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Executive Summary

The *Evaluation of Rate Enhancement Programs* is submitted pursuant to the 2024-25 General Appropriations Act, House Bill (H.B.) 1, 88th Legislature, Regular Session, 2023 (Article II, Health and Human Services Commission [HHSC], Rider 30(d)).

Rider 30(d) requires HHSC to evaluate the rate enhancement programs paid in the Medicaid program to providers to increase reimbursements for direct care and attendant care services. The agency was also required to:

> Report on certain financial information regarding rate enhancement programs, including, but not limited to, the funding impact, by provider type and service, of the operation of the rate enhancement programs, the percentage of providers and services that participate in the programs, the efficacy of the programs in recruiting and retaining the workforce necessary to deliver services, and the cost of participation to providers for complying with the program requirements.

The full language of Rider 30(d) is provided in Appendix A.

1. Background

HHSC administers the Attendant Compensation Rate Enhancement Program and the Direct Care Staff Enhancement programs for eligible Medicaid fee-for-service contracted providers. Participating providers receive increased funding to incentivize higher compensation for attendants and direct care staff. Participating providers agree to spend the increased funds to meet program requirements, or they will be subject to recoupment of the Rate Enhancement funding.

For the remainder of the report, the term Rate Enhancement will represent both programs unless specifically stated.

History

The 76th Texas Legislature established the Direct Care Staff Enhancement program for nursing facilities and the Attendant Compensation Rate Enhancement program for community care providers.[1] These two programs were first implemented on September 1, 2000.

The 81st Texas Legislature expanded Attendant Compensation Rate Enhancement to include intellectual and developmental disability (IDD) providers delivering services, including through the Home and Community-based Services 1915(c) waiver (HCS), Texas Home Living 1915(c) waiver (TxHmL), or the Intermediate Care Facilities for Individuals with Intellectual or Developmental Disabilities (ICF/IID) program.[2] This expansion was implemented on September 1, 2010.

Title 1 of the Texas Administrative Code (1 TAC) Section 355.112, Attendant Compensation Rate Enhancement, and 1 TAC Section 355.308, Direct Care Staff Rate Component, govern the Rate Enhancement programs.

For more information on Rate Enhancement Authority, see Appendix B.

[1] H.B. 1, 76th Legislature, Regular Session, 1999 (Article II, Department of Human Services, Riders 37-38).
[2] Senate Bill (S.B.) 1, 81st Legislature, Regular Session, 2009 (Article II, Health and Human Services Commission, Rider 67).

Purpose of the Attendant Compensation Rate Enhancement Program

The original purpose of the Attendant Compensation Rate Enhancement program was to create a mechanism to allow participating providers to pay wages for attendant staff above the federal minimum wage. The program's intent was to incentivize community care providers to increase wages and benefits for personal attendant staff who were mostly paying the federal minimum wage in 1999 when the program was initiated.

As originally implemented, 1 TAC Section 355.112 froze the attendant portion of the rate, except for increases to the federal minimum wage:

> The attendant compensation rate component will remain constant over time, except for adjustments necessitated by increases in the minimum wage. In such cases, adjustments to the nonparticipating rates are limited to ensuring that these rates are adequate to cover mandated minimum wage levels.

In the original version of 1 TAC Section 355.112(l) and (m), the attendant portion of the rate for providers not participating in the Attendant Care Rate Enhancement program was limited to rates in effect on September 1, 1999. The rates effective on September 1, 1999, were sufficient to support the federal minimum wage at the time of $5.15 per hour. The attendant portion of the rate for participating providers was equal to the effective rates plus the Attendant Care Rate Enhancement add-on amounts.

It is HHSC's position that rate enhancement was built on the assumption that the federal minimum wage would increase over time. Consequently, changes in the federal minimum wage were expected to lead to proportional increases in the base attendant wage. The Attendant Compensation Rate Enhancement program was meant to continue to serve as an additional incentive above the federal minimum wage.

Additional information regarding the federal minimum wage is provided in the Key Considerations section of this report.

Purpose of the Direct Care Staff Enhancement Program

The original purpose of the Direct Care Staff Enhancement program was to incentivize providers to staff nursing facilities with registered nurses (RNs) and Licensed Vocational Nurses (LVNs) at higher levels and wages than what was occurring prior to the program's implementation. The program incentivized providers to staff at higher levels by establishing minimum staffing levels in the form of "minimum required LVN equivalent minutes per resident day of service" for participating providers by providing additional funding to support higher compensation for direct care staff. Providers receiving the additional funds are required to demonstrate compliance with enhanced staffing requirements associated with each enhancement level.

Additional information regarding the original program's purpose and the Quality Incentive Payment Program (QIPP) are provided in the Key Considerations section of this report.

2. Rate Enhancement Overview

HHSC administers Rate Enhancement for eligible HHSC-contracted providers who deliver services in the Medicaid fee-for-service model. Managed Care Organizations (MCOs) are required to offer an attendant rate enhancement program for their contracted providers delivering services in STAR+PLUS. However, MCOs are not directed on how to implement or administer their respective rate enhancement programs. Since HHSC maintains a minimum fee schedule for nursing facilities, HHSC administers the Direct Care Staff Enhancement program for nursing facility providers with both fee-for-service and managed care contracts. The information contained in this report is related to the Rate Enhancement programs administered by HHSC unless specifically stated otherwise.

Participation in Rate Enhancement is voluntary. As mentioned above, participating providers receive increased funding to incentivize higher compensation for attendants and direct care staff. Participating providers agree to spend the increased funds to meet program spending requirements. Providers who fail to meet spending requirements are subject to recoupment of Rate Enhancement funding.

Eligible Programs/Services

HHSC-contracted providers who provide services under the following programs are eligible to enroll in Rate Enhancement. The Direct Care Staff Enhancement Program is administered for nursing facility services. The Attendant Compensation Rate Enhancement program is administered for:

- Community Living Assistance and Support Services (CLASS) – Direct Service Agency (DSA);
- Day Activity and Health Services (DAHS);
- Deaf-Blind with Multiple Disabilities Waiver (DBMD);
- Home and Community-based Services (HCS);
- Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions (ICF/IID);
- Primary Home Care (PHC), Community Attendant Services (CAS), Family Care (FC);

- Residential Care (RC); and
- Texas Home Living (TxHmL).

Appendix C provides a full list of programs and services that are eligible to participate in the Rate Enhancement programs.

Ineligible Programs and Services

Multiple services that are eligible for the Attendant Compensation Rate Enhancement program also have a Consumer-directed Services (CDS) service delivery option. However, only the services delivered through the traditional "agency option" are eligible for the program. In other words, services delivered through CDS are not eligible for Rate Enhancement. Determining compliance for the CDS client, who is the employer of record, would be administratively burdensome for the client and HHSC. The current CDS rate methodology adds the attendant compensation rate enhancement add-on associated with the average participating agency provider's rate enhancement level to the CDS rate minus $1.00 to address the exclusion from the Attendant Compensation Rate Enhancement program. While the CDS rate methodology provides an adjustment for the exclusion of CDS service delivery options within Rate Enhancement, the CDS providers are not held accountable for their spending via cost and accountability reports.

There are "attendant-like" programs and services that are not eligible to participate in Rate Enhancement. One example is the Personal Care Services (PCS), which is a Medicaid benefit available through the Early and Periodic Screening, Diagnosis, and Treatment - Comprehensive Care Program, which in Texas is known as the Texas Health Steps-Comprehensive Care Program. Another example is respite services. In HCS and TxHmL waiver programs, respite was included in the attendant compensation rate enhancement program. However, respite services were excluded from the program for community care waivers such as CLASS and DBMD.

Rate Enhancement in the Managed Care Model

While HHSC administers Rate Enhancement programs for HHSC-contracted providers delivering fee-for-service Medicaid services, MCOs administer their own attendant compensation rate enhancement programs. MCOs are required to offer a rate enhancement program for their contracted attendant care providers delivering

services in STAR+PLUS. However, they are not directed on how to implement or administer their respective rate enhancement programs. Providers contracted directly with an MCO can enroll in the MCO's attendant compensation rate enhancement program through the applicable MCO.

Some services are provided in both the fee-for-service and managed care environments. MCOs will likely include services in their attendant compensation rate enhancement programs that are also in the HHSC administered Rate Enhancement programs. MCOs may choose to include other services that are only provided in a managed care model. An example of a managed care-only service that has been mentioned by stakeholder groups is Protective Supervision. This Medicaid service provides supervision when it is necessary to protect a person from injury due to their cognitive or memory impairment and/or physical weakness. While the purpose of the service is supervision, and not attendant care, the service can be provided by an attendant.

If HHSC directed MCOs on how to administer their rate enhancement programs, then it would be considered a directed payment program and require Centers for Medicare & Medicaid Services (CMS) approval through CMS's preprint process, anticipated to be a yearly process.

Enrollment

Open enrollment for current HHSC contracted providers is held in July of each year. For instance, the state fiscal year 2025 Rate Enhancement open enrollment period was July 1-31, 2024. Eligible providers may choose to participate in Rate Enhancement by submitting a signed Enrollment Contract Amendment (ECA) to enroll and indicate their requested level of enhanced add-on rate. No enrollment action is required for participating Rate Enhancement providers who wish to "roll over" their current level of enhanced add-on rate.

Newly contracted providers may enroll throughout the year. HHSC Provider Finance Department staff are notified of new contracts from the respective HHSC contracting departments. Once notified, staff will contact the newly contracted provider of the Rate Enhancement program and their opportunity to enroll. New providers have 30 days once the new contract is active to enroll in Rate Enhancement.

Providers undergoing a Change of Ownership (CHOW) will assume the prior owner's level of enhanced add-on rate. If the prior owner did not participate in Rate

Enhancement, the new provider can enroll during the next open enrollment period, held in July of each year.

Additional information related to the administrative functions of these activities is provided in the Rate Enhancement Administration section of this report.

Levels of Enhanced Add-On Rates

The Rate Enhancement programs have varying levels that an eligible provider can request during enrollment.

- For Community Care providers, Level 35 is the highest enhancement add-on level.
- For IDD providers, level 25 is the highest enhancement add-on level.
- For Nursing Facility providers, Level 27 is the highest enhancement add-on level.

The amount of the add-on by Rate Enhancement level also varies by program and service. More information on each of the enhancement add-on levels is provided in Appendix D.

Participating providers request their respective Rate Enhancement level during enrollment by submitting an ECA. In accordance with 1 TAC Section 355.308, nursing facilities are limited to increase their level by no more than three levels. This rule provision does not apply to the Attendant Compensation Rate Enhancement program. Requested enhancement add-on rate levels are granted in accordance with TAC requirements and within available funds.

Spending Requirement and Minimum Staffing Requirement

Participating providers in the Attendant Compensation Rate Enhancement program are required to spend at least 90 percent of the Rate Enhancement add-on revenue for allowable expenses.

Participating providers in the Direct Care Staff Enhancement program are required to spend at least 70 percent of the Rate Enhancement add-on revenue for allowable expenses. Prior to September 1, 2023, the spending requirement for the Direct Care Staff Enhancement program was 85 percent of the Rate Enhancement add-on

funding for allowable expenses. The Direct Care Staff Enhancement spending requirement was reduced during the Texas Administrative Code rule amendment process when HHSC was implementing the Direct Care Spending Requirements, pursuant to 2024-25 General Appropriations Act, House Bill 1, 88th Legislature, Regular Session, 2023 (Article II, Health and Human Services Commission, Rider 24). The Nursing Facility Direct Care Spending Requirements became effective on September 1, 2023, and apply to all nursing facilities, not just participating providers in the Direct Care Staff Enhancement program. Recoupment based on direct care staff spending may be offset within specified limits by allowable dietary and fixed capital asset costs over those components of the Medicaid rates.

In addition to the spending requirement, nursing facilities participating in the Direct Care Staff Enhancement program also agree to maintain a minimum level of staffing. Staffing requirements for participants are based on the statewide average direct care staff hours associated with the direct care staff rate component for nursing facilities, adjusted for each facility's case mix. All times are expressed in terms of LVN equivalent minutes. This requirement will end on September 1, 2025, or once the new nursing facility payment methodology, Patient Driven Payment Model for Long-Term Care (PDPM LTC) is implemented. This change was included in the TAC amendment process to establish PDPM LTC and is a result of the change in the new nursing facility payment methodology.

Compliance with Rate Enhancement spending requirements may be evaluated in aggregate for all contracts controlled by common ownership.

Allowable Expenses

1 TAC Section 355.112 and Section 355.308 define the allowable expenses that providers can incur to meet the Rate Enhancement spending requirements for the respective program.

Allowable expenses include:

- Staff salaries and wages subject to Federal Insurance Contributions Act (FICA) and Medicare Payroll Taxes.
- Contracted staff salaries.
- Provider portion of the FICA and Medicare Payroll Taxes and State and Federal Unemployment Taxes.

- Benefits: Paid leave, provider cost of health, life and disability insurance, and contributions to a tax-deferred retirement or pension plan.
- Mileage reimbursement.

Determination of Compliance

1 TAC Section 355.112 and Section 355.308 provide that Rate Enhancement participating providers submit an attendant compensation report or staffing and compensation report to HHSC to determine compliance with the Rate Enhancement requirements. HHSC utilizes the providers' cost/accountability reports to collect the financial and program information to determine Rate Enhancement requirements. Cost/accountability reports are collected through the online State of Texas Automated Information Reporting System (STAIRS).

HHSC collects and examines cost reports in accordance with 1 TAC Chapter 355, Subchapter A, Cost Determination Process. Most providers submit biennial cost reports. If a provider is participating in Rate Enhancement, they are also required to submit an accountability report during their non-cost report year. Cost report preparers are required to complete cost/accountability report training prior to completing their respective cost and/or accountability report.

The HHSC cost/accountability report collection period is held from February through April of each year. HHSC also collects cost/accountability reports throughout the year for participating providers undergoing a CHOW or exiting Rate Enhancement. In these circumstances, the provider may be required to submit an accountability report for the time-period from their last submitted and certified report and when their HHSC contract terminates and/or if they no longer participate in Rate Enhancement.

Once cost and accountability reports are submitted and certified by providers, HHSC Provider Finance Department staff conduct financial examinations in accordance with 1 TAC Section 355.106. Once the financial examination is completed, HHSC Provider Finance Department staff conduct a reconciliation process that includes determining if the Rate Enhancement participating provider has met their respective requirements.

Providers are notified of adjustments made during the financial examinations of the cost or accountability report and if an estimated recoupment was determined. Within thirty days of the notification, providers can either agree or disagree with the adjustments made during the financial examination. If a provider disagrees,

they can file an informal review. If the provider is not satisfied with the informal review decision, the provider can then file a formal appeal. Once the cost/accountability process is completed, including the resolution of any applicable informal reviews or formal appeals, HHSC will process any recoupments, as applicable.

Recoupments

Rate Enhancement participants are subject to recoupment of Rate Enhancement funds if the Rate Enhancement requirements are not met. The participating provider’s Medicaid base rate will not be less after the recoupment.

Recoupments are primarily processed by the HHSC Claims Management Division, upon direction by the HHSC Provider Finance Department, by reprocessing adjudicated claims for the specified cost report time period. In some instances, the HHSC Provider Finance Department will allow providers to submit recoupment payments based on an agreed-upon payment plan.

3. Rate Enhancement Administration

HHSC administration of the Rate Enhancement programs requires routine and extensive collaboration between multiple agency areas and providers. HHSC Provider Finance Department has a dedicated team that provides customer service, information, communications, and training for long-term care providers. The team supports all applicable Long-term Services and Supports programs/services as they relate to the functions of the HHSC Provider Finance Department, including Rate Enhancement. In addition, other HHSC Provider Finance Department staff and agency areas support Rate Enhancement.

Open Enrollment

HHSC Provider Finance Department administers the Rate Enhancement enrollment for all eligible providers in July of each year. During the open enrollment period, Provider Finance Department staff:

- Update the enrollment portal to align with the applicable state fiscal year's program structure and information;
- Notify all eligible providers of the enrollment period, including enrollment instructions, log-in information, and reminders of the deadline;
- Provide training for eligible providers; and
- Assist providers during enrollment with system/portal or enrollment-specific questions.

Awarding Levels

After the enrollment period closes, HHSC Provider Finance Department staff evaluate enrollment data to identify providers who have submitted the ECA requesting to participate in Rate Enhancement or increase or decrease their Rate Enhancement levels. In addition to enrollment data, the Provider Finance Department will also identify current providers who did not submit an ECA during the open enrollment period. The Rate Enhancement levels for these providers will roll over to the upcoming state fiscal year program.

Once the Rate Enhancement enrollment data is finalized, the HHSC Provider Finance Department staff utilize historical claims data trended to the applicable state fiscal year to estimate the program size based on the requested awarded

levels. Requested add-on rate levels will be granted, beginning with the lowest level requested and then successive levels, until the requested enhancements are granted within the available funds.

Once the Rate Enhancement awarded levels are finalized, HHSC Provider Finance Department staff coordinate with HHSC Claims Management Division to update the participating providers' awarded Rate Enhancement level. Due to the number of providers participating in the Rate Enhancement program and the required system updates, it is common for these updates to occur after the beginning of the state fiscal year, thus resulting in reprocessing of adjudicated claims back to the beginning of the state fiscal year.

Fee-for-Service Contract Modifications

In addition to the open enrollment period, HHSC Provider Finance Department staff routinely coordinate Rate Enhancement actions throughout each year. This coordination includes providing customer service to currently participating providers and coordinating with the provider and agency colleagues when contract modifications occur.

The respective HHSC contracting teams are required to notify the HHSC Provider Finance Department when a provider's fee-for-service contract/component code undergoes a CHOW, is terminated, or when a new provider's contract/component code is awarded. New contracts/component codes, CHOWs, and terminating contracts result in an action taken by HHSC Provider Finance Department staff. This action can include, but is not limited to:

- Contacting new eligible providers of the applicable Rate Enhancement program and providing enrollment instructions;
- Coordinating new eligible provider enrollments received and then coordinating with HHSC Claims Management staff to update the system based on awarded levels;
- Coordinating with providers undergoing a CHOW to include requesting a cost/accountability report for the provider who no longer will have ownership of the facility/provider organization;
- Coordinating with providers terminating their contract to include requesting a cost/accountability report; and

- Tracking when the existing providers' cost/accountability reports are complete to coordinate the recoupment process and the release of any applicable vendor holds associated with the cost/accountability report submission and Rate Enhancement requirements.

In addition, providers who are exiting the Rate Enhancement program either due to a CHOW or terminated contract will be placed on a vendor hold for thirty days prior to the effective date of the CHOW or contract termination date. This hold ensures that the HHSC Provider Finance Department can recoup Rate Enhancement funds if the providers have not met the Rate Enhancement requirement. The provider will be required to submit a cost/accountability report within STAIRS to determine the spending requirement. Once the cost/accountability process is completed, including the resolution of any applicable informal reviews or formal appeals, HHSC Provider Finance Department staff will process any recoupments, as applicable, and request the release of the vendor hold.

Cost/Accountability Reports

HHSC collects Medicaid cost/accountability reports to support the fee-for-service rate methodologies. The HHSC Provider Finance Department collects between 5,000 to 6,000 cost/accountability reports per year. If a provider participates in Rate Enhancement, the respective cost/accountability report is also utilized to determine if a Rate Enhancement participating provider has met program requirements.

As mentioned previously in this report, each cost/accountability report is examined by the HHSC Provider Finance Department in accordance with 1 TAC Section 355.106. The financial examination is conducted to ensure that all financial and statistical information reported in the cost reports conforms to all applicable rules and instructions. This examination includes reviewing reported costs to verify they are allowable, reasonable, and necessary.

Once the financial examination is completed, HHSC Provider Finance Department staff conduct a reconciliation process that includes determining if the Rate Enhancement participating provider has met their respective requirements. Providers are notified of adjustments made during the financial examinations of the cost or accountability report and if an estimated recoupment was determined, if applicable. Within thirty days of the notification, providers can either agree or disagree with the adjustments made during the financial examination. If a provider disagrees, they can file an informal review and then a formal appeal.

The HHSC Provider Finance Department administers the informal review process in accordance with 1 TAC Section 355.110. The purpose of an informal review is to provide for the informal and efficient resolution of the matters in dispute. An informal review is not a formal administrative hearing but is a prerequisite to obtaining a formal administrative hearing.

A provider who disagrees with the results of an informal review conducted may file a formal appeal of the review. A formal appeal is an administrative hearing requested by a provider and is conducted in accordance with 1 TAC Sections 357.481–357.498, relating to Hearings Under the Administrative Procedure Act.

Processing Recoupments/Payment Plans

Once the cost/accountability report is considered complete, including the conclusion of any informal reviews or formal appeals, HHSC Provider Finance Department staff will coordinate with the HHSC Claims Management Division to reprocess adjudicated claims for the specified period if the provider did not meet the Rate Enhancement requirements. In certain instances, HHSC will allow recoupment payments to be based on an agreed upon payment plan.

If a provider fails to submit their cost/accountability report, the HHSC Provider Finance Department will request that HHSC Provider Recoupments and Holds place that provider on vendor hold due to non-submittal of their cost/accountability report, in accordance with 1 TAC Section 355.111. The vendor hold is placed after the cost/accountability report deadline and after notices are distributed to the provider. The notices include a notice of the requested cost/accountability report, reminders of the cost/accountability report deadline, a vendor hold warning, and a vendor hold notice. If an acceptable report is not received, the HHSC Provider Finance Department will recoup all Rate Enhancement funds for the specified period.

In summary, the administration of the Rate Enhancement programs requires extensive collaboration within HHSC and with providers. This collaboration is a result of the complexities and nuances of the Rate Enhancement programs' design and the required coordination to administer the Rate Enhancement programs in accordance with the respective TAC.

4. Rate Enhancement Data

HHSC considered an array of data elements during the Rate Enhancement evaluation. These data elements were also presented and/or discussed during the stakeholder sessions described later in this report. These data elements and stakeholder feedback were vital in determining HHSC's identified Key Considerations.

Financial Data

The state fiscal year's Rate Enhancement program size is based on final enrollment data, trended utilization, and available funding. The Attendant Compensation Rate Enhancement program funding for Community Care Providers includes CLASS DSA, DAHS, DBMD, PHC, CAS, FC, and RC providers. The Attendant Compensation Rate Enhancement program funding for IDD providers includes HCS/TxHmL and ICF/IID. The Direct Care Staff Enhancement program funding is for nursing facility providers.

Table 1 reflects estimated Rate Enhancement program size, which is based on final enrollment data, trended utilization, and available funding. The Attendant Compensation Rate Enhancement program received additional appropriations, pursuant to the 2020-21 General Appropriations Act (GAA), House Bill 1, 86th Legislature, Regular Session, 2019 (Article II, Health and Human Services Commission, Rider 44-45) and the 2024-25 General Appropriations Act (GAA), House Bill 1, 88th Legislature, Regular Session, 2023 (Article II, Health and Human Services Commission, Rider 30). With the investments to the Attendant Compensation Rate Enhancement program, the program funding has increased over time.

Table 1. State fiscal year 2019-2024 estimated Rate Enhancement program size by provider type

Program	2019	2020	2021	2022	2023	2024
Community Care Providers	$111,886,958	$133,213,666	$135,193,874	$129,986,526	$157,641,842	$163,285,145
IDD Providers	$11,922,770	$13,738,973	$48,050,497	$52,512,594	$48,089,033	$67,623,973

Program	2019	2020	2021	2022	2023	2024
Nursing Facility Providers	$74,981,201	$91,504,971	$65,036,165	$56,227,146	$42,390,182	$75,350,493

Participation Data

One measure of the success of the Rate Enhancement programs is through provider participation since higher participation by providers allows more attendants and direct care staff to be eligible for additional funds.

Participation in the Rate Enhancement programs is voluntary. HHSC has historically observed higher participation in certain programs/services and lower participation in other programs/services. While there have been increased funding for the Attendant Compensation Rate Enhancement program, as outlined above, the participation levels by program have remained consistent. Table 2 represents the percentage of contracts/component codes that are participating in the Attendant Compensation Rate Enhancement and the Direct Care Staff Enhancement program, respectively, in state fiscal year 2024.

HHSC also evaluated the percentage of adjudicated claims for state fiscal year 2024 participating Rate Enhancement providers to the total adjudicated claims for the program/services. HHSC utilized 2022 adjudicated claims for this evaluation since long-term care providers have up to 365 days to submit a claim.

As a result of the evaluation, HHSC identified the percentage of providers who provide eligible Medicaid services enrolled in Rate Enhancement, as well as their percentage of overall program/service utilization. For example, in the Direct Care Staffing Enhancement program, approximately ninety-three percent of nursing facilities participate in the rate enhancement program. Of those participating providers, their 2022 adjudicated claims represented approximately 90 percent of all 2022 nursing facility adjudicated claims. Another example, in the Attendant Compensation Rate Enhancement program, approximately thirty-five percent of HCS/TxHML providers participate in the rate enhancement program. Of those participating providers, their 2022 adjudicated claims represent approximately fifty-three percent of all 2022 HCS/TxHML adjudicated claims.

Table 2. State fiscal year 2024 Direct Care Staff Enhancement program: Percentage of Participating Providers and Percentage of Total Utilization.

Program/ Service	Participating Providers	Total Number of HHSC Contracted Providers	Percentage of Participating Providers	2022 Utilization for participating providers	Total 2022 Utilization for all providers	Percent of RE Participant Program/ Service Utilization
Nursing Facility	1107	1187	93%	14,820,911	16,430,448	90.20%

Table 3. State fiscal year 2024 Attendant Compensation Rate Enhancement program: Percentage of Participating Providers and Percentage of Total Utilization.

Program/ Service	Participating Providers	Total Number of HHSC Contracted Providers	Percentage of Participating Providers	2022 Utilization for Participating providers	Total 2022 Utilization for all providers	Percent of RE Participant Program/ Service Utilization
PHC/CAS/FC	1840	2096	88%	72,412,215	75,346,091	96.11%
Priority	1824		87%	717,446	751,468	95.47%
Non-Priority	1837		88%	71,694,770	74,594,624	96.11%
DAHS	252	282	89%	1,046,740	1,157,454	90.43%
RC	20	52	38%	21,098	60,774	34.72%
CLASS	103	116	89%	8,153,849	12,276,867	66.42%
DBMD	37	49	76%	472,920	581,122	81.38%
ICF/IID	88	125	70%	1,096,501	1,611,084	68.06%
HCS/TxHmL	241	696	35%	20,974,421	39,622,852	52.94%

Program/ Service	Participating Providers	Total Number of HHSC Contracted Providers	Percentage of Participating Providers	2022 Utilization for Participating providers	Total 2022 Utilization for all providers	Percent of RE Participant Program/ Service Utilization
Residential	216		31%	2,280,557	3,082,435	73.99%
Individualized Skills and Services (ISS)	211		30%	16,069,383	26,327,010	61.04%
Non-ISS	206		30%	2,624,481	10,213,407	25.70%

HHSC acknowledges that the Attendant Compensation Rate Enhancement program may create a potentially significant cost to comply by requiring providers to submit additional reports to HHSC. Therefore, participation may not be worthwhile for some providers.

Efficacy of Rate Enhancement

As mentioned above, HHSC's position is that one measure of success of the Rate Enhancement programs is through provider participation since higher rates of participation allow for more attendants and direct care staff to be eligible for additional funds. HHSC evaluated cost/accountability report data to evaluate the estimated hourly wage differential between participating and non-participating providers and recruitment and retention information.

Estimated hourly wages across provider types ranged from negligible to up to 16 percent differential and appear to be correlated to participation rates. For provider types with high participation levels in the Rate Enhancement program the hourly wage differences were negligible. This included a range of one to four percent differential when comparing attendant median hourly wages for DAHS, CLASS, PHC, CAS and FC providers. HHSC estimated a seven percent differential in attendant median hourly wages for ICF providers, and a 16 percent differential in attendant median hourly wages for HCS/TxHML providers.

In addition to hourly wage evaluation, HHSC explored recruitment and retention data available to the agency. Attendant recruitment and retention data has been collected through HHSC cost reports since 2019, beginning with fiscal year 2018 cost reports. HHSC published the *Community Attendant Workforce Development Strategic Plan*, pursuant to the 2020-21 General Appropriations Act, House Bill 1, 86th Legislature, Regular Session (Article II, Health and Human Service Commission, Rider 157). In the report, HHSC cited limitations that come with collecting recruitment and retention information from cost reports and not from a separate survey dedicated to the topic of attendant workforce issues. For instance, cost report preparers are typically contracted accountants or other individuals whose purviews involve financial information and not information about hiring and turnover. And yet, these cost report preparers are the ones tasked with answering hiring and turnover questions which are not directly related to financials.

HHSC conducted a voluntary survey during the open Rate Enhancement enrollment in July 2024. In the voluntary survey, HHSC included questions to determine if a provider was or was not participating in the Rate Enhancement programs, and retention information based on full-time equivalent positions. Unfortunately, information collected regarding retention was deemed invalid. The survey responses only represented a small number of eligible providers, 491 providers in total. Of the providers who submitted responses, some either left the retention information blank and/or the reported information was incomplete. Therefore, HHSC was unable to appropriately make determinations regarding the efficacy of Rate Enhancement participation based on recruitment and retention.

Rate Enhancement Participation by Level

Participating providers' Rate Enhancement awarded levels vary amongst participating providers. This could be a result of participating providers requesting levels based on their business/staffing needs, the Rate Enhancement program design, or funding.

As mentioned above, participating providers can "roll over" their current participation levels from one state fiscal year to another. The only exception is if participating providers are limited to a level based on not meeting a prior year's spending requirement. In addition, there are limitations for current participating providers requesting a modification to their awarded level and for new providers requesting to enroll in the Rate Enhancement

program. Specifically for nursing facilities participating in the Direct Care Staff Enhancement program, providers are limited to increases by no more than three levels. All Rate Enhancement awarded levels are within available appropriation amounts.

In state fiscal year 2024, new nursing facility providers were limited to level one in the Direct Care Staff Enhancement program. New community care providers participating in the Attendant Compensation Rate Enhancement were limited to level 32. New ICF/IID and HCS/TxHmL providers participating in the Attendant Compensation Rate Enhancement program were limited to level nine for all participation categories, except for ICF/IID day habilitation which was limited to level one. HHSC maintains and publishes an awarded Rate Enhancement levels by contract/component code for each state fiscal year.

Participating providers may be able to maintain higher Rate Enhancement levels, particularly if they enrolled in earlier years of the program or in a year where additional funding was allocated for the specific programs; while newer providers may not be able to be awarded higher Rate Enhancement levels unless additional funding is appropriated to the Rate Enhancement programs or if current providers, at higher levels, exit the program. The varying levels and the potential limitations for newer providers to be awarded higher levels, may deter providers from participating in Rate Enhancement program.

Recoupment Data

HHSC also evaluated recoupment by provider type. The recoupment data was pulled from the 2019-20 cost/accountability reports since subsequent cost/accountability reports can be evaluated only after any informal reviews or formal appeals have been exhausted. RC were not included in the table below due to the small number of cost reports/providers and little to no determined recoupments.

Table 4. 2019-20 Rate Enhancement Recoupment by Cost/Accountability Report

Cost/Account-ability Report by Program/ Service	Count of Entities	Count of Entities Recouped	Percent of Entities Recouped	Sum of Recoupments
CPC Reports (CLASS and CAS, FC, PHC)	2,099	89	4.2%	$ 4,050,086
DAHS Reports	490	43	8.8%	$94,486
DBMD Reports	19	7	36%	$141,113
HCS/TxHmL Reports	712	55	7.7%	$1,066,166
ICF/IID Reports	130	25	19.2%	$1,219,442
Nursing Facility Reports	1172	138	12%	$8,323,355

5. Stakeholder Sessions

HHSC held a series of stakeholder sessions with identified associations to review the Direct Care Staff Enhancement program and the Attendant Compensation Rate Enhancement program separately. These sessions enabled HHSC to receive information and feedback from the associations specific to the providers they represented.

Direct Care Staff Enhancement

The stakeholder associations that participated in the Direct Care Staff Enhancement stakeholder sessions were the Texas Health Care Association, the Independent Coalition of Nursing Home Providers, and LeadingAge Texas.

During the initial stakeholder session on February 20, 2024, representatives from two of the stakeholder associations were able to attend. HHSC staff provided an overview of the Direct Care Staff Enhancement program, including program information and the statistical information outlined above. Discussions and feedback were centered around three options: maintain, modify, or discontinue the Direct Care Staff Enhancement program. According to the feedback received from these stakeholder associations, HHSC recorded the associations' collective recommendation that the Direct Care Staff Enhancement program be discontinued, and the funding be allocated to increase the applicable Medicaid base rates.

HHSC held another stakeholder session on April 5, 2024, with the remaining stakeholder association. HHSC staff provided the same overview that was presented during the February 20, 2024 stakeholder session and discussed the same three options listed above. The stakeholder association opposed any efforts to discontinue the program and supported modification of the program to support an improved version of the program. For improvements, the stakeholder association recommended aligning the enhancement commensurate with the increase of inflation, increasing the maximum add-on rate per day, and expanding incentives based on higher CMS ratings.

Attendant Compensation Rate Enhancement

The stakeholder associations that participated in the Attendant Compensation Rate Enhancement stakeholder sessions were the Private Providers Association of Texas,

Providers Alliance for Community Services of Texas, Texas Association for Home Care and Hospice, and Texas Council of Community Centers.

HHSC held three stakeholder sessions with the associations mentioned above on February 20, 2024, March 19, 2024, and April 16, 2024. HHSC staff provided an overview of the Attendant Compensation Rate Enhancement program, including program information and statistical information outlined above. Discussions and feedback centered around three options: maintain, modify, or discontinue the Attendant Compensation Rate Enhancement program.

All stakeholder associations provided recommendations for modifying the Attendant Compensation Rate Enhancement program. Recommendations primarily focused on the following areas:

- increasing the add-on amount per level;
- modifying the number of levels;
- streamlining, removing, or simplifying the spending requirement;
- expanding the program to include all applicable attendant services;
- providing clarification on the allowability of aggregation amongst an entity for spending requirements; and
- improving provider awareness of the program and resources, including the Rate Enhancement worksheets and training.

During the stakeholder sessions, the final CMS Rule Ensuring Access to Medicaid Services Final Rule (CMS-2442-F) had not yet published. However, the proposed rule was subsequently published. Stakeholder associations did acknowledge that the anticipated final rule would need to be considered, as it would likely create duplication of the Rate Enhancement program. More information regarding the Rule is outlined in the Key Considerations section of this report.

Provider Survey

In addition to the stakeholder sessions, HHSC conducted a voluntary survey during open enrollment to collect feedback from providers. HHSC received 491 responses to the survey. The results of the survey are provided in Appendix E.

6. Key Considerations

Misalignment with Original Purpose

As discussed earlier in this report, it is HHSC's position that the original purpose of the Attendant Compensation Rate Enhancement program was to create a mechanism to allow participating providers to pay attendants' wages above the federal minimum wage. Furthermore, HHSC assumes that the original presumption of the program was that the federal minimum wage would increase over time. As a result of federal minimum wage changes, HHSC also assumes that the base attendant portion of the wage would receive proportional increases. The Attendant Compensation Rate Enhancement program would remain as an incentive above the federal minimum wage.

The federal minimum wage has not been increased since 2009 and remains at $7.25 per hour. HHSC was directed to implement a base wage for personal attendant services above the federal minimum wage, establishing a new, state-defined base wage for community attendant services (commonly referred to as a minimum wage). As reflected in Table 5, the attendant base wage has increased based on legislative direction and supporting appropriations.

Table 5. History of Federal Minimum Wage and Attendant Base Wage.

Effective Date	Federal Minimum Wage	Attendant Base Wage	Legislative Citation
Sep. 1, 2000	$ 5.15	$ 5.15	
Jul. 24, 2007	$ 5.85	$ 5.15	
Aug. 1, 2007	$ 5.85	$ 5.85	
Jul. 24, 2008	$ 6.55	$ 5.85	
Aug. 1, 2008	$ 6.55	$ 6.55	
Jul. 24, 2009	$ 7.25	$ 6.55	
Aug. 1, 2009	$ 7.25	$ 7.25	
Sep. 1, 2013	$ 7.25	$ 7.50	S.B. 1, 83rd Legislature, Regular Session, 2013 (Article II, Special Provisions, Section 61)

Effective Date	Federal Minimum Wage	Attendant Base Wage	Legislative Citation
Sep. 1, 2014	$ 7.25	$ 7.86	S.B. 1, 83rd Legislature, Regular Session, 2013 (Article II, Special Provisions, Section 61)
Sep. 1, 2015	$ 7.25	$ 8.00	H.B. 1, 84th Legislature, Regular Session, 2015 (Article II, Special Provisions, Section 47)
Sep. 1, 2019	$ 7.25	$ 8.11	H.B. 1, 86th Legislature, Regular Session, 2019 (Article II, Health and Human Services Commission, Rider 45)
Sep. 1, 2023	$ 7.25	$ 10.60	S.B. 1, 88th Legislature, Regular Session, 2023 (Article II, Health and Human Services Commission, Rider 30(a))

Since the personal attendant base wage has been established above the federal minimum wage, providers can pay above the federal minimum wage through appropriations supported by the attendant base wage. Therefore, the original purpose of the Attendant Compensation Rate Enhancement—to support providers to pay wages above the federal minimum wage—is no longer applicable.

The legislative direction to increase attendant wages above the federal minimum wage has historically been supported by a policy position that increases in the base wage are necessary to recruit and retain qualified staff. Further, advocacy organizations have indicated that the use of Rate Enhancement has evolved to be used to offer salaries necessary to recruit staff rather than as an enhancement to offer additional benefits, bonuses, or retention raises. Presumably, this evolution has happened because the cost of delivering care has met or exceeded the base wage. This feedback leads HHSC to conclude that Rate Enhancement is no longer needed as its original purpose is no longer relevant due to the unchanged federal minimum wage.

Inequity Across Attendant Services

A significant issue in the existing Attendant Compensation Rate Enhancement program is its limited applicability to all attendant services. The attendant base wage applies more uniformly to all attendant services regardless of a program or funding mechanism. However, the Attendant Compensation Rate Enhancement program is inconsistently distributed amongst providers. This inconsistency is based on factors such as appropriated legislative funding for specific programs, the timing of a provider's enrollment, and the level awarded to the provider at that time. As a result, the Attendant Compensation Rate Enhancement program may create disparities between and among providers delivering attendant services.

Another source of potential disparity is related to how rate enhancement functions in managed care. As previously discussed, HHSC requires each MCO to offer a rate enhancement program for their attendant care providers. HHSC does not direct how MCOs administer their programs including provider enrollment, the amount of add-ons per unit of service, or the number of levels in the program. Since each MCO has the flexibility to implement their program to support their contracted providers as they see fit, there are likely disparities across the STAR+PLUS program and between providers operating in both managed care and fee-for-service. The differences in the program across both the managed care and fee-for-service environment not only have the inevitable result of attendant care providers being paid different amounts but also cause confusion and increase administrative burden for providers.

Nursing Facility Staffing Requirements

During the Rider 30 evaluation, HHSC evaluated the potential duplication between the Direct Care Staff Enhancement program and QIPP, specifically the QIPP staffing measures. QIPP is a directed payment program designed to incentivize nursing facilities to improve the quality and innovation of their services. While QIPP has eligibility requirements for both non-state government-owned and private nursing facilities, 85 percent of nursing facilities participate in QIPP for the state fiscal year 2025 program period.

CMS recently approved a multi-year preprint for state fiscal year 2025-2027 QIPP with an annual estimated program size of $1.75 billion. The state share of QIPP is funded by intergovernmental transfers. QIPP participating providers earn payments by meeting performance requirements in four components. QIPP Component Two focuses on workforce development and includes three metrics related to staff-to-

patient ratios. The metrics are measured in Hours Per Resident Day (HPRD) and are based on data nursing facilities provide quarterly to CMS through the Payroll Based Journal. The three metrics are:

- Metric 1: Reported Certified Nursing Assistant HPRD
- Metric 2: Reported Licensed Nursing HPRD
- Metric 3: Reported Total Nursing Staff HPRD

HHSC has identified duplications in relation to incentivizing workforce development between the Direct Care Staff Enhancement program and QIPP. It is HHSC’s position that the enhanced staffing requirements have become largely superseded by QIPP due to staffing measure changes implemented in state fiscal year 2025.

Moreover, HHSC is transitioning to the PDPM LTC as a new reimbursement methodology for nursing facilities, effective September 1, 2025. Medicaid providers lack experience operating under this new reimbursement methodology, and HHSC does not possess historical data to support the appropriate enhanced staffing levels necessary to meet the original intention of the program.

In addition, CMS published the Medicare and Medicaid Programs: Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting Final Rule (CMS 3442-F) in April 2024. The potential impacts of the new federal requirements are outlined below.

New Federal Requirements

CMS published the Ensuring Access to Medicaid Services Final Rule (CMS-2442-F) in April 2024. As part of this new federal requirement (directly quoted from CMS-2442-F [B] Home- and Community-Based Services):

- In three years, states will be required to report on their readiness to collect data regarding the percentage of Medicaid payments for homemaker, home health aide, personal care, and habilitation services spent on compensation to the direct care workers furnishing these services;
- In four years, states will be required to report on the percentage of Medicaid payments for homemaker, home health aide, personal care, and habilitation services spent on compensation to the direct care workers furnishing these services, subject to certain exceptions; and

- In six years, states will be required to generally ensure a minimum of 80% of Medicaid payments for homemaker, home health aide, and personal care services be spent on compensation for direct care workers furnishing these services, as opposed to administrative overhead or profit, subject to certain flexibilities and exceptions (referred to as the HCBS payment adequacy provision).

While further guidance is anticipated to be shared by CMS, HHSC anticipates the federal rules apply to some attendant and direct care staff. CMS' rules apply to homemaker, home health aide, personal care, and habilitation services. HHSC's Attendant Compensation Rate Enhancement program applies to a different group of attendant services than contemplated by the CMS rule. The CMS rules appear to apply to hourly attendant services, and do not include Rate Enhancement eligible services such as ICF/IID, RC, and DAHS. However, the CMS rules apply to a larger base of providers than the Rate Enhancement programs, many of which do not currently submit cost/accountability reports to HHSC. For example, CMS requirements apply to home health aides and HHSC does not currently require cost reports for home health services. HHSC expects to double the number of cost/accountability reports we collect annually to meet the federal compliance requirements.

HHSC also acknowledges the requirements differ from the current Rate Enhancement program requirements. For instance, the CMS Rules apply to the total Medicaid base rates and associated Medicaid payments, while the Rate Enhancement programs apply only to attendant compensation revenue and expenses. CMS also defines attendant compensation slightly differently than the definition used in HHSC's Rate Enhancement program. For example, CMS excludes attendant mileage reimbursement from their calculation of attendant compensation.

Furthermore, the compliance threshold of the CMS Rules is based on an 80 percent requirement of total Medicaid revenue, whereas the Rate Enhancement spending requirement is 90 percent of attendant revenue in the Attendant Compensation Rate Enhancement program and 70 percent of direct care revenue in the Direct Care Staff Enhancement program. While CMS relies on a lower percentage, CMS' requirement may be more stringent for some providers to achieve than HHSC's 90 percent requirement because compliance is on total Medicaid revenue rather than the attendant compensation revenue.

If the Rate Enhancement programs are maintained, the variations between the programs and the new CMS regulations will result in participating providers being

held accountable for varying requirements, compliance thresholds or spending requirements, and eligible programs or services.

It is nearly impossible to maintain a discretionary and variable add-on for attendant compensation if providers are held to ensure eighty percent of their Medicaid revenue are spent on attendant expenditures without modifying HHSC's program requirements. Any increase in Medicaid revenue would be subject to the CMS requirements and shift the percentages between attendant compensation and administrative portion of the rate. HHSC's add-on could not be limited to attendant expenditures without having the effect of increasing the total amount of the reimbursement and thus impacting the remaining amount of revenue to be spent on allowable administrative expenses.

As mentioned above, CMS also published the Medicare and Medicaid Programs: Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting Final Rule (CMS 3442-F) in April 2024. "CMS is finalizing a total nurse staffing standard of 3.48 hours per resident day (HPRD), which must include at least 0.55 HPRD of direct registered nurse (RN) care and 2.45 HPRD of direct nurse aide care. Facilities may use any combination of nurse staff (RN, licensed practical nurse [LPN] and licensed vocational nurse [LVN], or nurse aide) to account for the additional 0.48 HPRD needed to comply with the total nurse staffing standard. CMS is also finalizing enhanced facility assessment requirements and a requirement to have an RN onsite 24 hours a day, seven days a week, to provide skilled nursing care."

The Direct Care Staff Enhancement program currently incentivizes nursing facilities to meet higher staffing levels based on LVN-equivalent minutes. The current staffing levels in the program are not consistent with the new federal requirements. HHSC modified the Texas Administrative Code rules to remove enhanced staffing levels based on LVN-equivalent minutes when the PDPM LTC methodology is implemented on September 1, 2025. Staffing measures were also incorporated into the QIPP program as mentioned above. CMS states, "We believe that establishing a national floor (baseline) for nurse staffing in nursing homes will lead to improvements in quality across all States and reduce disparities in care."

In addition to the minimum staffing requirements, states will be required to "…collect and report on the percent of Medicaid payments that are spent on compensation for direct care workers, and support staff, delivering care in nursing facilities and intermediate care facilities, for individuals with intellectual disabilities." CMS indicates: "This requirement is designed to inform efforts to address the link

between sufficient payments being received by the institutional direct care and support staff workforce and access to and, ultimately, the quality of services received by Medicaid beneficiaries. In addition, the requirements being finalized in this final rule are consistent with efforts to address the sufficiency of payments for home and community-based services (HCBS) to direct care workers and access to and the quality of services received by beneficiaries of HCBS finalized in the Ensuring Access to Medicaid Services final rule." HHSC will continue to monitor CMS guidance to identify potential impacts to the Direct Care Staff Enhancement program.

HHSC Resources

HHSC administration of Rate Enhancement requires extensive coordination both internally and externally. This coordination enables HHSC to ensure the Rate Enhancement programs are administered as designed, ensure providers are informed, and hold providers accountable to the respective requirements. However, HHSC believes the agency's dedicated resources could be redirected to focus on other functions that would benefit Medicaid programs/services and be leveraged to address some of the staff resources that will be required to meet CMS's new federal regulations.

By either discontinuing or modifying the Rate Enhancement programs, the HHSC Provider Finance Department anticipates redirecting resources to initiatives that have been identified, but not implemented due to available staff resources. These initiatives include enhancements to the cost report process that will benefit providers, improve the quality of data reported and utilized in rate methodology evaluations, enhance the financial examination processes, and advance data analytics/reporting. HHSC plans on improving and clarifying cost/accountability report instructions and applicable worksheets, providing advancing trainings offered by the agency, and performing advanced data analytics on cost report data. The data analytics will enable HHSC to have data-driven functions and tasks that will enable the agency to identify potential outliers, trends, and areas of improvement in relation to reported and examined data, and foster transparency in providers' costs from one cost report period to another.

If the Texas Legislature desires to maintain the Rate Enhancement programs, HHSC has outlined modifications that could be considered in Appendix F.

Impacts to Participating Providers

During the stakeholder sessions, HHSC received varying feedback. In terms of the Direct Care Staff Enhancement program, two stakeholder associations recommended discontinuing the program, and one stakeholder association recommended modifying the program. Key factors in this feedback appeared to be based on the historically high participation of nursing facilities, the duplication between the Direct Care Staff Enhancement program and the QIPP, and the Direct Care Spending Requirement implemented on September 1, 2023 for all nursing facilitates.

Stakeholder associations representing providers eligible to participate in the Attendant Compensation Rate Enhancement program provided consistent feedback. While recommendations received focused on modifying the Attendant Compensation Rate Enhancement program, the associations also acknowledged HHSC's position on the original purpose of the Rate Enhancement program and the duplication and complexities represented by the new CMS Rules.

All stakeholder associations indicated that if the Rate Enhancement programs are discontinued, then the program funding should be utilized to increase the applicable Medicaid base rates. This can be implemented appropriation neutral. However, it is likely certain Rate Enhancement providers may experience a reduction in Medicaid Revenue if the Rate Enhancement program funding is utilized for Medicaid base rate increases that would be available to all applicable providers. This will more likely impact participating providers who are at the higher Rate Enhancement levels. Stakeholder associations discussed the need for a hold harmless provision, which could reduce the potential impact to providers.

7. Conclusion

HHSC assessed whether the current Rate Enhancement programs are effective or if adjustments could reduce administrative burden and costs, enhance program efficacy, and improve functionality in a hybrid fee-for-service and managed care environment.

After evaluating the Rate Enhancement programs, including the key considerations outlined in this report, HHSC recommends discontinuing the Attendant Compensation Rate Enhancement and the Direct Care Staff Enhancement programs effective September 1, 2025. HHSC further recommends reallocating the Rate Enhancement funding to increase the Medicaid base rate for the applicable programs/services.

To effectuate the discontinuation of the HHSC administered Rate Enhancement programs, HHSC would need to amend the TAC, amend the State Plan, submit waiver amendments, conduct rate hearings to adopt new fee-for-service rates, and conduct provider communication efforts.

Since MCOs administer their own rate enhancement programs, the MCOs may choose to continue or discontinue their programs. With that said, HHSC anticipates the MCO contracts may also need to be amended. HHSC does not anticipate an impact to the gross-up factor for managed care premium administrative costs.

HHSC acknowledges that while this recommendation is appropriation-neutral, the Texas Legislature may desire to proceed with this recommendation while also ensuring Rate Enhancement participating providers do not experience a reduction in their overall Medicaid revenue. HHSC has estimated an appropriation funding need that would address the potential revenue reduction. Please see Appendix G for more information.

List of Acronyms

Acronym	Full Name
CAS	Community Attendant Services
CDS	Consumer Directed Services
CFC PAS/HAB	Community First Choice Personal Assistance Services/Habilitation
CHOW	Change of Ownership
CLASS	Community Living Assistance and Support Services
CMS	Centers for Medicare & Medicaid Services
DAHS	Day Activity and Health Services
DBMB	Deaf-blind with Multiple Disabilities
DSA	Direct Service Agency
EA	Employment assistance
ECA	Enrollment Contract Amendment
FC	Family Care
HCS	Home and Community-Based Services
HPRD	Hours Per Resident Day
ICF/IID	Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions
IDD	Intellectual and Developmental Disability
ISS	Individualized Skills and Socialization
LVN	Licensed Vocational Nurse
MCO(s)	Managed Care Organization
PDPM LTC	Patient Driven Payment Methodology for Long-Term Care (PDPM LTC),
PHC	Primary Home Care
RC	Residential Care
RN	Registered Nurse
SE	Supported Employment
STAIRS	State of Texas Automated Information Reporting System
TAC	Texas Administrative Code
TxHmL	Texas Home Living
QIPP	Quality Incentive Payment Program

Appendix A. Rider 30(d)

(d) Out of funds appropriated in Strategy B.1.1, Medicaid & CHIP Contracts & Administration, HHSC shall evaluate the rate enhancement programs paid in the Medicaid program to providers to increase reimbursements for direct care and attendant care services. HHSC shall report on certain financial information regarding rate enhancement programs, including, but not limited to, the funding impact, by provider type and service, of the operation of the rate enhancement programs, the percentage of providers and services that participate in the programs, the efficacy of the programs in recruiting and retaining the workforce necessary to deliver services, and the cost of participation to providers for complying with the program requirements. HHSC shall report on the evaluation and findings and recommendations to the Governor's Office, the Legislative Budget Board, the Lieutenant Governor, and the Speaker of the House of Representatives by October 1, 2024.

Appendix B. Rate Enhancement Authority

Rate Enhancement is governed by the following authority, as broken out into the two Rate Enhancement programs below.

The Medicaid state plan sections cited below are approved by CMS in accordance with Title 42 of the Code of Federal Regulations §431.10. The home and community-based services waivers cited below are approved by CMS in accordance with §1915(c) of the Social Security Act.

Attendant Compensation Rate Enhancement:

- 1 TAC Section 355.112, relating to Attendant Compensation Rate Enhancement
- 1915(c) Home and Community-Based Services Waiver for Community Living Assistance and Support Services (CLASS)
- 1915(c) Home and Community-Based Services Waiver for Deaf Blind with Multiple Disabilities
- 1915(c) Home and Community-Based Services Waiver for Home and Community-Based Services (HCS) Program
- 1915(c) Home and Community-Based Services Waiver for Texas Home Living Program
- Texas Medicaid State Plan Attachment 4.19-B Method and Standards for Establishing Payment Rates – Community Services: 14. Primary Home Care (PHC)
- Texas Medicaid State Plan Attachment 4.19-B Method and Standards for Establishing Payment Rates – Community Services: 15. Day Activity and Health Services (DAHS)
- Texas Medicaid State Plan Attachment 4.19-D Reimbursement Methodology for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)

Direct Care Staff Enhancement:

- 1 TAC Section 355.308, relating to Direct Care Staff Rate Component
- 1 TAC Section 355.320, relating to Nursing Care Staff Rate Enhancement Program for Nursing Facilities

- Human Resources Code, Title 2, Section 32.028 relating to Fees, Charges, and Rates
- Texas Medicaid State Plan Attachment 4.19-D Reimbursement Methodology for Nursing Facilities

Appendix C. Providers and Services Eligible for Attendant Compensation Rate Enhancement

HHSC administers the Attendant Compensation Rate Enhancement program to the following fee-for-service program provider types. Specific services are listed below each provider type, where applicable.

- **Community Attendant Services (CAS)**
  - Non-priority
  - Priority
- **Community Living Assistance and Support Services 1915(c) Waiver (CLASS)**
  - Community first choice personal assistance services/habilitation (CFC PAS/HAB), habilitation, and habilitation transportation
  - Employment assistance (EA) and supported employment (SE)
- **Deaf-blind with Multiple Disabilities 1915(c) Waiver (DBMD)**
  - CFC residential habilitation, residential habilitation, and habilitation transportation
  - Chore services
  - EA and SE
  - Individualized skills and socialization (ISS) on-site and off-site
  - Intervener services
- **Day Activity and Health Services (DAHS)**
- **Family Care (FC)**
  - Non-priority
  - Priority
- **Home and Community-based Services 1915(c) Waiver (HCS)**
  - CFC supported home living and supported home living transportation
  - EA and SE

- ISS in-home, on-site, and off-site
- Respite in-home
- Respite out-of-home
- Supervised living (3-bed) and residential support services (4-bed)

- **Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions (ICF/IID)**
  - Day habilitation services
  - Residential services
- **Primary Home Care (PHC)**
  - Non-priority
  - Priority
- **Residential Care**
  - Apartment
  - Non-apartment
- **Texas Home Living 1915(c) Waiver**
  - CFC community support services and community support services transportation
  - EA and SE
  - ISS in-home, on-site, and off-site
  - Respite in-home
  - Respite out-of-home

Appendix D. Rate Enhancement Add-On Amounts

HHSC Rate Enhancement add-on amounts vary by level and vary across the eligible programs/services.

Table 6. State fiscal year 2024 Attendant Compensation Rate Enhancement Add-On Amount for Community Care programs/services.

Program/Service	Maximum Levels	Add-on Per Level	Unit
PHC, CAS, FC	35	$ 0.05	Hourly
CLASS	35	$ 0.05	Hourly
DBMD	35	$ 0.05	Hourly
RC	35	$ 0.05	Hourly
DAHS	35	$ 0.05	Hourly

Table 7. State fiscal year 2024 Attendant Compensation Rate Enhancement Add-On Amount for IDD programs/services: HCS/TxHmL.

Program/Service	Maximum Levels	Add-on Per Level	Unit
ISS	25	$ 0.05	Hourly
Non-ISS	25	$ 0.05	Hourly
Residential	25	$ 0.40	Daily

Table 8. State fiscal year 2024 Attendant Compensation Rate Enhancement Add-On Amount for IDD programs/services: ICF/IID.

Program/Service	Maximum Levels	Add-on Per Level	Unit
Day Habilitation	25	$ 0.30	Daily
Residential	25	$ 0.40	Daily

Table 9. State fiscal year 2024 Direct Care Staffing Enhancement Add-On Amount.

Program/Service	Maximum Levels	Add-on Per Level	Unit
Nursing Facility	27	$ 0.40	Daily

Appendix E. State Fiscal Year 2025 Open Enrollment Survey

HHSC conducted a voluntary survey during the state fiscal year 2025 open enrollment, which was held July 1-31, 2024. The data below represents the survey results. The data was self-reported by the respondent and not independently verified by HHSC.

HHSC identified 491 independent respondents to the open enrollment voluntary survey. On certain questions, the 491 respondents could provide more than one response, which is why the number of total responses below may be higher than the number of independent respondents. The highest percent of responses were provided by respondents indicating they participated in PHC/CAS/FC. The lowest percentage of responses were provided by respondents indicating they participated in DBMD.

Table 10. State fiscal year 2025 Rate Enhancement Open Enrollment Survey Responses by Program.

Program	Response Count	Percentage of Total Responses Received
PHC/CAS/FC	285	50%
NF	102	18%
DAHS	63	11%
HCS	63	11%
TxHmL	15	3%
CLASS	13	2%
ICF	13	2%
RC	8	1%
DBMD	4	1%
Total Responses	**566**	**100%**

Survey respondents were able to report the number of state fiscal years they have participated in Rate Enhancement or indicate they currently do not participate. Seventy percent of respondents indicated they have participated in rate enhancement for five years of more.

Table 11. State fiscal year 2025 Rate Enhancement Open Enrollment Survey Participation in Prior Rate Enhancement program periods.

Prior Number of Participation Years	Response Count	Percentage of Total Responses Received
I do not currently participate	61	12%
3–5 years	89	18%
More than 5 years	341	70%
Total	**491**	**100%**

As part of the survey, HHSC inquired about providers' costs to participate in the Rate Enhancement program. As mentioned above, this data was self-reported by providers. As represented in Table 11, sixty-one respondents indicated they had not previously participated in a Rate Enhancement program; however, all respondents indicated a cost they incurred for participation. HHSC assumes that providers (even those who have not yet participated in Rate Enhancement) may have incurred a cost associated with the enrollment process. The majority of the 491 responses indicated the administration cost exceeding $5,000 per program period/state fiscal year.

Table 12. State fiscal year 2025 Rate Enhancement Open Enrollment Survey Participation Providers' Cost.

Estimated Providers' Cost for Rate Enhancement Participation	Response Count	Percentage of Total Responses Received
$1,000 - $2,000	52	11%
$2,0001 - $3,000	45	9%
$3,001 - $5,000	87	18%
$5,000+	307	62%
Total	**491**	**100%**

As part of the survey, HHSC collected recommendations from providers for Rate Enhancement program improvement. While some respondents indicated no changes to Rate Enhancement were warranted, eighty-eight percent of the responses indicated some or all areas of Rate Enhancement were warranted.

Table 13. State fiscal year 2025 Rate Enhancement Open Enrollment Survey Program Improvements.

Improvement Need	Response Count	Percentage of Total Responses Received
All areas to be improved	66	12%
One or more areas to be improved	404	72%
No improvement needed	87	16%
Total	**557**	**100%**

If a respondent indicated that one or more areas of the Rate Enhancement program needed to be improved, they were asked to select which categories needed improvement. The responses appeared to prioritize the design/structure of Rate Enhancement. Respondents also had an “other” option to indicate specific modifications HHSC should focus on. Many responses focused on increasing the Medicaid base rates or the personal attendant base wage.

Table 14. State fiscal year 2025 Rate Enhancement Open Enrollment Survey Program Improvements by Category.

Rate Enhancement Category	Response Count	Percentage of Total Responses Received
Enrollment application and process	142	18%
Modify the rate enhancement program add-ons per level	171	22%
Modify the cost/accountability reporting requirements	208	27%
Modify the rate enhancement program levels	258	33%

Rate Enhancement Category	Response Count	Percentage of Total Responses Received
Total	**779**	**100%**

Appendix F. Alternative Rate Enhancement Options

If the Texas Legislature desires to modify the Rate Enhancement programs, then HHSC would recommend modifying the current Rate Enhancement programs to address the key considerations outlined earlier in the report.

Modifications to the current programs could include:

- Creating and defining a new purpose for the Rate Enhancement program. The programs should be based on an underlying, clearly defined methodology.
- Developing meaningful add-ons that consider the Medicaid base rate and the personal attendant base wage.
- Simplifying the Rate Enhancement programs to alleviate the administrative burden for HHSC and providers, increase transparency, and reduce complexity. This simplification may include:
  - Reducing the number of Rate Enhancement levels;
  - Maintaining an attendant definition across all applicable programs/services;
  - Maintaining requirements across all applicable programs/services;
  - Streamlining Rate Enhancement enrollment to only once a year; and
  - Streamlining determination of compliance.

Appendix G. State Fiscal Year 2026-27 Appropriation Need to Mitigate Impact Potential Medicaid Loss

Tables 15-17 represent the net appropriation needed to discontinue the HHSC administered Rate Enhancement programs and to implement a "hold harmless” to reduce the likelihood a provider may experience a Medicaid revenue reduction. Tables 15-16 represent the annual net appropriation need for state fiscal years, 2026-2027 respectively. Table 17 represents the biennium total estimated net appropriation need for state fiscal year 2026-27. The estimates assume every eligible Medicaid provider would have enrolled and received the maximum level within the applicable current Rate Enhancement programs. These estimates can be scalable and HHSC can provide further estimates based on different scenarios.

Since MCOs administer their own rate enhancement programs, the estimated fiscals do not include an appropriation need for program and services in the MCO environment. The only exception is related to the Direct Care Staff Enhancement program. Since there is a minimum fee schedule for Nursing Facility services, the below tables assume the rate increase is applied to both the fee-for-service and MCO environments.

In addition, the estimates do not include services that are provided in the applicable CDS service delivery option. As outlined previously in the report, services delivered through CDS are not eligible for Rate Enhancement. In addition, the CDS rate methodology provides an adjustment for the exclusion of CDS service delivery options within Rate Enhancement. HHSC can update the CDS rate methodology without adopting a rate modification.

Table 15. State fiscal year 2026 Fiscal Estimate to Increase Medicaid Base Rate for Hold-harmless provision.

Program	State	Federal	All Funds
PHC, CAS, FC	$1,483,048	$2,171,580	$3,654,628
CLASS	$221,149	$323,821	$544,971
DBMD	$105,651	$154,702	$260,353
RC	$29,387	$43,030	$72,417
DAHS	$101,286	$148,309	$249,595
Subtotal	$1,940,521	$2,841,443	$4,781,964
HCS/TxHML	$8,092,914	$11,850,196	$19,943,111
ICF/IID	$1,937,390	$2,836,859	$4,774,249
Subtotal	$10,030,304	$14,687,055	$24,717,360
Nursing Facility	$58,308,540	$85,379,335	$143,687,875
Total	**$70,279,364**	**$102,907,833**	**$173,187,199**

Table 16. State fiscal year 2027 Fiscal Estimate to Increase Medicaid Base Rate for Hold-harmless provision.

Program	State	Federal	All Funds
PHC, CAS, FC	$1,499,619	$2,191,296	$3,690,915
CLASS	$221,422	$323,549	$544,971
DBMD	$105,782	$154,572	$260,353
RC	$29,423	$42,994	$72,417
DAHS	$101,410	$148,185	$249,595
Subtotal	$1,957,656	$2,860,596	$4,818,251
HCS/TxHML	$8,102,886	$11,840,224	$19,943,111
ICF/IID	$1,955,355	$2,857,234	$4,812,589
Subtotal	$10,058,241	$14,697,458	$24,755,699
Nursing Facility	$61,119,621	$89,310,162	$150,429,783
Total	**$73,135,519**	**$106,868,216**	**$180,003,734**

Table 17. State fiscal year 2026-27 Fiscal Estimate to Increase Medicaid Base Rate for Hold-harmless provision.

Program	State	Federal	All Funds
PHC, CAS, FC	$2,982,667	$4,362,876	$7,345,543
CLASS	$442,571	$647,371	$1,089,943
DBMD	$211,433	$309,274	$520,706
RC	$58,810	$86,024	$144,834
DAHS	$202,695	$296,494	$499,189
Subtotal	$3,898,176	$5,702,039	$9,600,215
HCS/TxHML	$16,195,801	$23,690,421	$39,886,221
ICF/IID	$3,892,745	$5,694,092	$9,586,838
Subtotal	$20,088,545	$29,384,513	$49,473,060
Nursing Facility	$119,428,161	$174,689,497	$294,117,658
Total	**$143,414,883**	**$209,776,049**	**$353,190,933**