B. 189 (2024).
<https://mgaleg.maryland.gov/2024RS/bills/hb/hb0189E.pdf>

members highlighted the critical need to examine the LTSS*Maryland* infrastructure to allow interoperability with external provider software, thereby reducing administrative burdens. Furthermore, specific recommendations advised the State to evaluate overtime reimbursement rates to preserve continuity of care. Finally, members collectively requested leveraging the upcoming HCBS Cost Survey results to accurately evaluate the actual costs of delivering care and supply reliable data for future budgetary decisions. A complete compilation of these individual member contributions is detailed in Appendix 3.

Recommendations from Ms. Allison Yunda

On behalf of the National Domestic Workers Alliance, Worker Organization Representative Ms. Allison Yunda submitted three (3) key recommendations. First, to address high turnover rates highlighted in the 2025 RSA Annual Report, Ms. Yunda suggested establishing a \$20 per hour wage floor for direct care workers by 2030. To support this and align with the Access Rule's Payment Adequacy provision— which mandates allocating at least 80 percent of payment rates to direct care workers— she recommended increasing Medicaid reimbursement rates for personal care services. Second, Ms. Yunda advised providing dedicated funding to guarantee paid leave, noting that because the 2018 Earned Sick and Safe Leave law only applies to employers with 15 or more employees, very few providers offer paid sick leave, forcing employees to work while ill. Finally, she recommended expanding the IPAG mandate to require meetings at least quarterly and to adopt a public education and communication plan to actively engage the direct care workforce and consumers across Maryland.

Recommendations from Ms. Caitlin Houck

Representing the Maryland-National Capital Homecare Association (MNCHA), the Employer Trade Association Representative Ms. Caitlin Houck offered four (4) recommendations. Ms. Houck suggested an annual 3.5 percent increase in personal care service reimbursement rates for FY 2028 through FY 2030 to help providers remain competitive in the labor market and support the direct care workforce. Ms. Houck also urged an expedited analysis of the 2026 HCBS Cost Survey data immediately following the September 30, 2026 submission deadline, with findings provided to IPAG by December 31, 2026, to inform budget decisions during the 2027 legislative session.

Ms. Houck encouraged the Department to present current service provider reimbursement rates and cost-of-care data categorized by HCBS program or waiver type at a 2027 IPAG meeting to ensure equitable fund distribution and quality care outcomes. Ms. Houck also recommended evaluating the cost of enhancing the LTSS*Maryland* system's integration capabilities to interface with electronic medical records (EMR) and operational software systems used by the provider community, with findings to be presented at the 2027 IPAG meeting.

Recommendations from Ms. Erica Clifton

The RSA Representative Ms. Erica Clifton recommended establishing a targeted overtime reimbursement mechanism for applicable HCBS and private duty nursing services. Ms. Clifton stated that current reimbursement rates fail to address the costs of legally required overtime, contributing to provider instability, workforce shortages, caregiver turnover, and gaps in patient

care. To reflect the actual cost of service delivery, she suggested building a rate structure that reimburses eligible overtime at 1.5 times the base rate or creating a direct labor overtime add-on for personal assistance services, Certified Nursing Assistant/home health aide services, respite, companion services, and private duty nursing.

To ensure overtime is utilized only as necessary, Ms. Clifton recommended limiting reimbursement to authorized service hours and implementing a cap of 16 overtime hours per worker per week—mirroring Virginia's model—with exceptions separately authorized for extraordinary clinical or access-related needs. She also proposed requiring providers to maintain clear records and use a specific billing modifier to track overtime costs separately from base utilization.

Furthermore, Ms. Clifton suggested incorporating overtime usage and workforce compensation—such as benefits and livable wages—into the HCBS Cost Survey to evaluate rate sufficiency and monitor whether overtime reimbursement improves staffing outcomes and offered specific benchmarks.

Recommendations from Ms. Loraine Arikat

The Worker Organization Representative, Ms. Loraine Arikat from 1199 SEIU United Healthcare Workers East, recommended that the Department provide regular updates on the HCBS Medicaid Waiver waitlist to capture the growing demand for home health aide and personal care services. Additionally, Ms. Arikat urged the Department to initiate discussions on standardizing key benefits for home care workers across all personal care aide agencies, including paid sick leave and paid commute time, to address inadequate compensation. Ms. Arikat also emphasized the critical need to include direct care workers' voices in IPAG discussions to help shape solutions regarding adequate Medicaid rates, competitive wages and benefits, and workforce retention.

Recommendations from Dr. William Harvey

The RSA Representative Dr. William Harvey submitted six (6) recommendations to address challenges in beneficiary access to care. First, Dr. Harvey recommended increasing personal assistance service rates, as the current reimbursement structure hinders caregiver recruitment and retention. Second, Dr. Harvey stressed that workforce instability should be reframed and addressed as an access problem that disrupts service delivery, rather than an internal provider challenge, noting that frequent turnover and vacancies directly create barriers to care.

Third, Dr. Harvey pointed out that the current LTSS *Maryland* system should be evaluated to ensure it interacts smoothly with provider systems, connecting operational workflows to remove manual workarounds and administrative burden. Fourth, Dr. Harvey recommended providing dedicated funding for nursing oversight, which is currently a mandatory activity whose costs providers must absorb. Establishing explicit reimbursement for mandatory activities would provide needed relief for providers operating under strained reimbursement rates.

Fifth, Dr. Harvey suggested accounting for the real costs of mandated caregiver training, including onboarding, annual education, and documentation, in future rate-setting policies. Finally, Dr. Harvey proposed utilizing the HCBS Cost Survey to examine payment adequacy and

inform necessary rate adjustments, rather than completing the survey simply to fulfill a compliance requirement.

V. Conclusion

The Department has worked rigorously to meet the federal Access Rule requirements alongside the accelerated timelines mandated by HB 1142, allowing Maryland to become the first state in the nation to establish and convene an IPAG. While data collection and analysis methodologies continue to be refined to ensure the publication of meaningful data for IPAG members and the general public, the Department remains committed to collaborating with stakeholders.

The Maryland Department of Labor (MD Labor), a key partner in this work, is aware that direct care is both a fast-growing sector of the economy and one of the lowest-paid sectors. MD Labor is also aware that direct care workers are disproportionately likely to experience wage violations. MD Labor will continue to examine strategies to both deter and remedy wage violations and expand opportunities for the direct care workforce.

Moving forward, these ongoing partnerships will support efforts to ensure rate sufficiency across all HCBS while actively evaluating and addressing barriers to client access to care.

VI. Appendices

Appendix 1. Summary of data required by the Access Rule*

Required data	Availability	Applicability date	Source
Current and proposed payment rates	Transmittals, To be determined	July 9, 2026	42 CFR 447.203(b)(6)(iii)
Payment adequacy reports	HCBS Cost Survey	July 9, 2027	42 CFR 441.302(k)
Access to care metrics - Average wait time for new beneficiaries (initial approval to start of services)	To be determined	July 9, 2027	42 CFR 441.311(d)(2)(i)
Access to care metrics - Percentage of authorized service hours actually delivered	To be determined	July 9, 2027	42 CFR 441.311(d)(2)(ii)

*The actual data files are available on the dedicated IPAG website under the Materials section <https://health.maryland.gov/mmcp/longtermcare/Pages/Interested-Parties-Advisory-Group.aspx>.

Appendix 2. Summary of data required by HB 1142*

Required data	Availability	Applicability date	Source
HCBS payment transparency reports	Transmittals	July 9, 2026	42 CFR 447.203(b)(1)

BLS publicly available wage data and other labor market and workforce data	Available and reported	At least 30 days before the meeting	HB 1142
Benchmarking and rate studies for HCBS conducted by the Department	HCBS Cost Survey	At least 30 days before the meeting	HB 1142
Rate information from neighboring or similarly situated States	Available and reported	At least 30 days before the meeting	HB 1142
Access to care metrics - Number of beneficiaries receiving applicable services	Available and reported	At least 30 days before the meeting	HB 1142
Access to care metrics - Number of utilization hours for applicable service categories	Available and reported	At least 30 days before the meeting	HB 1142

*The actual data files are available on the dedicated IPAG website under the Materials section <https://health.maryland.gov/mmcp/longtermcare/Pages/Interested-Parties-Advisory-Group.aspx>.

Appendix 3. LTSS provider rate increases from FY 2019

The following lists the past LTSS provider rate increases funded by the State budget, HB 166/SB 280 *Labor and Employment – Payment of Wages – Minimum Wage (Fight for Fifteen)* (Chs. 10/11 of the Acts of 2019),¹⁹ the Governor’s Supplemental Budget,²⁰ American Rescue Plan Act (ARPA),²¹ and SB 555 *The Fair Wage Act of 2023*.²²

- 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, emergency 4% rate increase by ARPA 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

¹⁹ Labor and Employment – Payment of Wages – Minimum Wage and Enforcement (Fight for Fifteen), Md. H.B. 166 (2019). https://mgaleg.maryland.gov/2019RS/chapters_noln/Ch_10_hb0166E.pdf

²⁰ 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>

²¹ For more information regarding MDH’s ARPA spending plan, see the quarterly updates posted here: <https://health.maryland.gov/mmcp/Pages/Public-Notices.aspx>

²² Fair Wage Act of 2023, Md. S.B. 555 (2023). 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 remained unchanged and did not receive an increase.
- FY 2027: Service rates remained unchanged and did not receive an increase.

Not all rate increases applied to the providers delivering services for the DDA and the Behavioral Health Administration (BHA) programs, as they received different rate adjustments.

Appendix 4. Recommendations from IPAG members

Recommendations from Ms. Allison Yunda

(1) Create a Wage Floor of \$20 an hour by 2030.

The most pressing and critical way to stabilize the direct care workforce, i.e., recruiting more care workers to meet the need and retaining the caregivers, is to offer competitive wages. Turnover continues to be a persistent problem, as verified by the provider data collected by the Maryland Department of Labor pursuant to the Homecare Workers Employment Act of 2024, which noted around a 28 percent turnover rate and was consistent across providers with varying sizes.

Competitive wages entail not only higher reimbursement rates for personal care services (as the largest service of the three identified for the IPAG) to agencies, but also a guarantee that those rate increases are passed through as compensation to the workforce. This was the impetus behind the Access Rule, which established the target national minimum standards of 80 percent of rates being passed on to the workforce in the form of compensation. A competitive wage necessarily has to be higher than the minimum wage in the state, which is \$15 per hour. To be competitive, home care workers should earn at minimum 150 percent of the minimum wage, at \$22.5 per hour. Also, given the affordability crisis that communities of color and low-wage workers are facing due to rising costs that also stem from higher rates of inflation, care jobs must be good jobs in order to fill the growing need, as the aging population continues to grow in the state of Maryland. The rates must be sufficient operationally to offer competitive wages and the necessary overhead to agencies.

Currently, Residential Service Agencies are entitled to a reimbursement rate for personal care services at \$6.40 per 15 min, or **\$25.60 per hour**. It is notable that the recommended reimbursement rate as part of the most recent 2018 rate study recommended an increase to \$25.54 in 2019. It has taken an additional seven (7) years to reach that level, and other industries such as retail and fast food have significantly raised their wages in these interim years. Maryland's neighboring states have higher reimbursement rates; Delaware's current reimbursement rate is \$29.51, and Pennsylvania's is \$33.32 (personal care services are the largest of the programs/service codes under the IPAG mandate and impact the greatest number of workers).

In 2030, the Access Rule will mandate that 80 percent of the reimbursement rate for personal care services go towards compensation for direct care workers. The definition of compensation includes wages and benefits as well as the employers' share of payroll taxes (Federal Insurance

Contributions Act (FICA), 7.65 percent of income).

If we consider 80 percent of the current rate, guaranteed compensation would total \$20.48 per hour. If we estimate that employers' costs for benefits are approximately 20 percent of an employee's base wage. This takes into consideration: unemployment insurance, workers' compensation insurance, the new Maryland Family and Medical Leave Insurance (FAMLI) program, as well as the employer's share of FICA payroll taxes (Social Security & Medicare), and guaranteed paid sick leave. At \$20.48, employers can currently afford to give a base wage of \$17 per hour. To combat turnover, there must be guaranteed graduated increases over time.

Year	Required Hourly Wage	Wages + Benefits (with payroll taxes)	Medicaid Reimbursement Rate Required to Meet 80/20 standard	Percentage Reimbursement Increase *
2026	\$17.00	\$20.40	\$25.60	0
2027-2028	\$18.00	\$21.60	\$27.00	5.47%
2029	\$19.00	\$22.80	\$28.50	5.56%
2030	\$20.00	\$24.00	\$30.00	5.26%

*Amount by which PCS reimbursement rates will need to increase to allow employers to dedicate 80% of rate to meet proposed direct care worker compensation (base wage, benefits, and employer share of payroll taxes) obligations.

(2) Funding to Guarantee Paid Sick Leave

Currently, Maryland's 2018 Earned Sick and Safe Leave law only guarantees paid sick time for employers with 15 or more employees. Only 32 of the 231 Providers in the aforementioned data collection conducted by the Maryland Department of Labor indicated that they offer paid sick leave— which is only 14 percent. The ability to preserve one's own health while delivering long-term care services to those in need is vital, and direct care workers should not feel pressure to report to work when ill, or face challenges to their economic security should they fall ill.

Agencies should be able to receive funding separately that guarantees **paid** sick time for all personal care aides, 24 hours upfront (around three (3) days), and then offering paid leave accrued thereafter at the same rate as law mandates (one (1) hour for 30 hours worked). Ensuring that home care workers are able to utilize paid sick time is also necessary to protect the health of the Medicaid beneficiaries who rely on their services.

(3) Expansion of IPAG's mandate

The IPAG should meet at least on a quarterly basis and also adopt a public education and communication plan to engage the broader direct care workforce and consumers across the state as part of its mandate. The cost survey offered an opportunity for Maryland to do deep engagement with providers in the state, and there is not an analogous plan for the direct care workers and consumers, which is one (1) of the goals of the IPAG: to elevate their voices and ensure inclusion

of their perspectives.

Recommendations from Ms. Caitlin Houck

Utilization of the New Medicaid HCBS Cost Survey

As the Department's first Medicaid HCBS Cost Survey is currently being implemented and more data is being collected to paint a clearer picture of the HCBS care ecosystem, it is important to consider these recent efforts within the greater historical context that is marked by Maryland's longstanding underinvestment in Medicaid HCBS services.

Personal care agencies are currently reimbursed \$25.59 per hour. This rate has been in place since FY 2025 (July 1, 2024), and level-funding was approved for the two (2) most recent fiscal years. Prior to FY 2025, there were annual increases in Medicaid personal care reimbursement for three (3) consecutive years in FY 2022 - FY 2024 due to pandemic-related investments and the State's minimum wage increase. The current reimbursement rate is still far short of the \$24.80 hourly rate recommended by the 2018 Hilltop study that was required by the General Assembly. If adjusted for inflation (3.0 percent annually), this rate would now be \$31.42.

In a recent IPAG meeting during the presentation of the draft cost survey, the Department and Myers and Stauffer LC indicated that they expected it to take three (3) years of survey responses to result in data robust enough for the State to use in setting its rate build-up methodology. To this end, and in light of the historical underinvestment discussed above, it is not reasonable to postpone any and all decisions on reimbursement rate improvements over the next three (3) years.

Recommendation 1: Maryland-National Capital Homecare Association (MNCHA) strongly suggests that the IPAG endorse an annual 3.5 percent increase in the personal care service reimbursement rates for each of the next three (3) years, FY 2028 through FY 2030.

Reasoning: In the absence of any increase for what will be the three (3) most recent fiscal years, this provides an interim mechanism for personal care service providers to remain competitive in the labor market and address the immediate and short-term needs of the direct care workforce, who are central to service provision and care access. This rate is less than the average rate increase for LTSS programs from FY 2017 through FY 2027; it is on par with the rate increases for DDA- and BHA-operated programs within the same period, and it is also on par with the current national inflation rate.

Recommendation 2: MNCHA recommends that Myers and Stauffer LC perform an expedited analysis of the 2026 HCBS Cost Survey data immediately following the close of the survey on September 30, 2026, and present back to the IPAG, at a minimum, its preliminary findings on the cost of care across and within service types on or before December 31, 2026.

Reasoning: This serves as a valuable baseline for reimbursement rate sufficiency and provides more immediate insight into where gaps could exist between current rates versus the actual cost of care. This is also critical information for IPAG members, all relevant HCBS stakeholders, policymakers, and legislators to have prior to the start of the 2027 session when budget

decisions are being made.

Equitable Program Utilization of Medicaid HCBS Funds

The Medicaid HCBS Cost Survey will examine the cost of care by service type. In order for the IPAG to take a whole-system approach to considering rate sufficiency and access to care obstacles, it is important for current reimbursement rates and costs to also be compiled and analyzed by service provider within the program and waiver type. For example, within the Community Personal Assistance Services (CPAS) Program, program services include nurse monitoring, personal assistance services, and supports planning. For every dollar that Maryland Medicaid spends on the CPAS Program, the percentage that is spent on each of these three services is valuable comparative data.

Data presented in this manner will help the IPAG ensure equitable utilization of Maryland Medicaid's dollars across provider types, particularly as greater emphasis will be placed on quality and outcomes within HCBS programs in the future. Additionally, it will allow a closer examination of any unintended consequences that could lead to reduced provider capacity. This aligns with the Department's existing provider capacity concerns, which were detailed in its 2024 Joint Chairmen's Report.

Recommendation 3: MNCHA recommends that the Department, with the assistance of Myers and Stauffer LC, present current service provider reimbursement rates and costs of care (the latter per the 2026 HCBS Cost Survey results) by HCBS program or waiver type at a scheduled calendar year 2027 IPAG meeting.

Reasoning: It has already been established that there is not historically a consistent methodology being applied to rate setting within Maryland Medicaid's HCBS programs, and the State's Medicaid funds continue to be stretched. In its advisory capacity and based on its role in ensuring adequate access to services, the IPAG needs more data to establish the extent to which there is equitable utilization of funds among the various service providers relative to one another and in a manner that reflects the impact of each service type on care quality and outcomes.

Investments in Integrated Technology

The availability and ease of technology integration is a key factor that also relates to developing provider capacity and system-wide efficiencies that promote and sustain access to care within Maryland's Medicaid programs. *LTSSMaryland*, as a closed system, hampers the service providers who must utilize it for end-to-end operations— scheduling, Electronic Visit Verification (EVV) and documentation compliance, communication and service delivery, and billing. More software improvements to *LTSSMaryland* are needed on a routine basis, and it should be able to integrate with the EMR and operational software systems that the provider community utilizes so that workflows can be made more efficient, thereby minimizing manual processes, duplication and errors, and uncompensated administrative burden.

Recommendation 4: The Department should examine the cost of building integration capabilities within its current *LTSSMaryland* system and perform a comparative cost analysis among alternative systems that already have these capabilities. This should be presented at a scheduled calendar year 2027 IPAG meeting.

Reasoning: Planning and investment in technology infrastructure in a manner that enhances the capabilities of all its users and creates a repository of robust, reliable data is central to Maryland Medicaid's future program capacity and integrity. This is especially true as the Department enhances its compliance expectations and requirements of provider agencies, and as the importance of program quality and outcomes continues to grow. Integrated networks are a keystone component of the Department supporting provider network adequacy and meeting the future volume of qualified beneficiaries.

Recommendations from Ms. Erica Clifton

Recommended Position

Several important issues have already been identified by providers and stakeholders, including rate adequacy, workforce instability, caregiver recruitment and retention, provider administrative burden, required Registered Nurse (RN) oversight, mandated caregiver training, and the need for the HCBS Cost Survey to lead to meaningful action. The recommendations also make clear that access is not just about whether services are approved on paper, but whether providers can actually staff, support, and sustain those services in the community. My recommendation is intended to build on those concerns by adding one (1) additional issue that should be evaluated: whether Maryland Medicaid should establish an overtime reimbursement rate for applicable home- and community-based services and private duty nursing services when overtime is necessary to maintain continuity of care.

At its core, this is still an access issue. Participants may be approved for Medicaid services, but approval alone does not guarantee care. Real access means that a qualified caregiver, aide, Licensed Practical Nurse (LPN), or RN is available to work the shift, remain on the case, and provide consistent care over time. When providers cannot pay competitive wages, cannot cover legally required overtime, and cannot support employee benefits, the workforce becomes unstable. That instability shows up as delayed starts of care, unfilled hours, caregiver turnover, provider refusals, family stress, and avoidable gaps in care.

Maryland Medicaid should therefore evaluate rate sufficiency not only by looking at the base reimbursement rate, but by looking at whether the rate structure supports the real cost of delivering care. That includes livable wages, applicable overtime, payroll taxes, workers' compensation, supervision, training, benefits, EVV compliance, scheduling, billing, and administrative support. A rate that only works when every hour is straight-time is not fully sufficient for high-hour, medically complex, or hard-to-staff cases.

Why Overtime Should Be Part of the Rate Adequacy Conversation

Maryland's current Medicaid rates may appear workable in some service categories when viewed only as straight-time rates. For example, Maryland's FY 2025 CFC and Community Personal Assistance Services personal assistance rate is \$6.3962 per 15-minute unit, or approximately \$25.58 per hour. The shared attendant rate is \$4.2597 per 15-minute unit, or approximately \$17.04 per hour. For nursing services, Maryland's FY 2025 rate for one-participant RN services is \$19.8739 per 15-minute unit, or approximately \$79.50 per hour, and the LPN rate is \$12.8813 per 15-minute unit, or approximately \$51.53 per hour.

The issue is that providers do not operate only in a straight-time world. Federal overtime requirements generally require covered nonexempt employees to be paid at least one (1) and one-half (1/2) times their regular rate of pay for hours worked over 40 in a workweek. When overtime is necessary to keep a case staffed, the provider may be required to pay the caregiver or nurse at time-and-a-half (1.5), even though Medicaid reimbursement remains at the same base rate.

That creates a real financial problem. For example, if an LPN is paid \$35 per hour, the overtime wage alone becomes \$52.50 per hour. Maryland's LPN reimbursement rate is approximately \$51.53 per hour, which means the reimbursement does not even fully cover the overtime wage before payroll taxes, workers' compensation, insurance, supervision, compliance, documentation, scheduling, billing, and administrative costs are considered. The provider is then placed in a difficult position: absorb a loss, split the case among more workers, decline the case, or risk leaving authorized hours unstaffed. None of those outcomes support access.

Why Livable Wages and Benefits Matter

Paying caregivers a livable, market-competitive wage, along with applicable overtime when overtime is necessary, would not only help maintain continuity of care for participants but would also support a more stable and sustainable caregiver workforce. When reimbursement rates allow providers to pay fair wages and cover legally required overtime, providers are better positioned to recruit and retain qualified caregivers, reduce turnover, and offer or maintain employee benefits such as health insurance, dental, vision, paid leave, retirement support, life and disability coverage, tuition assistance, and other workforce supports.

This point is directly connected to the Access Rule. Federal HCBS Payment Adequacy provision defines direct care worker compensation to include salary, wages, other remuneration, benefits such as health and dental benefits, paid leave, retirement, and tuition reimbursement, as well as the employer share of payroll taxes. That means benefits should not be treated as separate from rate adequacy. Benefits are part of workforce compensation, and workforce compensation is part of access.

Caregiver benefits are not just a "nice to have." They affect whether workers can afford to stay in the field. If caregivers leave for jobs with better wages, more predictable schedules, and stronger benefits, Medicaid participants experience the consequences. They lose familiar caregivers. Families have to retrain new staff. Providers struggle to fill open shifts. Participants may receive fewer hours than authorized. In high-acuity cases, disruptions can create safety risks.

For that reason, Maryland should treat caregiver wages, overtime, and benefits as part of the access infrastructure. A strong HCBS system depends on a strong workforce. A strong workforce requires a reimbursement structure that reflects the actual cost of keeping qualified workers in the field.

Access to Care Challenges

The Access Rule makes clear that access to HCBS must be evaluated in practical terms, including payment adequacy, direct care worker compensation, waiting lists, service delivery timeliness, quality measures, and public transparency. Federal regulations also state that HCBS

payment rates must be adequate to ensure a sufficient direct care workforce to meet beneficiary needs and provide access to services in the amount, duration, and scope specified in person-centered service plans.

Maryland's own data shows that access challenges are real. As of June 30, 2025, the Community Options Waiver registry had 23,461 registrants, up from 22,349 one (1) year earlier, with an average of 650 individuals added to the registry each month during FY 2025. Maryland also acknowledged that provider capacity is critical to serving participants and that nationwide shortages in direct service professionals and nursing workforces will present a greater challenge. The same report notes that the IPAG will advise on Medicaid payment rate sufficiency and provider network adequacy for access to homemaker services, home health aide services, personal care services, and habilitation services.

This is not a Maryland-only issue. KFF reported that all responding states reported home care workforce shortages in 2025, including shortages among direct support professionals, nursing staff, personal care attendants, home health aides, and certified nursing assistants. KFF also reported that 41 states experienced permanent closures of home care providers within the prior year.

These facts support one (1) clear conclusion: Maryland cannot evaluate access without evaluating workforce economics. If the reimbursement structure does not support livable wages, benefits, and applicable overtime, then the reimbursement structure itself contributes to access barriers.

Virginia's Overtime Logic

Maryland does not have to build this idea from scratch. Virginia has already recognized that overtime can be necessary in Medicaid-funded home care. Virginia Medicaid authorized time-and-a-half (1.5) for consumer-directed personal assistance, respite, and companion services for a single attendant who works more than 40 hours per week. The Virginia model allowed up to 16 overtime hours beginning July 1, 2021, meaning a non-live-in attendant could work up to 56 hours per week, with hours over 40 paid at time-and-a-half (1.5) times the regular rate. Virginia also included an important guardrail: the hours worked must remain within authorized service hours.

Maryland should consider using similar logic. The purpose would not be to encourage unnecessary overtime. The purpose would be to recognize that overtime sometimes becomes the most practical, safest, and most stable way to maintain care, especially when a participant has complex needs, limited available caregivers, overnight coverage needs, or a high number of authorized hours.

Recommendation

Maryland Medicaid should create a targeted overtime reimbursement mechanism for applicable HCBS and private duty nursing services.

The recommendation should include the following elements:

1. **Eligible services.** The overtime rate should apply to applicable direct care services where continuity of care is essential, including personal assistance services, Certified Nursing Assistant/home health aide services, respite, companion services, private duty nursing, and other comparable HCBS categories.
2. **Trigger for payment.** The overtime rate should apply when a nonexempt employee works more than 40 hours in a workweek providing authorized Medicaid-covered services.
3. **Rate structure.** Maryland should reimburse eligible overtime hours at time-and-a-half (1.5) times the applicable Medicaid base rate, or at minimum create a direct labor overtime add-on equal to the additional half-time premium.
4. **Weekly cap.** Maryland should consider a cap of up to 16 overtime hours per worker per week, similar to Virginia’s model, unless additional overtime is separately authorized due to extraordinary clinical or access-related need.
5. **Authorized-hours limitation.** Overtime should only be reimbursed when the hours are already authorized in the participant’s plan of care or plan of service. This keeps the policy focused on access and continuity, not unnecessary service expansion.
6. **Documentation requirements.** Providers should be required to maintain payroll records, EVV records where applicable, schedule records, and documentation showing that the overtime hours were worked for authorized Medicaid services.
7. **Billing mechanism.** Maryland should create a clear overtime modifier or billing code so the overtime cost can be tracked separately from base service utilization.
8. **Cost survey inclusion.** Maryland’s HCBS Cost Survey should ask providers whether overtime is used, how often it is necessary, whether it is reimbursed, what the financial impact is, and whether lack of overtime reimbursement contributes to case refusals, missed shifts, or reduced provider capacity.
9. **Workforce and benefits analysis.** The cost survey evaluates whether current rates allow providers to offer livable wages and employee benefits. This includes health insurance, dental, vision, paid leave, retirement, training support, and payroll-related costs.
10. **Access monitoring.** Maryland should track whether overtime reimbursement improves staffing outcomes, including fewer missed shifts, fewer unstaffed authorized hours, improved worker retention, reduced participant disruptions, and fewer provider refusals for high-hour cases.

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Recommendations from Ms. Loraine Arikat

Recommendation: Provide MDH updates on HCBS Medicaid Waiver Waitlist

As Maryland's aging population grows, the demand for the services of home health aides and personal care aides will continue to increase. The demand is demonstrated by Maryland's Medicaid waiver waitlist for HCBS. An additional equity consideration includes centering the voices of Marylanders struggling to access home care services in our IPAG discussions.

Recommendation: Establish discussion on the benefits that home care workers need versus the number of agencies providing it

Despite the increasing demand and essential nature of home care, the caregiving work of personal care aides is still not valued—workers receive low pay and few benefits. It would be helpful to discuss how to make paid sick leave, paid commute time, and other benefits a standard in Maryland home care jobs.

In Maryland, there are approximately 51,200 direct care workers, the majority of whom are Black and women of color. 1199 SEIU believes that those closest to the problem are often closest to the solution. Thus, it is imperative to ensure direct care workers' voices lead the state to adequate Medicaid rates that can increase wages, benefits, improve retention, and ensure the state has the workforce to deliver high-quality care to our state's most vulnerable.

Recommendations from Dr. William Harvey

1. Maryland should move toward a meaningful rate increase for personal assistance services

If the State wants to improve access to personal assistance services, it has to be willing to talk seriously about rates.

The biggest barrier we face is not a lack of need. It is not a lack of eligible participants. It is not even a lack of providers willing to do the work. The biggest barrier, more and more, is that the reimbursement structure does not allow providers to pay caregivers at a level that keeps pace with the labor market and supports a stable workforce.

That matters because access to care lives and dies with the workforce.

If providers cannot recruit and retain enough caregivers, then services cannot be staffed consistently. Cases sit open. Starts of care are delayed. Families wait. Participants experience disruptions. Providers are forced to make difficult decisions about what they can reasonably accept and sustain. None of that is theoretical. That is what inadequate rates look like in practice.

So when we talk about the Access Rule and what it is asking states to evaluate, I think we need to be very plain: if the rate does not support a viable caregiver wage structure, then the rate is contributing to a barrier to access.

Maryland should use this moment, and this cost survey, to take a real look at whether personal assistance reimbursement is sufficient to:

- Recruit caregivers,
- Retain caregivers,
- Reduce turnover,
- Support continuity of care, and
- Maintain provider participation across the State.

If the answer is no, then the rate needs to change.

2. Workforce instability should be treated as an access problem, not just a provider problem

Too often, caregiver recruitment and retention are framed as internal provider challenges. I believe that is too narrow.

When a participant has services authorized but no available caregiver to work the case, that is not simply an internal staffing inconvenience. That is an access problem.

When a provider cannot fill a schedule, cannot sustain a case, or loses caregivers because wages are not competitive enough to hold them, that directly affects whether Marylanders can receive the services they have been approved for. That is exactly the kind of issue IPAG should be elevating.

I would strongly encourage the final report to connect workforce instability to access explicitly. That means acknowledging that:

- Low reimbursement contributes to wage pressure,
- Wage pressure contributes to turnover and vacancy,
- Turnover and vacancy contribute to delayed or unstable services, and
- Delayed or unstable services undermine meaningful HCBS access.

The workforce is not adjacent to the access conversation. It is the access conversation.

3. Maryland should be more open and practical when it comes to provider technology and system integration

I also believe the State should take a harder look at how LTSS*Maryland* and related systems interact with provider operations.

Providers today are expected to manage billing, scheduling, EVV, compliance, documentation, communication, and service delivery across multiple systems. The more disconnected those systems are, the more providers are forced into manual workarounds, duplicate entry, administrative burden, and avoidable inefficiency.

That burden does not stay in the back office. It pulls time, energy, and resources away from what should matter most: staffing, participant support, caregiver engagement, and service quality.

Maryland should move toward a more open and practical approach to allowing provider electronic medical records and operational systems to connect with LTSS*Maryland* in a structured and supported way. That includes the ability to better manage:

- Billing,
- Scheduling,
- Caregiver location and EVV workflows,
- Service corrections,
- Compliance monitoring and internal reporting.

This is not just a convenience issue. Administrative inefficiency is a real cost driver and, over time, it becomes another access issue because it weakens provider capacity.

If the State wants a strong HCBS network, it should want providers spending less time fighting systems and more time serving participants.

4. Maryland should address reimbursement for required RN assessments and oversight

Another area that deserves direct attention is the cost of required RN assessments and nursing oversight.

Providers are expected to complete RN assessments and provide ongoing clinical oversight where required. Those functions are not optional. They are mandated parts of compliant service delivery. And yet, in practice, agencies are often expected to absorb those costs inside a reimbursement structure that is already strained.

That means providers are expected to carry the cost of:

- Initial RN assessments,

- Ongoing nursing supervision,
- Documentation,
- Medication-related oversight,
- Retraining or instruction when indicated,
- Travel time, and
- The administrative coordination that comes with all of the above.

If Maryland requires those activities, then Maryland should be willing to address how they are paid for.

I believe the State should seriously consider either:

- A separate reimbursement for RN assessments and supervisory activities, or
- A more explicit adjustment to the personal assistance rate methodology that accounts for those required nursing functions.

It is difficult to talk honestly about provider cost without talking about nursing oversight, because those costs are real, recurring, and directly tied to regulatory compliance.

5. Maryland should recognize the cost of mandated caregiver training

The same is true for mandated caregiver training.

Providers are expected to onboard, train, monitor, document, and in some cases retrain caregivers in accordance with State requirements and operational expectations. Even where those requirements are appropriate, they still come with real cost.

That includes:

- Orientation,
- Required training topics (such as Alzheimer's and Dementia training),
- Refresher/annual education,
- Documentation and tracking,
- Staff time spent coordinating or delivering the training, and
- Time spent making sure training is current and defensible in the event of audit or review.

Those costs are often treated as if they are simply absorbed by providers as part of “doing business.” But if the State expects that training to happen, and expects it to happen well, then the financing structure should reflect that reality.

In my view, the final report should recommend that Maryland explicitly examine mandated training costs in the HCBS Cost Survey and consider how those costs are recognized in future rate development.

6. The cost survey should drive action, not just produce a report

Finally, I would urge that the upcoming HCBS Cost Survey not be treated as a compliance exercise alone.

Maryland has an opportunity here to do something meaningful. The survey can either become one (1) more reporting obligation, or it can become a real tool for understanding what it actually costs to provide HCBS in today’s environment.

That means asking the right questions and being willing to act on the answers.

If the cost survey shows that rates are not supporting adequate caregiver wages, required nursing oversight, training obligations, technology needs, and basic provider sustainability, then the report should say that clearly. And if the report says that clearly, it should lead to real policy discussion about rate adequacy and access improvement.

Anything less will feel disconnected from the reality providers, caregivers, and participants are living every day.

Conclusion

I believe Maryland’s HCBS system is too important for us to be vague in this moment.

If we want people to remain safe in the community, then we need a provider network that can actually deliver on that promise. That requires more than authorizations and program design. It requires rates that support workforce stability, reimbursement that reflects required oversight and training, and systems that do not unnecessarily burden the very providers the State depends on.

So my recommendations are straightforward:

1. Reevaluate and meaningfully increase personal assistance reimbursement.
2. Treat workforce instability as an access issue.
3. Improve LTSS*Maryland* openness and interoperability with provider systems.
4. Address reimbursement for required RN assessments and oversight.
5. Recognize mandated caregiver training costs in rate policy.
6. Use the HCBS Cost Survey to drive real action on access and payment adequacy.

These recommendations are offered respectfully, but also urgently, because the challenges they address are not abstract. They are showing up every day in the field, in provider operations, in caregiver staffing, and in determining whether Marylanders can actually receive the care they have been approved for.

That, ultimately, is the standard I believe this report should be working toward.