Rates: Intermediate Care Facilities and Certain Waiver Providers

As Required by
2022-23 General Appropriations Act, Senate Bill 1, 87th Legislature, Regular Session, 2021 (Article II, Health and Human Services Commission, Rider 30)

Texas Health and Human Services Commission

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Executive Summary

The *Rates: Intermediate Care Facilities and Certain Waiver Providers* Report is submitted pursuant to the 2022-23 General Appropriations Act, Senate Bill 1, 87th Legislature, Regular Session, 2021 (Article II, Health and Human Services Commission, Rider 30).

Rider 30 required Health and Human Services Commission (HHSC), in collaboration with stakeholders, to "evaluate the rate setting methodology" for Home and Community-based Services waiver (HCS), Texas Home Living waiver (TxHmL), and Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Condition (ICF/IID) programs, "including collection of any necessary data, in order to develop reimbursement methodologies that more accurately reflect the costs of services and report back to the Eighty-eighth Legislature."

HHSC contracted with a third-party vendor, Deloitte Consulting LLP (Deloitte) to analyze the HCS/TxHmL and ICF/IID rate methodologies. Deloitte's full report, *Texas HCS, TxHmL, and ICF/IID Rate Setting Methodology Evaluation*, is in Appendix A.

The *Rates: Intermediate Care Facilities and Certain Waiver Providers* Report contains information that was developed by HHSC to provide context and additional information regarding the current HCS/TxHmL and ICF/IID rate methodologies, the cost report process, and Deloitte's report to address Rider 30.

1. Introduction

HHSC contracted with Deloitte to conduct the rate methodology analysis in collaboration with stakeholders for the HCS/TxHmL and ICF/IID rate methodologies, pursuant to Rider 30 requirements.

Beginning in September 2021, Deloitte began the rate methodology analysis, which consisted of the following:

- Convening a provider workgroup consisting of HHSC staff, contracted providers, and representatives from the three main provider associations in Texas: Providers Alliance for Community Services of Texas (PACSTX), Private Providers Association of Texas (PPAT), and Texas Council of Community Centers;
- Conducting an environmental scan of comparable states for similar services to HCS/TxHmL and ICF/IID rate methodologies, where publicly available;
- Conducting provider interviews with a geographically diverse group of HCS/TxHmL and ICF/IID providers; and
- Collection of limited data and available provider feedback to inform the rate methodology analysis and considerations for HHSC.

HHSC appreciates Deloitte's thorough analysis of the rate methodologies and the participation of the stakeholders and contracted providers throughout the rate methodology evaluation process.

2. Background

Current Rate Methodology

HCS and TxHmL are Medicaid waiver programs that supply services and support to Texans with an intellectual or developmental disability (IDD) or a related condition so they can live in the community. An individual receiving services through HCS may live in a residential setting such as a host home or three- or four-bed group home. Individuals receiving services through TxHmL may live in their own homes or family homes. The ICF/IID program provides residential and habilitation services to people with intellectual disabilities or related conditions in a small, medium, or large facility setting.

The existing HCS/TxHmL and ICF/IID current rate methodologies were determined through a model-based rate setting approach using cost, financial, statistical, and operational information collected during site visits performed by the Deloitte & Touche Consulting Group during an evaluation between 1995 and 1997. The data was collected from Medicaid cost reports and the service providers' accounting systems. Additionally, the state fiscal year 1996 state wage data, the state fiscal year 1994 Medicaid cost data, and the state fiscal year 1995 data from service providers were reviewed and analyzed. The base model rate year was calendar year 1997. The current rate structure was developed using data from state fiscal year 1994-1996. The HCS/TxHmL rate methodology is established in accordance with Title 1 of the Texas Administrative Code (1 TAC) Section 355.723. The ICF/IID rate methodology is established in accordance with 1 TAC Section 355.456.

For purposes of this report, one can understand the rate methodology to be the mathematical formula used to calculate rates; however, the variables, or data, are refreshed within that formula based upon more current information, when it is available. HHSC has maintained the rate methodology for HCS/TxHmL, and ICF/IID rate setting and updates wage data, facility, administration, and operations data from the most recently examined Medicaid cost report on a biennial basis.

While rates are recalculated on a biennial basis using updated cost report data, HCS/TxHmL and ICF/IID rate methodologies rely on programmatic assumptions related to assumed staffing ratios and caseload assumptions that support Level of Need (LON) tiering in rates that vary by an individual's acuity. Moreover, the

HCS/TxHmL methodology currently relies on fixed weights to allocate administrative costs across all waiver services. Lastly, the rates may be determined based upon legislatively directed appropriations that do not consider the rate methodology.

Medicaid Cost Reports Process

To recommend accurate rates, HHSC uses a two-step process: cost determination and rate determination. In accordance with 1 TAC Section 355.101(c)(2):

> The objective of the cost determination process is to define direct and indirect costs that are allowable and, therefore, may be considered for use in the overall reimbursement determination process. The cost determination process seeks to collect accurate financial and other statistical data that constitutes the foundation upon which reimbursements are determined.

HHSC requires providers to submit biennial Medicaid cost reports to support the cost determination process. The cost report collects allowable direct and indirect service costs, including direct service wages, benefits, contract services, and staffing information; facility costs; operations costs; and administration costs of the providers incurred through the delivery of Medicaid program services during a provider's cost reporting period. Providers also report the units of service delivered during their cost reporting period on a per-service basis. HCS/TxHmL and ICF/IID providers submit even-year cost reports. For example, HCS/TxHmL and ICF/IID providers will submit their 2022 cost reports by May 1, 2023.

In accordance with 1 TAC Section 355.101(c)(2)(A):

> In order to ensure adequate financial and statistical information upon which to base reimbursement, HHSC requires that each contracted provider submit a periodic cost report or supplemental report. It is the responsibility of the provider to submit accurate and complete information, in accordance with all pertinent HHSC cost reporting rules and cost report instructions, on the cost report and any supplemental reports required by HHSC.

HHSC's cost determination process seeks to ensure allowable costs reported on the Medicaid cost reports and used for rate setting accurately reflect the provider's costs of delivering program services. In accordance with 1 TAC Section 355.102(c),

> Accurate cost reporting is the responsibility of the contracted provider. The contracted provider is responsible for including in the cost report all costs

> incurred, based on an accrual method of accounting, which are reasonable and necessary, in accordance with allowable and unallowable cost guidelines in this section and in §355.103 of this title, revenue reporting guidelines in §355.104 of this title (relating to Revenues), cost report instructions, and applicable program rules. Reporting all allowable costs on the cost report is the responsibility of the contracted provider. The Texas Health and Human Services Commission (HHSC) is not responsible for the contracted provider's failure to report allowable costs; however, in an effort to collect reliable, accurate, and verifiable financial and statistical data, HHSC is responsible for providing cost report training, general and/or specific cost report instructions, and technical assistance to providers. Furthermore, if unreported and/or understated allowable costs are discovered during the course of an audit desk review or field audit, those allowable costs will be included on the cost report or brought to the attention of the provider to correct by submitting an amended cost report.

Furthermore, HHSC conducts financial examinations on all cost reports as part of the cost determination process. In accordance with 1 TAC Section 355.106,

> [HHSC conducts] desk reviews and field audits of provider cost reports in order to ensure that all financial and statistical information reported in the cost reports conforms to all applicable rules and instructions. Cost reports must be completed according to instructions and rules in accordance with §355.105(b)(4) of this title (relating to General Reporting and Documentation Requirements, Methods, and Procedures). HHSC may require supporting documentation other than that contained in the cost report to substantiate reported information.

Adjustments during the financial examination process may either remove unallowable costs or include unreported or understated allowable costs based on supporting documentation or further clarification from providers. Costs may also be adjusted to an amount considered reasonable and necessary, if the data appears to indicate a provider has incurred expenses that are unreasonable or unnecessary in a fair market.

In accordance with 1 TAC Section 355.107, providers are notified of exclusions and adjustments. In accordance with 1 TAC Section 355.110, providers also can

> request an informal review or formal appeal regarding an action or determination under §355.102 of this title (relating to General Principles of Allowable and Unallowable Costs), §355.103 of this title (relating to Specifications for Allowable and Unallowable Costs), §355.104 of this title (relating to Revenues), and §355.105 of this title (relating to General Reporting and Documentation Requirements, Methods and Procedures), or program-specific allowable or unallowable costs, taken specifically in regard to the interested party.

Examined cost reports are used in the determination of statewide prospective rates as part of HHSC's rate determination process. In accordance with 1 TAC Section 355.101(c)(3),

> The reimbursement determination process takes the evaluation of allowable costs one step further by comparing allowable costs across providers to identify those levels of cost, either for individual cost items or groups of cost items, which must be incurred by efficient and economic providers of services meeting all state and federal standards.

Rates are recalculated every biennium by trending the most recent cost report data from the reporting year to the prospective rate year. Final rates are limited within available appropriations. In some cases, rates have exceeded methodologically calculated rates as a result of legislatively directed rate increases.

Medicaid Cost Report Templates, Instructions and Training Materials

HHSC evaluates each cost report template, instructions and training materials each year or biennially, depending on when the cost reports are collected. Modifications to the cost report template, instructions and training materials are based on, but not limited to: legislative mandates that impact the program/service; modification to the applicable program/service; programmatic or policy changes that may impact the applicable service description; data needs; and feedback from contracted providers, cost report preparers and staff during prior cost report collection efforts.

HHSC provides requested cost report template modifications to HHSC’s third-party contracted vendor to implement prior to the cost report collection process. For example, HCS/TxHmL and ICF/IID providers’ cost reports are collected every even-

year. The 2022 HCS/TxHmL and ICF/IID Cost Reports will be collected February 1 - May 1, 2023. Modifications to the cost report template were provided to the contracted vendor by August 2022 to ensure implementation prior to February 1, 2023.

Each program's cost report instructions are posted on HHSC's website prior to February 1, 2023 and includes a section that details any updates made from the prior cost report instructions. In addition, HHSC hosts cost report webinars throughout the year to provide cost report preparers and providers the required training prior to them completing the applicable cost reports. All webinars and registration information are posted to the Texas Health and Human Services website in January of each year.

Prior and Ongoing Provider Concerns with Policy or Billing Limitations, Regulatory Requirements, and Reimbursement Rates

The Rider 30 workgroup raised several items related to policy or regulatory considerations that are not directly tied to the existing rate methodology. Pursuing some of the policy and regulatory items that the stakeholders raised would necessitate either a change in rate methodology, development of a new rate, or would have a fiscal impact (but could be calculated within the current rate methodology if benefit or billing policies were modified).

In general, rate methodologies are intended to capture the allowable direct and indirect costs of existing Medicaid policy requirements of a program for authorized and billable services delivered to a Medicaid eligible and enrolled individual.

Regulatory requirements may influence the cost of business operations, but the rate methodology for Medicaid services is not a mechanism to reimburse providers for all costs of operating a business or for services that are not included in Medicaid policies or service descriptions, other non-allowable expenses, or expenses incurred for non-Medicaid enrolled or eligible individuals.

Rider 30 directs an evaluation of the rate methodology – which would not include examining billing or policy changes, regulatory requirements, or other more comprehensive program reforms that may be desired and even beneficial. If a topic would necessitate either a policy or regulatory change, it is out of scope of the evaluation of the rate methodology. Through information gathering and stakeholder

feedback, considerations were identified that were outside of the Rider 30 directives. These considerations have been summarized in the Appendix of the full report.

Temporary Rate Add-On for Direct Care Costs

The 2020-21 General Appropriations Act, House Bill 1, 86th Legislature, Regular Session, 2019 (Article II, HHSC, Rider 44) required "a rate increase with the intent that the additional funds be spent for the benefit of direct care staff, including direct care staff wages" HHSC implemented temporary rate add-ons on to the attendant compensation rate component for Supervised Living and Residential Support Services (SL/RSS) rates in the HCS program effective January 1, 2020. HHSC promulgated 1 TAC Section 355.727, regarding Add-on Payment Methodology for Home and Community-Based Services Supervised Living and Residential Support Services to ensure add-on rate funding was directed to direct care staff. The temporary add-on rates were set to expire on August 31, 2021; however, HHSC extended the temporary add-on rates through August 31, 2023 pursuant to Rider 30.

When implemented, the temporary add-on rates exceeded the methodological rate calculated for the 2020-21 biennium. HHSC has recalculated the methodological rates for SL/RSS services for the 2024-25 biennium. The recalculated methodological rates demonstrate that provider costs have increased to support maintaining these rates on an on-going basis.

3. Deloitte's Rate Methodology Considerations

Deloitte's report, *Texas HCS, TxHmL, and ICF/IID Rate Setting Methodology Evaluation,* includes High-Level Considerations and Service-Specific Considerations. Deloitte developed these considerations after an extensive evaluation process that included an environmental scan, provider interviews, data collection efforts, and coordination of a workgroup consisting of HHSC staff, contracted providers, and provider associations.

Table 1 below summarizes Areas of Concern identified as a result of the Deloitte analysis, considerations, and HHSC's responses to these considerations. It also includes actions taken or potential actions HHSC may implement, fiscal impact determinations, identified dependencies and the associated timeline. More detailed information about the various considerations and HHSC's response can be found in the sections of the report that follow.

Table 1. Summarized HHSC's Responses to Areas of Concern and Considerations

Areas of Concern	Consideration	HHSC's Response	HHSC's Action or Potential Action
Cost reporting is not currently capturing all costs of providing care, including allowable and billable costs, and allowable but non-billable costs	4.1.2.1 Revise cost report template and accompanying instructions, or consider pro forma or modeled rate approaches if data cannot be obtained or is not reliable	Providers should report all allowable costs in the relevant section of the cost report.	HHSC evaluated and has determined all applicable cost report template fields would capture all relevant allowable costs. HHSC has modified the 2022 Cost Report Instructions and Training to provide further clarification on allowable costs.
HHSC biennial rate reviews and rebasing with updated cost report data satisfy Centers for Medicare & Medicaid Services (CMS) requirements, but in some cases rate	4.1.2.2. Consider the appropriateness of rate components that are based on cost report data or other data sources on a recurring basis or define	All components of the rate methodology should be based on applicable data and updated	HHSC is proposing an establishment of a formalized Random Moment Time Study (RMTS) process on an ongoing basis, similar to the RMTS process already administered

Areas of Concern	Consideration	HHSC's Response	HHSC's Action or Potential Action
components have not been updated with more recent cost report data or are based on studies performed 20+ years ago, including attendant caseload assumptions. In these cases, the reimbursement methodology may not be reflective of the cost to provide service	assumptions as a matter of policy.	on a recurring basis.	by HHSC for School Health and Related Services (SHARS) and Medicaid Administrative Claiming (MAC) providers. A RMTS would allow HHSC to standardize the collection of applicable staff's time and effort by each LON for services with variable rates by applicable service.
Direct care wages were consistently identified by providers across services as their biggest concern with the current rates, and the 80% rule shifts direct care costs outside of direct care in the cost reporting	4.2.3.1 Evaluate the appropriateness of the 80% rule, the impact the rule has on where costs are reported on cost reports, and the resulting reimbursement impact.	HHSC does not yet have data to indicate the percentage of direct care costs that may be shifted outside of direct care of the cost report.	HHSC modified the 2022 HCS/TxHmL and ICF/IID Cost Report Template to collect data related to the provider's non-attendant staff performing attendant services, less than 80% of the time. The 2022 HCS/TxHmL and ICF/IID Cost Reports will be collected by April 2023. HHSC will then conduct a financial examination of these cost reports and other reports received.
The current administrative cost allocation methodology of using fixed weights for most services may not reflect the mix of administrative cost across services, and thus the reimbursement methodology may not	4.3.3.1 Evaluate alternatives to the current methodology of allocating administrative costs by fixed weights, and the appropriateness of administrative costs that have	The fixed weights should be evaluated further and on a reoccurring basis.	HHSC plans on incorporating data collection efforts in the formalized RMTS referenced in Consideration 4.1.2.2.

Areas of Concern	Consideration	HHSC's Response	HHSC's Action or Potential Action
reflect the actual costs to provide each service. **For other services, administrative costs are established as a matter of policy and may not be reflective of the actual cost to provide the service.**	been established as a matter of policy.		
Other states use inflators or other adjustments to account for non-billable but allowable costs required for the provision of quality, efficient, and economical care.	4.4.3.3 Consider rate adjustments to capture the impact of allowable but non-billable activities, or update cost reporting consistent with 4.1.2.1 as appropriate	The existing rate methodology incorporates a markup percentage that is applied to rates of either 4.4 or 7 percent depending on the service. The markup factor that exists already may satisfy this purpose.	HHSC will defer to legislative considerations provided by the 88th Legislature.
Transportation cost allocation is across all services as opposed to just the specific services utilizing transportation. Additionally, data is not currently available to evaluate other reimbursement methodologies for transportation that may more accurately capture the cost of providing transportation services.	4.5.3.1 Consider capturing transportation cost by service, as well as the gathering of data to evaluate transportation costs and other reimbursement methodologies	HHSC does not yet have data to evaluate transportation cost by service.	HHSC plans on evaluating an update to the 2024 HCS/TxHmL and ICF/IID Cost Report Templates to capture allowable transportation cost by service. The data will be collected by April 2025. HHSC will then conduct a financial examination of these cost reports and other reports received. In addition to the evaluation of the costs by service, HHSC is

Areas of Concern	Consideration	HHSC's Response	HHSC's Action or Potential Action
			planning on evaluating if any rate methodology updates may impact other programs/services.
Related party cap is not applied to all Long-Term Services and Supports (LTSS) providers, TAC §355.722(h) defines a related party cap that is applied only to attendant care for IDD providers	4.6.2.1 Where appropriate, standardize related party policy across LTSS providers	Appropriate and standardized related party policies should be consistent across similar provider types.	HHSC plans on evaluating the related party cap to ensure consistency in applicable rate methodologies by the end of 2023 to all programs.
The majority of Host Home/Companion Care (HH/CC) providers contract out the service; as a result, the attendant wage and compensation data in the cost report for HH/CC is rarely populated, and an allowable and attributable portion of facility and operations costs not currently captured in the cost report or through the rate methodology	5.2.3.1 Consistent with 4.1.2.1, revise cost report template and accompanying instructions, or consider pro forma or modeled rate approaches if data cannot be obtained or is not reliable	All components of the rate methodology should be based on applicable data and updated on a recurring basis.	HHSC plans on evaluating the need to modify the cost report template/instructions or model rates from some other data element by the end of 2023.
The administrative component of the rate is not developed using actual service costs, but set equal to the administrative and facility cost component of habilitation services in the Community Living Assistance and Support Services	5.4.3.2 Consistent with 4.3.3.1, consider evaluating alternatives to the current administrative cost methodology.	The administration and operations costs should be based on current provider costs once a new cost allocation methodology is determined.	HHSC will defer to legislative considerations provided by the 88th Legislature.

HHSC has highlighted below a few overall considerations the agency factored into its specific responses to Deloitte's analysis.

HHSC's Overall Considerations

Data Collection Efforts

As noted in the Deloitte report, a data request survey was created to "to inform assumptions related to proposed rate methodology considerations." Deloitte reported:

> The providers included in the data survey process were limited to those involved in the provider workgroup, and the set of providers who agreed to be involved with the provider interviews. Limiting the number of providers enabled the Deloitte team to work directly with all involved providers to address questions they had in populating the data request and in the review of the data collected. The data request responses were evaluated for reasonableness, and clarification was requested from providers when data did not appear reasonable. Datapoints that were considered outliers, or were deemed unreliable, were excluded from our analysis.

A targeted approach was utilized to collect data from engaged providers, given past data collection efforts by HHSC that resulted in lower-than-ideal response efforts, which has consistently rendered results statistically insignificant and invalid. Please see information regarding the Random Moment Time Study (RMTS) in HHSC's Response to Consideration 4.3.3.1 for more information regarding prior data collection efforts. Based on Deloitte's data collection efforts:

> In all, 17 of the 37 providers who were invited to participate in the data collection effort provided data. These providers represent 18.6% of the total cost of the TX HCS program, as of the 2018 cost reporting, which is a small representative sample size.

Given that a financial examination of the collected data was not conducted, HHSC would not recommend using the data for rate methodology purposes. HHSC is committed to working with all contracted HCS/TxHmL and ICF/IID providers to capture data that better informs the rate methodology and provides some potential options as responses to Deloitte's Considerations below.

Pro-Forma Costing Approach

Deloitte reported that HHSC should consider:

Updating the cost report template and/or the cost report instructions to clarify where identified allowable and billable costs should be reported. HHSC could consider applying temporary rate adjustments to account for identified unreported costs to the extent they are material and reasonably able to be estimated. Given the lag between when costs are incurred by providers, and when cost reporting is used to develop the prospective rates by service, if adjustments are not made to rates in the interim, then the reimbursement methodology may not accurately reflect the costs of services. These temporary adjustments would no longer be applied in the rate methodology at the point in time the underlying cost reporting is capturing these costs. Deloitte also reported that HHSC should consider:

> Updating the cost report template and/or the cost report instructions to permit providers to report allowable but non-billable costs. These costs can be used to inform corresponding rate adjustments, such as productivity adjustments in the case of non-billable training time, a service coordination adjustment in the case of non-billable case management activities, an adjustment to account for the impact on the reported direct care hours related to the 80% rule, and to capture the impacts of non-billable nursing time. Similar to the above consideration, HHSC should also consider a temporary adjustment to the rates to account for these costs, until cost report data is available to inform the adjustment. "HHSC could also consider using pro forma, or modeled rate approaches, in cases where reliable data required to inform rate setting assumptions cannot be obtained through cost reporting."

HHSC currently relies on a pro-forma costing or modeling approach to rate setting for HCS/TxHmL services when appropriate. 1 TAC Section 355.101 defines HHSC's approach to pro forma costing as:

> When historical costs are unavailable, such as in the case of a new program, reimbursement may be based on a pro forma approach. This approach involves using historical costs of delivering similar services, where appropriate data are available, and estimating the basic types and costs of products and services necessary to deliver services meeting federal and state requirements.

A pro forma costing approach allows HHSC to use cost data for similar services, external data from reputable public or commercial sources, and necessary and reasonable programmatic assumptions. This data is used to develop anticipated costs and recommended payment rates for services when sufficient historical cost data are unavailable.

While HHSC relies on a pro forma costing approach to set some service rates, this approach is only accurate if the service description is sufficiently detailed to support modeled assumptions and external data used in rate calculations is appropriate to approximate the contracted service costs. HHSC also needs to ensure modeled assumptions can be revised with new data over time to reflect changes in service providers' time and effort to deliver services based on an individual's needs. HHSC prefers to calculate recommended payment rates using trended cost report data because it reflects actual provider experience of the allowable costs to deliver contracted services.

The pro forma costing approach requires a detailed description of the service or program model being provided and programmatic assumptions about provider level of effort to deliver services that can be associated with anticipated costs. Service descriptions should outline the minimum and reasonable requirements a provider must meet to deliver a particular service. Service requirements should also include:

- Provider credentials and qualifications;
- Minimum staffing levels to ensure access, safety, and quality of care; and
- The facility, transportation, and administration costs necessary to ensure service delivery.

The service description should also include any assumptions necessary for rate development. If rates vary by LON, HHSC needs to make informed assumptions regarding specific needs of an individual receiving services, including individual acuity, behavioral, or medical requirements. This description should inform the program model as appropriate based on the scope of each service; a comprehensive service description should serve as a model for all aspects of a program or service that could reasonably impact a provider's cost to deliver that service.

If providers fail to report all allowable costs to HHSC, it limits the methodological rate that is supported; it does not mean rate methodology is inherently flawed. To

encourage better compliance, HHSC is updating cost reporting instructions so providers will have increased awareness of where and how to report all allowable costs. Additional information about increased and improved data collection follows in the next section of this report.

Deloitte's Considerations and HHSC's Responses

4.1 Process Improvement - Cost reporting is not currently capturing all costs of providing care, including allowable and billable costs, and allowable but non-billable costs.

Consideration 4.1.2.1 - Revise cost report template and accompanying instructions, or consider pro forma or modeled rate approaches if data cannot be obtained or is not reliable.

HHSC Response: HHSC recognizes the importance of accurate data collection during the cost reporting process to ensure a reliable basis for determining appropriate reimbursement rates. As mentioned previously in the report, 1 TAC Section 355.102(c) states:

> Accurate cost reporting is the responsibility of the contracted provider. The contracted provider is responsible for including in the cost report all costs incurred, based on an accrual method of accounting, which are reasonable and necessary…in an effort to collect reliable, accurate, and verifiable financial and statistical data, HHSC is responsible for providing cost report training, general and/or specific cost report instructions, and technical assistance to providers.

Stakeholders expressed "concerns that the cost reports are not capturing all the costs required to provide quality, economical and efficient care." In response to these concerns, Deloitte reported:

> HHSC could consider updating the cost report template and/or cost report instructions to clarify where allowable and billable costs should be captured in the cost reporting and allow for reporting of allowable but non-billable costs. HHSC could also consider using pro forma, or modeled rate approaches, in cases where reliable data required to inform rate setting assumptions cannot be obtained through cost reporting.

HHSC has reviewed the cost report alongside the comments received from providers and has confirmed that all cost categories have an appropriate place where they could be reported on the cost report. As a result, HHSC believes that the failure to report costs is not a defect of the cost report itself, but rather a lack of clarity from providers about where to put costs. HHSC is committed to helping providers improve their compliance with cost reporting.

While the current cost report instructions include definitions, information, and/or examples of allowable and unallowable costs, HHSC is emphasizing and providing further clarification in the cost report instructions and the associated training. In evaluating Deloitte's Consideration 4.1.2.1, HHSC made modifications to the cost report instructions to clarify where certain items should be reported:

- HHSC added additional information to the 2022 cost report instructions to reinforce that all allowable costs — direct and indirect, billable and non-billable — incurred during the provision of contracted services should be reported on the Medicaid cost report. Information detailing the differences in these costs is provided below.

- HHSC added clarification that case management and service coordination staff costs should be reported as part of "Other Administrative Staff. "

- HHSC added language regarding how providers should report allowable staff training and orientation costs. If the costs for staff to attend trainings related to providing contracted services are subject to payroll taxes, costs should be reported with regular wages and compensation costs. Other training costs should be reported as part of administrative and operations costs.

It is not feasible for HHSC to develop an exhaustive list of all allowable costs for each program and service. HHSC encourages contracted providers and cost report preparers to contact the HHSC Provider Finance Department (PFD) LTSS if they have a question regarding the cost report. LTSS has a team dedicated to providing training and assistance related to the cost reports and other LTSS programs and services. This team can be reached during normal business hours at (737) 867-7817 or PFD-LTSS@hhs.texas.gov. Additional information regarding allowable, unallowable, billable, and non-billable costs is below.

Allowable and Unallowable Costs

In accordance with 1 TAC Sections 355.102(a), "Allowable and unallowable costs, both direct and indirect, are defined to identify expenses that are reasonable and necessary to provide contracted client care and are consistent with federal and state laws and regulations."

In accordance with 1 TAC Section 355.102(f)(1),

> Reasonable refers to the amount expended. The test of reasonableness includes the expectation that the provider seeks to minimize costs and that the amount expended does not exceed what a prudent and cost-conscious buyer pays for a given item or service. In determining the reasonableness of a given cost, the following are considered:
>
> - the restraints or requirements imposed by arm's-length bargaining, i.e., transactions with nonowners or other unrelated parties, federal and state laws and regulations, and contract terms and specifications; and
>
> - the action that a prudent person would take in similar circumstances, considering his responsibilities to the public, the government, his employees, clients, shareholders, and members, and the fulfillment of the purpose for which the business was organized.

Beyond the cost's reasonability, an allowable cost must also be necessary. In accordance with 1 TAC 355.102(f)(2),

> "Necessary" refers to the relationship of the cost, direct or indirect, incurred by a provider to the provision of contracted client care. Necessary costs are direct and indirect costs that are appropriate in developing and maintaining the required standard of operation for providing client care in accordance with the contract and state and federal regulations. In addition, to qualify as a necessary expense, a direct or indirect cost must meet all of the following requirements:
>
> A. the expenditure was not for personal or other activities not directly or indirectly related to the provision of contracted services;
>
> B. the cost does not appear as a specific unallowable cost in §355.103 of this title;

C. if a direct cost, it bears a significant relationship to contracted client care. To qualify as significant, the elimination of the expenditure would have an adverse impact on client health, safety, or general wellbeing;

D. the direct or indirect expense was incurred in the purchase of materials, supplies, or services provided to clients or staff in the normal conduct of operations to provide contracted client care;

E. the direct or indirect costs are not allocable to or included as a cost of any other program in either the current, a prior, or a future cost-reporting period;

F. the costs are net of all applicable credits;

G. allocated costs of each program are adequately substantiated; and

H. the costs are not prohibited under other pertinent federal, state, or local laws or regulations."

Unallowable costs are costs that are neither reasonable or necessary and should not be reported on the Medicaid cost report (1 TAC 355.102[g]). Providers may incur these costs, but these costs cannot be considered as part of HHSC's rate determination processes.

Billable and Non-Billable Costs

Billable costs are costs incurred to provide contracted client services for which a unit of service can be directly billed. These are costs often incurred through direct interaction with the individual receiving services. HHSC generally defines these billable costs as direct costs. In accordance with 1 TAC Section 355.102(f)(3),

> Direct costs are those costs incurred by a provider that are definitely attributable to the operation of providing contracted client services. Direct costs include, but are not limited to, salaries and nonlabor costs necessary for the provision of contracted client care. Whether or not a cost is considered a direct cost depends upon the specific contracted client services covered by the program. In programs in which client meals are covered program services, the salaries of cooks and other food service personnel are direct costs, as are food, nonfood supplies, and other such dietary costs. In programs in which client transportation is a covered program service, the

> salaries of drivers are direct costs, as are vehicle repairs and maintenance, vehicle insurance and depreciation, and other such client transportation costs.

Assuming the billable costs meet the test of reasonableness, direct costs are necessary for the provision of client care and are, by definition, allowable costs and should be reported on the Medicaid cost report.

HHSC generally defines non-billable costs as indirect costs. In accordance with 1 TAC Section 355.102(f)(4),

> Indirect costs are those costs that benefit, or contribute to, the operation of providing contracted services, other business components, or the overall contracted entity. These costs could include, but are not limited to, administration salaries and nonlabor costs, building costs, insurance expense, and interest expense. Central office or home office administrative expenses are considered indirect costs.

Indirect costs must be both reasonable and necessary in that they support the provision of client care and ensure the health, safety and wellbeing of individuals receiving services. However, they are not directly tied to a delivered service unit. Activities that are not directly client-facing, but are essential to deliver required services or ensure health and safety, are indirect and often non-billable costs. Nevertheless, these types of costs are allowable and should be reported on the Medicaid cost report.

Some examples of non-billable but allowable costs include staff training activities necessary for service delivery or ensuring an individual's health and safety. These may occur when the individual receiving services is absent. A nurse’s activities related to charting or other duties required to maintain his or her license and supporting contracted HCS/TxHmL or ICF/IID services are another example. These activities can be considered indirect and non-billable but are still allowable costs and should be reported on the Medicaid cost report. Other examples of indirect, non-billable costs include, but are not limited to costs such as telecommunications, rent/lease, mortgage, property taxes, office supplies, administration staff wages and benefits, and insurance costs.

As mentioned above, HHSC is committed to providing additional guidance related to allowable costs, whether direct or indirect, billable or non-billable, beginning with

the 2022 HCS/TxHmL and ICF/IID cost reports. HHSC does not anticipate an administrative fiscal impact for these revisions.

4.1 Process Improvement - HHSC biennial rate reviews and rebasing with updated cost report data satisfy CMS requirements, but in some cases, rate components have not been updated with more recent cost report data or are based on studies performed 20+ years ago, including attendant caseload assumptions. In these cases, the reimbursement methodology may not be reflective of the cost of providing service.

Consideration 4.1.2.2 - Consider the appropriateness of rate components that are based on cost report data or other data sources on a recurring basis or define assumptions as a matter of policy.

HHSC Response: In accordance with 1 TAC Section 355.101(c)(1), "Reimbursement amounts will be determined coincident with the state's biennium" and HHSC conducts a biennial fee review process for all service rates. During the biennial fee review, HHSC updates the HCS/TxHmL and ICF/IID rate models with the most recently examined median provider cost data trended from the cost reporting period to the prospective rate period. These cost areas include staff wages and benefits, facility, and total administrative costs. For services where rates vary by LON, the HCS/TxHmL and ICF/IID rate models rely upon a direct-care-hours-per-unit assumption. This assumption comes from a 1997 Deloitte & Touche study that weights the direct care costs to create tiers for each LON. HHSC currently does not collect data associated with staff time or effort to serve individuals for each LON on the cost report.

HHSC believes that the 1997 weights should be refreshed on a consistent and ongoing basis. To accomplish this, HHSC would collect data related to staff time/direct care hours for each LON to evaluate and support accurate variable rates through a formalized RMTS. HHSC would not recommend utilizing the cost report to collect the direct care hours for each LON for several reasons. The cost report is designed to collect annual financial and statistical data that can be easily aggregated. Staff time and effort are variable and may need to be reported more frequently to ensure accuracy. For example, HHSC has requirements around time studies defined in accordance with 1 TAC section 355.105, "The minimum allowable

statistical duration for a time study upon which to base salary allocations is four weeks per year, with one week being randomly selected from each quarter so as to assure that the time study is representative of the various cycles of business operations. One week is defined as only those days the contracted provider is in operation during seven continuous days. The time study can be performed for one continuous week during a quarter, or it can be performed over five or seven individual days, whichever is applicable, throughout a quarter. The time study must be a 100 percent time study, accounting for 100 percent of the time paid the employee, including vacation and sick leave."

From a data collection standpoint, HHSC recommends establishing a formal, recurring time study of HCS/TxHmL and ICF/IID providers that would identify time and effort for direct care staff associated with each LON. HHSC previously coordinated with a third-party vendor to perform a RMTS in 2020 to collect data to evaluate the administrative weights within the rate methodology. As detailed in HHSC's response to Consideration 4.3.3.1, the RMTS resulted in data that was not sound for modifying the administrative weights due to the providers' low response rate and the potential impact of Coronavirus disease 2019 (COVID-19). A formal RMTS would standardize the reporting and evaluation of staff time, effort, or both for each LON from the contracted providers and their staff directly on a reoccurring basis.

HHSC currently administers a RMTS for the SHARS and MAC Independent School Districts. Due to the differences between the SHARS, MAC, HCS/TxHmL, and ICF/IID programs, HHSC is not recommending combining the HCS/TxHmL and ICF/IID Time Study into the current structure of HHSC's SHARS and MAC Time Study program. However, HHSC will leverage current policies, procedures and practices, as appropriate, for the development and implementation of the HCS/TxHmL and ICF/IID time study. Additional information regarding the RMTS and identified dependencies for implementing the RMTS are included further in this report.

Contracted providers may incur additional costs and burdens in relation to the time study; these costs would be allowable on the Medicaid cost reports. However, HHSC cannot estimate a potential fiscal impact to the providers at the time of this report.

4.2 Direct Care Wages - Direct care wages were consistently identified by providers across services as their biggest concern with the current rates, and the 80% rule shifts direct care costs outside of direct care in the cost reporting.

Consideration 4.2.3.1 - Evaluate the appropriateness of the 80% rule, the impact the rule has on where costs are reported on cost reports, and the resulting reimbursement impact.

HHSC Response: In accordance with 1 TAC Section 355.112(b)(1), an attendant may perform some nonattendant functions.

> In such cases, the attendant must perform attendant functions at least 80 percent of his or her total time worked. Staff in these settings not providing attendant services at least 80 percent of their total time worked are not considered attendants.

Furthermore, 1 TAC Section 355.112(b)(1) requires time studies must be performed in accordance with 1 TAC §355.105(b)(2)(B)(i) for staff that are not full-time attendants but perform attendant functions to determine if a staff member meets this 80 percent requirement. Failure to perform the time studies for these staff will result in the staff not being considered attendants.

The 80 percent rule exists to ensure rate add-ons for attendant staff associated with participation in the Attendant Compensation Rate Enhancement program are paid to full-time attendant staff. If administrative staff costs are part of attendant compensation, HHSC would not be able to hold providers accurately accountable for their spending requirement under 1 TAC 355.112. The rule also functions to ensure direct care staff costs are not skewed by higher paid administrative staff costs when the attendant compensation cost component is calculated in the rate methodology.

The costs associated with administrative staff performing attendant or direct care functions are currently allowable on the cost report and are reported with the main wage costs of the staff person who is providing the attendant care less than 80 percent of their total time worked.

HHSC has modified the 2022 cost report templates to collect the direct care wages and hours provided by non-attendant staff that do not spend 80 percent or more of their time on direct care activities. This data will allow HHSC to evaluate the extent to which administrative staff are providing attendant functions. There are factors

that may influence the percentage of administrative staff performing attendant functions. One of these factors could be any increases to the attendant compensation rate component. The 2022 HCS/TxHmL and ICF/IID cost reports will be collected by April 2023 and will then proceed through the financial examination process described previously in this report. HHSC plans on evaluating the data collected once the financial examination process has been completed to begin assessing the potential impact of the 80 percent rule on the attendant rate component.

Further evaluation of the removal of or modification to the 80 percent rule, as it pertains to the Attendant Compensation Rate Enhancement Program, will be needed as well. To ensure enhancement funds are paid to staff who predominately perform personal attendant functions, HHSC may want to maintain the 80 percent rule solely for determining rate enhancement spending compliance. There may be a potential fiscal impact related to the modification or removal of the 80 percent rule as outlined in 1 TAC Section 355.112 (b)(1). HHSC cannot estimate the potential client services fiscal impact until the data is collected and evaluated.

The cost report templates modifications were absorbed with current resources and HHSC does not anticipate a fiscal impact related to any further cost report template modifications related to the 80 percent rule.

4.3 Administrative Cost Allocation - The current administrative cost allocation methodology of using fixed weights for most services may not reflect the mix of administrative costs across services, and thus the reimbursement methodology may not reflect the actual costs to provide each service. For other services, administrative costs are established as a matter of policy and may not be reflective of the actual cost of providing the service.

Consideration 4.3.3.1 - Evaluate alternatives to the current methodology of allocating administrative costs by fixed weights, and the appropriateness of administrative costs that have been established as a matter of policy.

HHSC Response: The current HCS/TxHmL rate methodology allocates administration and operations costs using fixed weights. The fixed weights were

developed over a decade ago and may no longer be properly allocating administrative costs.

In 2019, HHSC, in discussion with HCS/TxHmL provider associations, agreed that there was a need to evaluate the HCS/TxHmL administrative weights. HHSC contracted with Public Consulting Group (PCG) to conduct a RMTS among HCS/TxHmL providers.

Beginning in January 2020, PCG engaged in a multi-step process to conduct the RMTS. This process included routine meetings with HHSC staff, meetings with provider associations, development of the RMTS question structure, determination of valid sample size, development of an activity list as a first-time RMTS process, collection of staff rosters for identified agencies/participants, training for participants and provider associations, the administration of the RMTS, and analysis of the RMTS results. The RMTS was paused in mid-2020 due to the COVID-19 federally declared public health emergency and then reinstated in August 2020. The RMTS was conducted from October 15 to November 15, 2020.

After the RMTS was conducted, HHSC assessed the data to ensure soundness as the basis for the new administrative weights. For instance, HHSC compared the RMTS data to claims data for the participating providers. While this evaluation is imperfect because the claims data was not associated with the same RMTS time-period, it did serve as a good proxy for evaluation selection error in the RMTS. Based on this evaluation, HHSC identified approximately 21 percent of the RMTS selections that did not match providers' billing data. Furthermore, HHSC evaluated the RMTS results compared to utilization of services. The administrative cost allocation based on PCG RMTS percentages resulted in a shift of costs from services with higher utilization to services with lower utilization. This shift leads to significantly higher administrative cost components rates in the most underutilized services on a per-unit basis.

In addition to the above, HHSC identified potential considerations related to the soundness of the RMTS data. First, PCG indicated the response rate was lower than what is considered ideal. Overall, 674 providers were determined as eligible to participate in RMTS. Of those 674 providers, 406 (60 percent) submitted staff rosters to participate in the RMTS. After the RMTS sample was generated, 292 provider agencies were assigned at least one moment survey to one participant. At the conclusion of the RMTS, at least one staff member answered one or more moment surveys from 226 provider agencies. In other words, 77.4 percent (226) of

the sample (the group of providers assigned to participate in the survey was 292) participated by providing at least one complete survey. Every provider in the sample was sent multiple moments for responses. Overall, the RMTS had a response rate of 64.38 percent of completed survey responses. Secondly, the RMTS was conducted in 2020 when providers were responding to COVID-19. It is not known how COVID-19 may have impacted the results of the RMTS.

After evaluating the RMTS data as outlined above and discussing potential options with stakeholders, HHSC determined that it was not appropriate to adjust the administrative weights based on the RMTS data or results.

HHSC plans on evaluating the inclusion of data collection efforts into the formalized reoccurring RMTS HHSC is proposing in response to Consideration 4.1.2.2. Further information regarding the RMTS is located in the RMTS section of this report.

4.4 Inflators and Other Adjustments - Other states use inflators or other adjustments to account for non-billable but allowable costs required for the provision of quality, efficient, and economical care.

Consideration 4.4.3.3 - Consider rate adjustments to capture the impact of allowable but non-billable activities, or update cost reporting consistent with 4.1.2.1 as appropriate.

HHSC Response: Please see the response related to Consideration 4.1.2.1 regarding the modifications to the cost report instructions and training. If modifications pertaining to data collection outlined in Consideration 4.4.3.3 are required for the cost report template, HHSC anticipates that these can be made within current resources.

Productivity Adjustment

HHSC's rate methodologies for HCS/TxHmL in 1 TAC Section 355.112 and 1 TAC Section 355.723, and ICF/IID in 1 TAC Section 355.456, establish adjustment factors of 1.044 for community care services and 1.07 for facility-based services. These factor adjustments were implemented to cover potential costs not reported on the cost report, increase the recommended rates to above the median of reported provider costs, or both. These factor adjustments are being applied in rate methodologies across all LTSS programs and services.

Deloitte reported that HHSC could consider replacing the factor adjustments with factors that "can be updated on a repeatable basis with available or obtainable data multiple other adjustments", such as with a productivity adjustment "to account for allowable but not billable time spent on tasks that are necessary for providing high-quality care, such as staff training and quality review." It may be appropriate to revise the current factor adjustments with a productivity adjustment supported by data reported on the cost report; however, HHSC believes the majority of non-billable costs anticipated to be offset by a productivity adjustment are allowable, indirect costs and should be reported on the cost report as discussed in HHSC's response to Consideration 4.1.2.1.

Furthermore, the 2018-2019 General Appropriations Act, House Bill 1, 86th Legislature, Regular Session, 2019 (Article II, HHSC, Rider 44) directed HHSC "to increase the factor for HCS providers from 4.4 percent to 7.0 percent for facility-based services". HHSC would defer to legislative consideration before making a change regarding the factor adjustments.

Occupancy/Vacancy Adjustment

Deloitte reported that HHSC could consider replacing the factor adjustments with factors that "can be updated on a repeatable basis with available or obtainable data multiple other adjustments", such as an occupancy/vacancy adjustment in residential settings for days when beds cannot be filled. This adjustment differs from the occupancy adjustment applied to nursing facilities and residential care facilities in 1 TAC 355.308 and 1 TAC 355.509, respectively. The purpose of the occupancy adjustment in those rate methodologies is to lower facility, transportation, and administration expenses in determining the methodological rates.

The occupancy/vacancy adjustment Deloitte proposes would serve to increase rates by offsetting some provider costs related to "unavoidable empty bed days." However, HHSC believes providers should report all allowable costs for serving individuals in contracted services on the cost report. As long as providers are serving at least one individual in a residence for a HCS/TxHmL eligible service, all allowable costs for that home should be reported on the cost report. Allowable costs would include fixed costs such as rent/lease, mortgage, telecommunications, utilities, supplies and shared furnishings, and property taxes etc., are indirect costs and would be reflected in the current rate methodology if reported on the cost reports. Higher indirect costs due to empty beds results in less units of service being billed and therefore a higher methodological rate. As long as providers are

reporting allowable indirect costs for residential services, an occupancy/vacancy adjustment may not be necessary.

Service Coordination/Case Management Adjustment

As mentioned in HHSC's response to Consideration 4.1.2.1, HHSC modified the cost report instructions to indicate allowable service coordination staff costs should be reported under the "Other Administrative Staff Costs" category on the 2022 report. Providers should report costs only for activities incurred by contracted providers that are not duplicative of costs associated with service coordination and case management functions of the Local Intellectual and Developmental Disability Authorities.

4.5 Transportation - Transportation cost allocation is across all services as opposed to just the specific services utilizing transportation. Additionally, data is not currently available to evaluate other reimbursement methodologies for transportation that may more accurately capture the cost of providing transportation services.

Consideration 4.5.3.1 - Consider capturing transportation cost by service, as well as the gathering of data to evaluate transportation costs and other reimbursement methodologies.

HHSC Response: HHSC is open to considering revisions to the Medicaid cost report template to collect additional data related to transportation services in the HCS/TxHmL programs to evaluate reimbursement methodologies for transportation. Modifications to the cost report template can be absorbed within current sources, and could be applied to the 2024 HCS/TxHmL Cost Report template.

4.6 Related Party Considerations - Related party cap is not applied to all LTSS providers. TAC §355.722(h) defines a related party cap that is applied only to attendant care for IDD providers.

Consideration 4.6.2.1 - Where appropriate, standardize related party policy across LTSS providers

HHSC Response: HHSC agrees it is important to ensure consistency across programs and provider types where appropriate. HHSC plans on evaluating the related party cap as it applies to attendant care for LTSS providers by the December 31, 2023. Any modifications would require 1 TAC amendments and may result in a fiscal impact.

5.2 Host Home/Companion Care (HH/CC) - The majority of HH/CC providers contract out the service; as a result, the attendant wage and compensation data in the cost report for HH/CC is rarely populated, and an allowable and attributable portion of facility and operations costs not currently captured in the cost report or through the rate methodology.

Consideration 5.2.3.1 - Consistent with 4.1.2.1, revise cost report template and accompanying instructions, or consider pro forma or modeled rate approaches if data cannot be obtained or is not reliable.

HHSC Response: HH/CC care provides individuals with personal assistance with activities of daily living (grooming, eating, bathing, dressing and personal hygiene) and functional living tasks; assistance with planning and preparing meals; transportation or assistance in securing transportation; assistance with ambulation and mobility; reinforcement of behavioral support or specialized therapies activities; assistance with medications based upon the results of an Registered Nurse assessment; and supervision of the individual's safety and security. This service includes habilitation activities that facilitate the individual's inclusion in community activities, use of natural supports and typical community services available to all people, social interaction and participation in leisure activities, and development of socially valued behaviors and daily living and functional living skills.

HH/CC is provided in a private residence meeting HCS requirements by a HH/CC service provider who lives in the residence.

HH/CC is combined because the actual services provided are identical. The only distinction is which individual has the property interest in the home in which the services are being provided. In a host home arrangement, the host home service provider owns or leases the residence. In a companion care arrangement, the residence may be owned or leased by the companion care service provider or may be owned or leased by the individual.

The current HH/CC rate methodology is a model-based rate like other waiver services. However, this service differs as most HCS waiver providers contract with individuals to provide HH/CC. Since HH/CC providers do not contract with HHSC, they are not required to complete cost reports.

The current HH/CC rate model relies on programmatic assumptions related to the direct care cost component and rate tiering for each LON that HHSC has been unable to update with revised data. The modeled assumptions related to direct care have the effect of holding these costs constant which may artificially lower the methodological rates because the costs are not being adjusted for increases in costs beyond straight-line inflation. The model also lacks a coherent methodology to calculate tiered rates by LON. While HHSC has tried in the past to remodel the rate and develop a revised methodology, lack of available data has been an obstacle.

Deloitte reported that

> HHSC could consider comparing the average HCS only, contract non-attendant wages and compensation per day from the HH/CC cost reporting to the average attendant + non-attendant wages and compensation per day from the RSS/SL cost reporting. This would provide a proxy for the relativity in direct care costs between the services being provided in the RSS/SL setting and in the HH/CC setting. This relativity could then be applied to the RSS/SL direct care rate component, to develop an HH/CC direct care rate component with a data driven, repeatable methodology. The percentage used in this comparison could be based on the relationship in the most recent cost reporting, or methodologies such as a 3-year rolling average of the HH/CC costs as a proportion of the RSS/SL costs.

For the scenario modeling performed in Section 5.2.4., a 70% relativity of HH/CC direct care costs to RSS/SL direct care costs was considered based on reported costs. This approach uses the HH/CC costs that HHSC has reported on the cost report from a relatively small number of providers to compare with SL/RSS costs to

establish the HH/CC methodological rates as a percentage of the SL/RSS rates. Alternatively, the HH/CC rates could be aligned with the SL/RSS rates as both are residential services. HHSC would need to evaluate a change in the methodology. There would be a fiscal impact associated with this consideration.

5.4 Supported Home Living (SHL), Community Support Services (CSS), and Community First Choice, Personal Attendant Services/Habilitation - The administrative component of the rate is not developed using actual service costs but set equal to the administrative and facility cost component of habilitation services in the Community Living Assistance and Support Services.

Considerations 5.2.3.1 and 5.4.3.2 - Consistent with 4.3.3.1, consider evaluating alternatives to the current administrative cost methodology.

HHSC Response: In accordance with 1 TAC 355.723(d)(11):

> Effective July 1, 2017, the final recommended administration and operation cost component per unit of service for SHL in HCS, CSS in TxHmL, and high medical needs support in HCS is equal to the administrative and facility cost component of habilitation services in the Community Living Assistance and Support Services program as specified in §355.505 … (relating to Reimbursement Methodology for the Community Living Assistance and Support Services Waiver Program).

HHSC promulgated this TAC amendment in response to reductions to waiver rates in HCS/TxHmL programs based on appropriations in A.3.1 Strategy Home and Community-Based Services and A.3.4 Strategy Texas Home Living Waiver provided by the 2018-19 General Appropriations Act, Senate Bill 1, 85th Legislature, Regular Session, 2017 (Article II, HHSC). HHSC would not reverse a prior rate reduction unless directed by the Legislature to do so.

4. RMTS Proposal and Dependencies

In response to Considerations 4.1.2.2 and 4.3.3.1, HHSC believes it would be the best practice to administer a formalized RMTS for HCS/TxHmL and ICF/IID providers to capture relevant data to support and inform rate methodology components and assumptions. The RMTS would focus on the collection of staff's time and effort by each LON for services with variable rates by applicable service.

HHSC does not believe the current cost report template would be appropriate to collect this type of data, as the cost report is not designed to collect staffing activities at this level of detail. In addition, cost report preparers typically would not have access to or be able to accurately report staffing activities by service on the cost report. Furthermore, by requiring contracted providers to participate in the RMTS, HHSC will ensure an adequate participation level to capture statistically sound data.

HHSC currently administers a RMTS for SHARS and MAC providers, using a RMTS methodology approved by CMS. Due to the differences in HCS/TxHmL and ICF/IID providers when compared to SHARS and MAC providers, HHSC does not believe including HCS/TxHmL and ICF/IID providers in the current SHARS and MAC RMTS is appropriate. However, HHSC can leverage current policies and procedures, as deemed appropriate, when developing, implementing and administering the RMTS.

If the legislature directs HHSC to implement RMTS for these programs, HHSC would need the following resources, to include appropriations and full-time equivalent (FTE) authority to support seven FTE positions (Manager V, Program Specialist VII, Program Specialist VI, two Program Specialist Vs, Reimbursement Analyst III and a Reimbursement Analyst II) and a contract with a third-party entity to administer the HCS/TxHmL and ICF/IID RMTS. The third-party entity would be response for developing a system that would be utilized to certify each RMTS time-period participation list and request, collect, and calculate relevant RMTS data to inform the rate methodology components. The Manager and Program Specialist positions would join the HHSC Provider Finance Department Long-term Services and Supports Center for Information and Training team. This team is dedicated to providing assistance and training to providers, cost report preparers and the public related to the LTSS Medicaid Cost Reports, the rate enhancement program, the LTSS Medicaid Fee-for-Service rates, and other LTSS related-functions. The

Manager V position would be necessary to appropriately manage the activities of this team to include the addition of the RMTS functions, while the Program Specialist positions would primarily be dedicated to supporting the RMTS. The two Reimbursement Analyst positions would join the HHSC Provider Finance Department Long-term Services and Supports team, which is responsible for developing reimbursement methodology rules, for determining payment rates or rate ceilings for recommendation to the HHSC for LTSS-related Medicaid payment rates and non-Medicaid payment rates. The two Reimbursement Analyst positions would focus on the additional data collection and rate evaluation outlined in this report.

HHSC anticipates the RMTS would be administered for each state fiscal year. Each state fiscal year would consist of standardized RMTS time-periods, for instance each quarter or semi-annually. Prior to each RMTS time-period, the FTEs would contact applicable contracted providers to confirm the personnel who are eligible to participate in the RMTS. The participation list for each RMTS time-period would be entered in the system and certified by the provider. This participation list would be utilized for the applicable RMTS time-period to identify the provider personnel that may be included in the pool from which the sampled moments are randomly selected. The RMTS moment represents one minute at that particular time. The sampled participant must document what they were doing at that precise moment by answering a series of questions via the RMTS system, including what the participant was doing and which service the activity supports.

The RMTS method polls participants on an individual basis at random time intervals over a given time period and totals the results to determine work effort for the entire statewide population of participating staff over that same period. RMTS participants are not required to understand complicated Medicaid regulations or codes and the entire online response takes no more than a few minutes to complete.

The RMTS results would allow HHSC and the providers to determine the percent of total time the sampled group is spending on each activity and service. This process would ensure a statistically sound sample is collected to inform the HCS/TxHmL and ICF/IID rate methodology components.

HHSC is proposing to coordinate with identified stakeholders and contracted providers who participated in the Rider 30 workgroup to finalize the RMTS plan. HHSC would also coordinate with HHSC’s Procurement and Contracting Services

Division to issue a Request for Proposal for the RMTS services. Once the contract is awarded, HHSC would work with the contractor to develop and design the RMTS. HHSC anticipates implementation of the RMTS could occur in state fiscal year 2026.

The anticipated estimated fiscal impact for the contracted services and the FTEs is estimated at approximately $894,257 All Funds ($479,685 General Revenue/ $414,572 Federal Funds) in state fiscal year 2024 and $1,583,018 All Funds ($822,279 General Revenue/$760,739 in Federal Funds) in state fiscal year 2025. This includes appropriations to support the design and implementation of the RMTS estimated at $0 in state fiscal year 2024 and $750,00 in state fiscal year 2025. Capital authority would also be required.

5. Conclusion

As mentioned previously in the report, HHSC appreciates Deloitte's thorough analysis of the HCS/TxHmL and ICF/IID rate methodologies and the participation of the contracted providers and stakeholder associations.

HHSC is addressing five of the considerations in this report with existing resources by amending the cost report instructions, amending the cost report template to collect additional data for evaluation purposes, or conducting an evaluation for consistency among all applicable LTSS programs and services. Two considerations will require additional appropriations to support the proposed RMTS, which will allow HHSC to collect necessary data to evaluate and update the rate methodology components, as appropriate. Two other considerations will require legislative considerations and appropriations.

Overall, HHSC believes that the considerations presented in this report affirm that the existing rate methodology is substantially correct and reflects the costs of delivering services as described and allowed by current HHSC Medicaid policies.

List of Acronyms

Acronym	Full Name
CMS	Centers for Medicare & Medicaid Services
COVID-19	Coronavirus Disease 2019
FTE	Full-Time Equivalent
HCS	Home and Community-based Services
HHSC	Health and Human Services Commission
HH/CC	Host Home / Companion Care
ICF/IID	Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Condition
IDD	Intellectual or Developmental Disability
LON	Level of Need
LTSS	Long-Term Services and Supports
MAC	Medicaid Administrative Claiming
PACSTX	Providers Alliance for Community Services of Texas
PCG	Public Consulting Group
PPAT	Private Providers Association of Texas
RMTS	Random Moment Time Study
SHARS	School Health and Related Services
SHL	Supported Home Living
SL/RSS	Supervised Living and Residential Support Services
TAC	Texas Administrative Code
TxHmL	Texas Home Living

Appendix A. Texas HCS, TxHmL, and ICF/IID Rate Setting Methodology Evaluation

Deloitte.

Texas HCS, TxHmL, and ICF/IID Rate Setting Methodology Evaluation

Documentation in response to Rider 30

1-20-2023

Table of Contents

1. Executive Summary

Deloitte Consulting LLP ("Deloitte") was engaged by the Texas Health and Human Services Commission (HHSC) to assist in the assessment of the Home & Community Based Services (HCS), Texas Home Living (TxHmL) and Intermediate Care Facilities with an Intellectual Disability or Related Conditions (ICF/IID) rates in response to 2022-23 GAA Rider 30 ("Rider 30"). The language from Rider 30 that is considered in relation to the purview of this document is as follows:

> *"Included in amounts appropriated above in Strategy A.2.7, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), Strategy A.3.1. Home and Community-based Services (HCS), is funding to maintain rate increases authorized by House Bill 1, Eighty-sixth Legislature, Health and Human Services Commission Rider 44, Rate Increases: Intermediate Care Facilities and Certain Waiver Providers, through the 2022-2023 biennium. It is the intent of the Legislature that the Health and Human Services Commission, in collaboration with stakeholders, shall evaluate the rate setting methodology for these programs, including collection of any necessary data, in order to develop reimbursement methodologies that more accurately reflect the costs of services and report back to the Eighty-eighth Legislature."*

This report provides a detailed description of the process used to evaluate the existing rate methodologies, and the considerations to address existing gaps and potential issues with the current rate methodologies. For the purposes of rate methodology, HHSC considers "services" to be the service description as defined by Medicaid or CHIP as applicable, and allowable services as defined under the relevant billing guidelines. Concerns and considerations that were identified as part of this study, but did not meet the specific criteria of the Rider, are included in **Appendix 7.1 – Out of Scope Areas of Concern and Considerations**.

Deloitte worked collaboratively with HHSC and a provider workgroup from September 2021 through July 2022, holding meetings on a regular basis. The process began with establishing an understanding of the current rate structure, and working with HHSC and the provider workgroup, which was identified by HHSC and included representatives of the state's major provider associations, to identify areas that were of greatest concern in their experience with the rates and reimbursement methodology. An environmental scan was performed, collecting and reviewing HCS/TxHmL and ICF/IID rate methodologies used by a subset of comparable states

for similar services. Provider interviews were also conducted with several providers across Texas, representing the diverse mix across the services provided, the geographies served, and the number of Medicaid members served. Based on the workgroup's feedback, environmental scan, and provider interviews, the issues by major rate component were summarized and rate methodology considerations were identified to help address some of the concerns expressed. Working with both HHSC and the provider workgroup, considerations were prioritized for further evaluation. To help support the analysis of these considerations and potential rate methodology changes, additional data was captured from the provider workgroup and the providers participating in interviews. The data review included an iterative process of working back and forth with the providers to understand discrepancies in the reported data and addressing outliers. The data was used to support scenario testing on some of the underlying rate component assumptions and modeling the potential fiscal impact of incorporating or changing assumptions in the current rate methodologies.

The table below highlights the aspects of the current rate methodology that have been identified as areas of concern through this process. These areas of concern are generally consistent across services, where applicable, and considerations for HHSC have been identified to help address those areas of concern. Each of the considerations has been classified as either **Insufficient** or **Revisit**.

- **Insufficient** is used to indicate there is a methodological issue in the approach currently being utilized.
- **Revisit** indicates a consideration that should be revisited and potentially addressed but doesn't represent a methodological issue. As noted throughout, each consideration has been identified if further analysis is needed, additional data is needed, and/or regulatory, policy, or billing changes may be required. Beyond the items identified in the table below, there are service-specific considerations that are detailed by service within **Section 5**. **HCS and TxHmL Rate Setting Methodology Review by Service**, and **Section 6. ICF/IID Rate Setting Methodology Review by Service.**

Note: for HHSC to address the concerns and considerations for each service described below in further detail, additional staff resources, time, and investments may be necessary.

Table 1. Summary of High-Level Considerations.

Component	Areas of Concern	Consideration	Priority
4.1a **Process Improvement**	**Cost reporting** is not currently capturing all costs of providing care, including allowable and billable costs, and allowable but non-billable costs	4.1.2.1 Revise cost report template and accompanying instructions, or consider pro forma or modeled rate approaches if data cannot be obtained or is not reliable	Insufficient
4.1b **Process Improvement**	HHSC biennial rate reviews and rebasing with updated cost report data satisfy CMS requirements, but in some cases **rate components have not been updated with more recent cost report data or are based on studies performed 20+ years ago**, including attendant caseload assumptions. In these cases, the reimbursement methodology may not be reflective of the cost to provide service	4.1.2.2 Consider the appropriateness of rate components that are based on cost report data or other data sources on a recurring basis, or define assumptions as a matter of policy.	Revisit

Component	Areas of Concern	Consideration	Priority
4.2 **Direct Care Wages**	Direct care wages were consistently identified by providers across services as their biggest concern with the current rates, and the 80% rule[1] shifts direct care costs outside of direct care in the cost reporting	4.2.3.1 Evaluate the appropriateness of the 80% rule, the impact the rule has on where costs are reported on cost reports, and the resulting reimbursement impact	Revisit
4.3 **Administrative Cost Allocation**	The current **administrative cost allocation** methodology of using fixed weights for most services may not reflect the mix of administrative cost across services, and thus the reimbursement methodology may not reflect the actual costs to provide each service. For other services, **administrative costs are established as a matter of policy** and may not be reflective of the actual cost to provide the service.	4.3.3.1 Evaluate alternatives to the current methodology of allocating administrative costs by fixed weights, and the appropriateness of administrative costs that have been established as a matter of policy	Revisit

[1] As defined in TAC §355.112, which indicates that in order for staff hours to be considered attendant care, at least 80% of the time worked must be performing attendant functions.

Component	Areas of Concern	Consideration	Priority
4.4 Inflators and Other Adjustments	Other states use inflators or other adjustments to account for non-billable but allowable costs required for the provision of quality, efficient, and economical care.	4.4.3.1 Consider rate adjustments to capture the impact of allowable but non-billable activities, or update cost reporting consistent with 4.1.2.1 as appropriate	Revisit
4.5 Transportation	**Transportation cost allocation** is across all services as opposed to just the specific services utilizing transportation. Additionally, data is not currently available to evaluate other reimbursement methodologies for transportation that may more accurately capture the cost of providing transportation services.	4.5.3.1 Consider capturing transportation cost by service, as well as the gathering of data to evaluate transportation costs and other reimbursement methodologies.	Revisit
4.6 Related Party Considerations	Related party **cap is not applied to all LTSS providers**, TAC §355.722(h) defines a related party cap that is applied only to attendant care for IDD providers	4.6.2.1 Where appropriate, standardize related party policy across LTSS providers	Revisit

Additional detail related to the areas noted as concerns through the methodology assessment and considerations for methodology modifications is included in **Section 4. Rate Setting Methodology Review by Component of this report**.

In addition to the above generally applicable concerns and considerations as identified, there are also service-specific considerations that are summarized in the table below.

Table 2. Summary of Service-Specific Considerations.

Service	Areas of Concern	Consideration	Priority
5.2 Host Home/ Companion Care (HH/CC)	The majority of HH/CC providers contract out the service; as a result, **the attendant wage and compensation data in the cost report for HH/CC is rarely populated**, and an allowable and attributable portion of **facility and operations costs not currently captured** in the cost report or through the rate methodology	5.2.3.1 Consistent with 4.1.2.1, revise cost report template and accompanying instructions, or consider pro forma or modeled rate approaches if data cannot be obtained or is not reliable	Insufficient
5.4 Supervised Home Living (SHL), Community Support Services (CSS), and CFC PAS/Hab	**The administrative component of the rate is not developed using actual service costs**, but set equal to the administrative and facility cost component of habilitation services in the Community Living Assistance and Support Services	5.4.3.2 Consistent with 4.3.3.1, consider evaluating alternatives to the current administrative cost methodology	Revisit

Following the methodology prioritization discussions and data request gathering process, rate scenarios were developed utilizing the rate methodology considerations and the additional data gathered to highlight the potential budgetary impact of implementing some of the changes. Please note that these scenarios relied upon the data provided by a small sample size of providers. While significant outliers were removed, the data was not audited and to the extent the data contains errors or anomalies that were unknown at the time the data was provided, these scenarios may be impacted by those issues. Prior to implementing any methodology changes that require additional data from historically captured HHSC information, a more thorough data capture and review should be conducted. Please refer to the Data Limitations section for further discussion on the reliability and credibility of the dataset utilized.

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2. Introduction

The 2022-23 GAA Rider 30 directs HHSC, in collaboration with stakeholders, to evaluate the rate setting methodology for Home and Community Based Services (HCS) waiver, Texas Home Living (TxHmL) Waiver and Intermediate Care Facilities for Individuals with Intellectual Disability (ICF/IID), including collection of any necessary data, in order to develop reimbursement methodologies that more accurately reflect the costs of services and report back to the Eighty-eighth Legislature. HHSC requested support from Deloitte to conduct an evaluation of current methodology and development methodology considerations, coordinate with stakeholders, and collect data to support the evaluation. HCS provides individualized services and supports to people with intellectual and developmental disabilities who are living with their family, in their own home or in other community settings, such as small group homes. TxHmL supplies essential services and supports to Texans with an intellectual disability or related condition so that they can continue to live in the community. ICF/IID provides residential and habilitation services to people with intellectual and developmental disabilities and/or related conditions. The current HCS/TxHmL/ICF/IID reimbursement fees vary by service.

2.1. Background and Purpose

The HHSC HCS/TxHmL and ICF/IID rate methodologies were initially developed over 20 years ago, and while there have been some changes to aspects of the rate methodologies since then, the current methodology is still, by and large, consistent. The language from the 2022-23 GAA Rider 30 that is considered in relation to the purview of this document is as follows:

> *"Included in amounts appropriated above in Strategy A.2.7, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), Strategy A.3.1. Home and Community-based Services (HCS), is funding to maintain rate increases authorized by House Bill 1, Eighty-sixth Legislature, Health and Human Services Commission Rider 44, Rate Increases: Intermediate Care Facilities and Certain Waiver Providers, through the 2022-2023 biennium. It is the intent of the Legislature that the Health and Human Services Commission, in collaboration with stakeholders, shall evaluate the rate setting methodology for these programs, including collection of any necessary data, in order to develop reimbursement methodologies that more*

accurately reflect the costs of services and report back to the Eighty-eighth Legislature."

In response to this, HHSC engaged Deloitte to support the assessment of the current rate methodology build for HCS/TxHmL and ICF/IID rates and to provide rate methodology considerations to HHSC. Implicitly, this also included an assessment of the Texas Home Living (TxHmL) program, given the reimbursement methodology for this program is linked to the HCS methodology across services.

We also have taken into consideration that payments for waiver services must be consistent with 1902(a)(30)(A) of the Social Security Act, which reads:

"Payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."

2.2. Data Sources and Reliance

The analysis relied on data provided by HHSC, providers participating in the provider workgroup and provider interviews, as well as publicly available data. Some of the data provided by HHSC came from data sources developed by HHSC, while others were prepared or created by third parties and delivered to HHSC.

As part of the analysis, all data was reviewed for reasonableness, but an audit was not performed on the data. To the extent the data contains errors or anomalies that were unknown at the time the data was provided, the analysis may be affected by those issues. Publicly available information relied upon for this analysis may have changed since the time the review occurred, as such, some information may be inaccurate or incomplete. If the underlying data or information provided is inaccurate or incomplete, the results of the analysis may likewise be inaccurate or incomplete. In certain cases, the data is audited or reviewed by other sources, and this analysis considered the results and any conclusions from those reviews in determining whether the data was used in this report.

The rate scenarios developed in this report are estimates based on the best data available at the time of development. Methodologies and assumptions used to develop estimates may change over time as new information and emerging data becomes available. A change in methodology does not imply an error in previous estimates; rather, the revised methodologies and assumptions incorporate new

information. It may be expected that actual experience will vary from the values shown here due to unforeseen events and random fluctuation of experience.[2]

The following is a summary of key data items used in the study performed under Rider 30:

Table 3. Data Sources.

Report Section	Data Source	Description
Rate Methodology Review Process	Stakeholder Feedback	Information gathered through meetings with HHSC, the provider workgroup, and provider interviews.
Rate Methodology Review Process	HCS Program Billing Guidelines	Provider billing guidelines for HCS and TxHmL https://www.hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/long-term-care/hcs-billing-requirements.pdf.
Rate Methodology Review Process	ICF/IID Provider Manual	Provider billing guidelines for ICF/IID https://www.hhs.texas.gov/handbooks/licensed-icfiid-provider-manual.
Rate Methodology Review Process – Environmental Scan	State Medicaid Websites	Publicly available information related to rate methodologies, reimbursement methodologies, and service detail by waiver as posted on individual state Medicaid websites, sourced from October 2021 through January 2022.
Rate Methodology Review Process – Environmental Scan	State Administrative Code	Relevant sections of administrative code governing rate methodologies, reimbursement methodologies, and service detail as posted on individual state websites.
Rate Methodology Review Process – Environmental Scan	Medicaid.gov 1915(c) Waivers	Approved HCBS 1915(c) waivers by state.
Rate Methodology Review Process – Environmental Scan	Subject Matter Expert	External interviews with former Medicaid Directors

[2] Deloitte makes no representations regarding the contents of this report to an entity outside of HHSC. Other entities are instructed that they are to place no reliance upon this report prepared for HHSC that would result in the creation of any duty or liability under any theory of law by Deloitte or its employees to third parties. Other parties receiving this report must rely upon their own experts in drawing conclusions about the rates, assumptions, and trends.

Report Section	Data Source	Description
Rate Setting Methodology Considerations – Direct Care Wages	Bureau of Labor Statistics	Nationwide and Texas-specific wage data related occupation categories.
HCS & TxHmL Rates, and ICF/IID Rates - Current Methodology	SFY 22-23, and draft SFY 24-25 HHSC HCS, TxHmL, and ICF/IID Rate Models	Internal model from HHSC detailing the rate development by service, utilizing 2018 cost report data trended to 2022-2023, and 2020 cost report data trended to 2024-2025 respectively.
HCS & TxHmL Rates, and ICF/IID Rates - Current Methodology	Texas Administrative Code	Texas's governing rules and regulations for HCS, TxHmL, and ICF/IID including subchapters of §355.
Rate Setting Methodology Considerations	Provider Data Request	Excel-based data collection tool, with information provided voluntarily by provider workgroup and provider interview participants, used to inform new/updated rate component considerations by service.
Rate Setting Methodology Considerations	Provider Allowable / Billable Concerns Documentation	The provider workgroup provided documentation of primary concerns related to allowable and/or billable issues with the existing rate methodologies.
HCS & TxHmL Rates, and ICF/IID Rates - Current Methodology	Texas HCS Provider Finance Department website	https://pfd.hhs.texas.gov/long-term-services-supports/home-and-community-based-services-hcs
HCS & TxHmL Rates, and ICF/IID Rates - Current Methodology	Texas Home Living (TxHmL) Provider Finance Department website	https://pfd.hhs.texas.gov/long-term-services-supports/texas-home-living-txhml
HCS & TxHmL Rates, and ICF/IID Rates - Current Methodology	Texas ICF/IID Provider Finance Department website	https://pfd.hhs.texas.gov/long-term-services-supports/intermediate-care-facilities-individuals-intellectual-disability-or-related-conditions-icfiid

Report Section	Data Source	Description
HCS & TxHmL Rates, and ICF/IID Rates - Current Methodology	HHSC Documentation related to existing rate methodology and cost reporting	At the beginning of the engagement, HHSC provided a number of files documenting the rate methodology, cost reporting, and other related files. A summary of the files provided is included in **Appendix 7.2: HHSC Documentation**.

2.2.1 Data Request

To inform assumptions related to proposed rate methodology considerations, Deloitte, in collaboration with HHSC, created a data request survey to capture relevant datapoints. While building the data collection tool, we met with the provider workgroup multiple times to gain feedback on the layout, language, and user friendliness of the tool. Additionally, draft versions of the collection tool were shared with the workgroup providers to give them an opportunity to review offline in more detail and raise concerns before sending to the larger group of providers to complete.

The providers included in the data survey process were limited to those involved in the provider workgroup, and the set of providers who agreed to be involved with the provider interviews. These select providers had the relevant background on the goals of the engagement, were responsive and actively engaged in the process, and represented a cross-section of geographies served, services delivered, and provider size. In previous voluntary provider data surveys, HHSC found it challenging to receive credible data from all providers. Limiting the number of providers enabled the Deloitte team to work directly with all involved providers to address questions they had in populating the data request and in the review of the data collected. The data request responses were evaluated for reasonableness, and clarification was requested from providers when data did not appear reasonable. Datapoints that were considered outliers, or were deemed unreliable, were excluded from our analysis.

In all, 17 of the 37 providers who were invited to participate in the data collection effort provided data. These providers represent 18.6% of the total cost of the TX HCS program, as of the 2018 cost reporting, which is a small representative sample size.

A smaller-scale data request was also provided to HHSC to collect summary data from the cost reporting, including cost data, reported turnover, and wages by service.

Refer to **Appendix 7.5 Data Request Findings** for the files associated data request process.

3. Approach

To evaluate HCS/TxHmL rate methodologies for the Texas Medicaid program, an assessment of information was conducted including evaluating available utilization data, cost reports, stakeholder concerns, other state program approaches, and other available resources. In addition, areas where additional information may support further clarity on the costs of services have been documented.

The following section lays out the guiding principles that were followed as Deloitte and HHSC collaborated with the provider workgroup to identify rate methodology alternatives, the methodology considerations that were identified by HHSC as in-scope or out-of-scope for the purposes of the review, and rate methodology considerations that were discussed and proposed as part of the methodology prioritization discussions. The methodology prioritization discussions were focused at the rate component level, agnostic of the specific services, to ensure that methodological considerations for rate components that are consistent across services are applied in a consistent fashion.

3.1. Guiding Principles

HHSC established a set of guiding principles for Deloitte to use in the assessment of current methodology and evaluation of alternative rate methodology considerations. These guiding principles included:

- Prioritize data driven, repeatable methodologies for rate components
- Consider alignment of methodologies across services and consistency across waivers
- Provide clarity into the decisions made, and the development of the assumptions underlying the rate build
- Identify allowable, necessary costs to provide efficient and economical care being incurred and make sure they are appropriately accounted for in the rate methodology and/or the underlying cost reporting used to develop the rates
- Ensure reimbursement methodology aligns with how costs are realized
- Inform rate methodology and rate considerations by leading practices from other states with consideration for feedback from stakeholders

- Comply with all federal regulations and requirements
- Prioritize alternative rate methodologies and/or reimbursement methodology modifications presented for consideration

3.2. Scope of Analysis

Throughout the engagement, it was imperative for Deloitte to remain within the scope of the engagement as identified by HHSC. As providers voiced concerns over various components of the current rate methodology, some concerns did not fall within the scope of this engagement, but were still captured and shared with HHSC. The goals within the scope of this engagement were:

- Evaluate and identify considerations for updates to the current rate reimbursement for HCS, TxHmL, and ICF/IID
- Collect and consider stakeholder feedback throughout the process
- Identify allowable costs not reflected on the cost report
- Identify costs that are necessary for service provision but not directly reimbursable under Medicaid rules and collect any data pertaining to these costs
- Consider submission of costs that are necessary for service provision but not reimbursable for General Revenue (GR) funding requests and/or services provided due to HHSC requirements that were not reimbursed by Medicaid or other payment source for GR funding requests

Items not included in the scope of this engagement include the following; please refer to **Appendix 7.1: Out of Scope Areas of Concern and Considerations** for additional detail:

- Propose reimbursement methodologies for structural reforms that may occur in the future
- Consideration for non-cost report-based rate methodologies
- Evaluate and propose changes to current rate enhancement methodologies, including the attendant compensation rate enhancement and any existing rate add-ons
- Evaluate the Individualized Skills and Socialization services description or service definition, including the staffing ratios which are defined by HHSC Medicaid and CHIP Services policy

- Changes to service definitions, provider qualifications, billing rules (including allowable and unallowable costs), and considerations for how policy may change in the future
- Review of costs that were determined to be unallowable by HHSC as documented in the **Appendix 7.1: Out of Scope Areas of Concern and Considerations**.
- Alternatives to the Inventory for Client and Agency Planning (ICAP) assessment tool used to establish acuity tiering in the reimbursement methodology for specific services

Overall, this engagement was focused on evaluating the rate methodologies based on current policy as dictated by Texas Administrative Code (TAC)[3] and current billing rules.[4][5] It was not within the scope to consider how policy may change in the future for the evaluation of potential considerations and alternatives. To the extent policy changes are made, the considerations, data, and scenario modeling described in this report may need to be reviewed and revised.

3.3. Rate Methodology Review Process

To accomplish the goals set forth in Rider 30, including evaluating the rate setting methodology for the HCS, TxHmL, and ICF/IID programs, collecting any necessary data, and developing considerations for alternative rate and reimbursement methodologies that more accurately reflect the costs of services, the process was as follows:

3.3.1 Stakeholder involvement throughout the process

Provider Workgroup

At the beginning of the engagement, HHSC identified representatives from three provider associations across Texas, as well as some of the larger providers who

[3] TAC §355: https://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=4&ti=1&pt=15&ch=355.
[4] HCS Program Billing Guidelines: https://www.hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/long-term-care/hcs-billing-guidelines-june-2020.pdf
[5] ICF Provider Handbook: https://www.hhs.texas.gov/handbooks/licensed-icfiid-provider-manual

have significant experience with the programs, to participate in regular provider workgroups. Throughout the engagement, Deloitte, HHSC, and these providers met on a consistent basis, which allowed for continuous feedback to identify and better understand the most significant issues with the rate methodologies. The workgroup shared significant anecdotal evidence to support their concerns with the current program, and frequently voiced their opinions on potential alternatives to the methodology. The workgroup was also able to supply background information from their perspectives on decisions that have been made related to rate methodologies over the past 20+ years.

Provider Interviews

To collect more diverse perspectives, the workgroup developed a list of 15 providers to be included in additional interviews. In collaboration with HHSC, 15 additional providers were selected so that all 30 of the providers interviewed covered a broad range of geographies, services provided, and provider sizes. Participation in the interviews was voluntary for the providers.

During these interviews, which were facilitated across six separate sessions, the goal was to gather additional perspectives from providers representing different backgrounds to better understand whether the current methodology presented consistent or varied issues for them, and to help contextualize the issues providers throughout the state are facing. During the discussions, Deloitte received insights and feedback on each of the various components of the rate build for numerous HCS, TxHmL and ICF/IID services.

Following provider workgroup meetings and provider interviews, we debriefed with HHSC representatives to understand their perspectives related to issues that were raised, including administrative challenges and restrictions with current methodology, policy, and information captured from stakeholders.

3.3.2 Environmental Scan

To aid in assessing potential alternative methodologies for HHSC to consider, an environmental scan was performed to evaluate the methodologies used by other states with similar services and programs. The approach taken was as follows:

- Through conversations with HHSC, a preliminary list of states to be targeted for analysis was developed, which included New York, California, Tennessee, Illinois, Florida, Ohio, and Pennsylvania. Information for states that was

readily available to the team was also leveraged, including Maryland, Missouri, and Nebraska.

- Within these states, we identified analogous services to those offered under the HCS, TxHmL, and ICF/IID programs, documented the rate development methodologies for those services by state, and performed a comparative analysis of the methodologies utilized in other states relative to the methodologies currently employed by Texas.
- In cases where a state did not offer similar services or did not have the methodology information, the scan was focused on the subset of states where the service definitions were most closely aligned and information was available.
- The findings of the environmental scan were summarized and presented to the provider workgroup and HHSC, and methodologies that were of interest to both the workgroup and HHSC were identified for further analysis.

The findings from the environmental scan can be found in **Appendix 7.3: Environmental Scan**, and further discussion of the environmental scan findings specific to each service and rate component can be found in the corresponding sections **Environmental Scan Findings** by service within this report.

3.3.3 Allowable/Billable Considerations

Throughout the engagement, concerns were raised relating to whether specific costs were allowable and/or billable, and the implications of these issues. The provider workgroup provided an initial list of these concerns and identified additional concerns through the provider workgroup sessions and provider interviews. A summarized list of these concerns and considerations was captured throughout the engagement and provided to HHSC for their review. HHSC provided feedback from a MCS policy and cost reporting perspective for each line-item, detailing whether the costs are allowable and/or billable, and in cases where providers had identified they are not reporting costs that should be captured in the cost reporting, HHSC identified the appropriate sections of the cost reporting where each cost should be captured. This list can be found in the **Appendix 7.2: HHSC Documentation**.

3.3.4 Regulatory Change Considerations

HHSC identified potential regulatory changes that either are being implemented, or are likely to be implemented, that could have administrative cost implications for

providers. The identified list of potential regulatory changes can be found in **Appendix 7.2: HHSC Documentation**. These regulatory changes were discussed with HHSC, and a sub-set of the changes was identified as more likely to drive additional costs for providers. Through the data request, providers were asked to provide an estimate of the additional costs they believe they would incur as a result of the regulatory changes.

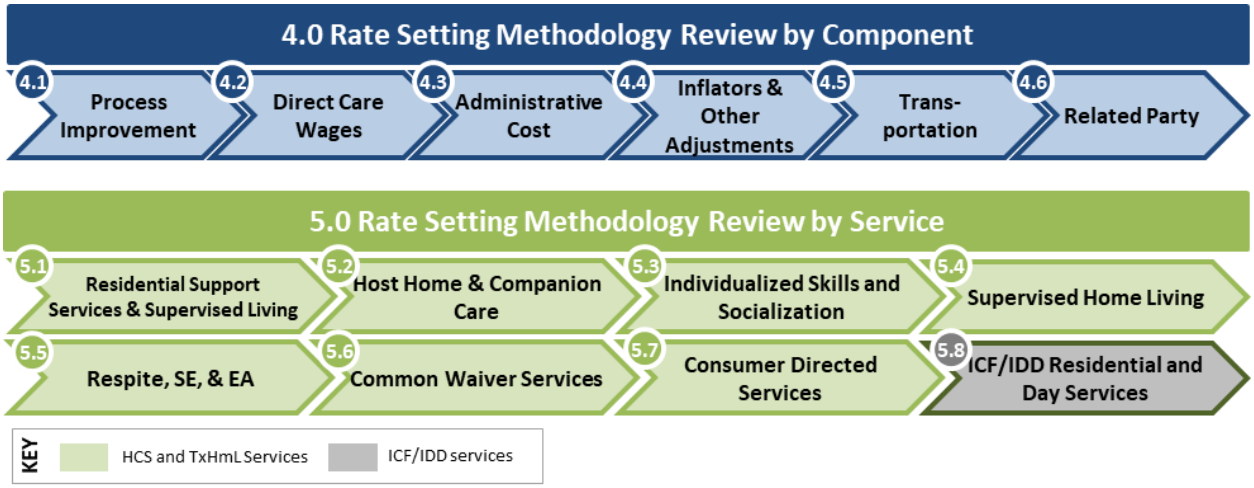
3.3.5 Methodology Prioritization

After capturing thoughts across stakeholders, HHSC and providers, and identifying potential considerations, a consolidated list of alternative methodology considerations was identified. Initially, alternative rate methodologies were discussed by rate component, agnostic of specific services, to allow for consistent application of the desired methodology across services. After HHSC indicated the methodologies by rate component they were interested in pursuing further, the application of the alternative methodologies were considered in the context of each service individually.

Supported through multiple joint discussions with both HHSC and the provider workgroup, HHSC prioritized the rate methodological changes for each rate component and services to further analyze and assess the potential rate impact.

These alternative methodologies are further elaborated upon within the following sections in this report, as well as represented in Figure 3 below, and are also summarized in the **Appendix 7.4: Methodology Prioritization**. First, the Rate Setting Methodology Review by Component section covers Process Improvement, Direct Care Wages, Administrative Cost, Inflators & Other Adjustments, Transportation, and Related Party. Subsequently, the service-specific sections that follow cover HCS/TxHmL services including Residential Support Services & Supervised Living, Host Home & Companion Care, Individualized Skills and Socialization, Supported Home Living, Respite, Supported Employment, and Employment Assistance, Common Waiver Services, and Consumer Directed Services, as well as ICF/IID Residential Care and Day Habilitation.

Figure 1. Methodology Prioritization Process.



3.3.6 Data Request

Following the prioritization sessions, methodological changes were identified which required additional data to assess the impact of new or revised rate components, or reimbursement structure. The data request, including the limitations related to the information gathered and the number of providers involved with the data gathering effort, is described in detail in **Section 2.2: Data Sources and Reliance**.

In all, 17 of the 37 providers who were invited to participate in the data collection effort provided data. These providers represent 18.6% of the total cost of the TX HCS program, as of the 2018 cost reporting, which is a small representative sample size. The data request responses were evaluated for reasonableness, and clarification was requested from providers when data appeared to be an outlier or misreported. Datapoints that were considered outliers, or were deemed unreliable, were excluded from our analysis.

The data request that was provided to providers, and the summarized findings from the data request can be found in **Appendix 7.5 Data Request Findings**.

3.3.7 Scenario Modeling and Impact Analysis

After reviewing the additional information gathered through the data request, and assessing for reasonability and credibility of the data received, the information was compared to existing assumptions in the current rates. Where the data varied from existing assumptions, or where new components were identified to consider incorporating, example scenarios were developed to understand the potential rate

and budgetary impact. Please note that these scenarios relied upon the data provided by a small sample size of providers, as described in the previous section.

4. Rate Setting Methodology Review by Component

The following sections detail considerations and concerns by rate component, as identified through the methodology prioritization process. Where appropriate, each topic is structured by discussing the current methodology, the primary concerns identified, findings from the environmental scan, and the proposed considerations by rate component. In **Section 5. Rate Setting Methodology Review by Service**, discussion of considerations by rate component will be structured in a similar fashion, to the extent there is additional detail for each service.

Figure 2. Rate Setting Methodology Review by Component.

Note: for HHSC to address the concerns and considerations for each service described below in further detail, additional staff resources, time, and investments may be necessary to implement.

4.1. Process Improvements

Throughout the engagement, numerous methodological concerns were discussed that apply to the overall process as a whole. Addressing the following items could lead to mitigation of many concerns expressed by providers as well as align Texas' methodology with other states.

4.1.1 Primary Concerns

Providers and HHSC expressed concerns related to information that is not being captured within the cost reporting.

- Providers expressed concerns that the cost reports are not currently capturing all allowable and billable costs of providing care, which providers attributed to a perceived lack of clarity on whether specific costs are allowable and should be included in the cost report, and if so where the costs should be reported. The Allowable/Billable Policy List, which can be found in the attached appendices, details the specific concerns that were raised by providers pertaining to costs not being captured on the cost reports.
- There are allowable but non-billable activities that are required in the delivery of care that are not currently being captured in the cost reporting, including direct care staff training activities that are not directly attributable to an individual, non-billable nursing time on activities that are required for nurses to retain their certifications and licensure, and service coordination/case management activities that are not directly billable. The list of these service coordination/case management activities can be found in **Appendix 7.2: HHSC Documentation**.
- Concerns were raised that many assumptions underlying the rate methodologies have not been evaluated in more than 20 years. Additionally, some rate components have been held constant, or have not been updated with more recent cost report or other available data on a recurring basis.

4.1.2 Considerations

4.1.2.1. Revise cost report template and accompanying instructions, or consider pro forma or modeled rate approaches if data cannot be obtained or is not reliable

To address the concerns that cost reports are not capturing all the costs required to provide quality, economical and efficient care, HHSC should consider the following:

- Update the cost report template and/or the cost report instructions to clarify where identified allowable and billable costs should be reported. HHSC should consider applying temporary rate adjustments to account for identified unreported costs to the extent they are material and reasonably able to be estimated. Given the lag between when costs are incurred by providers, and when cost reporting is used to develop the prospective rates by service, if adjustments are not made to rates in the interim, then the reimbursement methodology may not accurately reflect the costs of services. These

temporary adjustments would no longer be applied in the rate methodology at the point in time the underlying cost reporting is capturing these costs.

- Update the cost report template and/or the cost report instructions to permit providers to report allowable but non-billable costs. These costs can be used to inform corresponding rate adjustments, such as productivity adjustments in the case of non-billable training time, a service coordination adjustment in the case of non-billable case management activities, an adjustment to account for the impact on the reported direct care hours related to the 80% rule, and to capture the impacts of non-billable nursing time. Similar to the above consideration, HHSC should also consider a temporary adjustment to the rates to account for these costs, until cost report data is available to inform the adjustment. Further discussion on adjustments that could be considered through allowable but non-billable costs can be found in **Section 4.4 Inflators and Other Adjustments**.
- Consider a pro forma, or modeled rate approach in cases where reliable data required for rate setting assumptions cannot be obtained through cost reporting. An example relates to the Host Home / Companion Care service, where providers generally contract out this service, and as a result they are unable to report wage, benefits, and facility-related costs among others at the level of granularity of other services. In these cases, HHSC could consider a pro forma, or modeled rate approach, wherein rate assumptions are selected from reasonable proxies. Some examples of this would include relevant industry, national, or state data that is available such as Bureau of Labor Statistics wage data for a wage assumption, or leveraging data from similar types of services within the HCS/TxHmL program to inform assumptions.

To further understand these cost report considerations, the data request captured incremental costs associated with the identified issues. For a number of the allowable and billable items that were identified, the data was not deemed reliable for scenario modeling – please refer to the **Appendix 7.5 Data Request Findings** for additional detail. Further discussion related to the scenario modeling can be found in **Section 5. HCS and TxHmL Rate Setting Methodology Review by Service** and **Section 6. ICF/IID Rate Setting Methodology Review by Service**.

Consideration Priority

HHSC should consider updating the cost report template and/or cost report instructions to clarify where allowable and billable costs should be captured in the cost reporting, and allow for reporting of allowable but non-billable costs. HHSC could also consider using pro forma, or modeled rate approaches, in cases where reliable data required to inform rate setting assumptions cannot be obtained through cost reporting.

4.1.2.2. Consider the appropriateness of rate components that are based on cost report data or other data sources on a recurring basis, or define assumptions as a matter of policy

CMS requires waiver services payment rates to be reviewed or rebased at least every five years.[6] The 1915(c) application technical guide indicates:

> *"States must review their rate setting methodology, at minimum, every five years to ensure that rates are adequate to maintain an ample provider base and to ensure quality of services. This rate review process can encompass a variety of rate review methods. For example, a state could elect to rebase their existing rate setting methodology. Rate rebasing would involve evaluating an existing fee schedule rate setting methodology and adjusting or updating individual rate components with more current data."*

HHSC's biennial rate review process, in addition to the rate rebasing that occurs biennially with updated cost report data, is generally consistent with satisfying this requirement. However, there are two areas detailed below that HHSC could consider re-evaluating within this context.

- In some cases with the current methodology, specific rate components are reliant on staffing ratios, caseload assumptions, and programmatic

[6] Application for a 1915(c) HCBS Waiver – Instructions, Technical Guide, and Review Criteria. Appendix I-2: Rates, Billing, and Claims, page 289: https://wms-mmdl.cms.gov/WMS/help/35/Instructions_TechnicalGuide_V3.6.pdf

assumptions which have not been updated due to lack of available and reliable data, including the Residential Support Services and Supervised Living and Host Home / Companion Care Direct Rate components, as well as the HCS/TxHmL Allocated Administrative cost rate component.

- In other cases, specific rate components are not being rebased consistent with the most recent cost report data on a recurring basis due to budgetary allocations, including the ICF/IID Administrative cost rate component. With a cost report-based rate that lacks rebasing for specific rate components, this increases the possibility that the rates are not accurately capturing the cost of providing the service.

Staffing Ratios

For HCS Residential (RSS/SL) and ICF/IID services, the staffing ratios underlying the rates were established as part of a study performed more than 20 years ago. Within the rate methodology, the staffing ratios are converted to an assumed direct care hours per resident per day assumption.

Providers expressed concerns that the staffing ratios do not appropriately address the reality of staffing needs given policy and regulatory changes and changes in service delivery requirements that have occurred in the past two decades. Through the environmental scan, for the states where the relevant information was available (i.e., California, Ohio, Pennsylvania, Florida and Tennessee), the rate methodologies used a similar approach to Texas in terms of using staffing ratios to inform direct care hours assumptions within the rates. In some cases, the staffing ratios were established as a matter of policy; in other cases, studies informed the established staffing ratios.

HHSC should consider clearly defining staffing ratios for each service as a matter of policy, and/or assessing staffing ratios more frequently to address changing service delivery patterns. Staffing ratios should be evaluated on a recurring basis (at least every five years, consistent with CMS' rebasing requirement), or when there are substantial policy or regulatory changes, to understand whether care delivery patterns or policy changes have driven a shift in the necessary staffing patterns. This should be considered regardless of whether the staffing ratios are established as part of the rate methodology or in policy.

HHSC should consider mechanisms by which they can evaluate the appropriateness of the staffing ratios underlying the rate methodology, including exploring gathering information related to staffing patterns by setting or Level of Need (LON) in the cost

reports, or conducting regular studies to evaluate whether there have been significant shifts in the ways that providers are staffing their homes to meet the needs of program beneficiaries.

To evaluate the appropriateness of the existing staffing ratios, the data request sent to providers captured information related to the composition of residents by LON within each home that providers currently operate, how they currently staff those homes, and how, in an ideal world, they believe they need to staff the homes to provide quality, efficient and economical care. After reviewing the data and removing outliers, a range for staffing ratios was identified for consideration by LON. Based on the data provided, the staffing ratios by LON tier underlying the current rate methodology are at the low-end of the chosen range.

Further considerations related to these topics, to the extent they are relevant to each service, can be found in **4.3 Administrative Cost Methodology, Section 5. HCS and TxHmL Rate Setting Methodology Review by Service** and **Section 6. ICF/IID Rate Setting Methodology Review by Service**.

Consideration Priority

HHSC could consider revisiting the appropriateness of specific rate components based on cost report data or other data sources either as policy or regulatory changes impact the relevant assumption (such as policy or regulatory changes that would impact staffing patterns in a residence), on a prescribed basis such as every five years, to evaluate whether the assumptions are reflective of the costs to provide the service.

4.2. Direct Care Wages

4.2.1 Current Approach and Primary Concerns

Direct care wages are established by service, and are calculated as the unit-weighted median wage, trended to the prospective rate period. Some of the main

concerns that providers shared with the current approach for establishing the direct care portion of the rates generally and, more specifically, with the assumed wage, include:

- The wage assumption underlying the rates was consistently identified by the workgroup as the most significant issue, specifically for direct care staff and for nurses.
- Overall, existing wages are not high enough to attract and retain talent in the current environment, considering the wage pressures that exist today as a result of the competitive wage options available to individuals who would qualify to be attendant/direct care staff.
- Concerns related to the 80% rule as defined in TAC §355.112, which indicates that in order for staff hours to be considered attendant care, at least 80% of the time worked must be performing attendant functions. An implication of this rule is that direct care hours being performed by non-attendants are not being captured as direct care hours in the cost report. As a result, the direct care costs for many services are under-reported in the cost reporting.

4.2.2 Environmental Scan Findings

Based on the environmental scan data and ideas from HHSC and the provider workgroup, there were four alternative considerations discussed to address concerns related to the direct care wages.

Table 4. Direct Care Attendant Wage Environmental Scan Findings.

Alternative Approach	Description	Environmental Scan Results
Leverage BLS data to validate direct care wage	To validate the cost report wage data, Texas could consider utilizing the Bureau of Labor Statistics (BLS) data and various approaches such as lesser of, greater of, percentiles, etc.	Seen in: • Maryland • Ohio • Florida • Pennsylvania

Alternative Approach	Description	Environmental Scan Results
Implement distinct factor for wages	While HHSC currently uses the Personal Consumption Expenditures (PCE) index for all components of the rate, they could consider using a separate factor for wages that more accurately reflects changes in the market rate for direct care.	Seen in: • Maryland • Texas (Nursing)
Adjust median approach altogether	Texas could consider implementing a different percentile, besides the median, to determine the direct care wage component of the rate.	Maryland selects different BLS wage percentiles depending on the service.

4.2.3 Considerations

After discussions with HHSC and the provider workgroup, evaluating the impact of the 80% rule, and leveraging BLS wage data as a point of validation was a point of interest to both parties.

4.2.3.1. Evaluate the appropriateness of the 80% rule, the impact the rule has on where costs are reported on cost reports, and the resulting reimbursement impact

The 80% rule as defined in TAC §355.112 indicates that in order for staff hours to be considered attendant care, at least 80% of the time worked must be performing attendant functions. An implication of this rule is that direct care hours being performed by non-attendants are not being captured as direct care hours in the cost report. As a result, the direct care costs for many services are under-reported in the cost reporting. It can be argued that these costs are being captured as administrative costs or supervisor costs currently (depending on the non-attendant staff performing the direct care activities), and thus a corresponding decrease to the administrative cost could be considered as well.

However, using the supervisor as an example, the rate methodology by service does not necessarily replace those costs elsewhere on a 1:1 basis – the direct care However, using the supervisor as an example, the rate methodology by service does not necessarily replace those costs elsewhere on a 1:1 basis – the direct care supervisor rate component for RSS/SL assumes a span of control in excess of 1:17, as determined by the median from cost reporting. The implication of this in the rate

methodology, is that if a direct care supervisor provides 1 hour of 1:1 care for an LON 9 individual, but is unable to report that hour as direct care in the cost reporting, then the rate methodology is in essence capturing 1/17th of the impact, given the span of control and staffing assumptions, and the methodology building a person-specific daily rate.

Consideration Priority

HHSC could consider evaluating the appropriateness of continuing the 80% rule. In either case, through updates to the cost report, cost report instructions, and/or cost report templates, HHSC could consider gathering direct care hours provided by non-attendant staff that don't spend 80% or more of their time on direct care activities, as well as their normal job function, through cost reporting. Equipped with this information, HHSC could consider the implications to the rate methodology on a service-by-service basis and make adjustments to capture the impact of the shifting of cost between categories as a result of the 80% rule. The discussion by service, found in **Section 5. HCS and TxHmL Rate Setting Methodology Review by Service** and **Section 6. ICF/IID Rate Setting Methodology Review by Service**, addresses potential approaches to adjust for this issue, and the implications of the unallocated time within rate methodology.

4.3. Administrative Cost

4.3.1 Current Approach and Primary Concerns

The current methodology for allocating administrative costs uses a combination of reported units and Texas Administrative Code (TAC) established fixed weights, which were established more than 20 years ago, to distribute the administrative costs from the cost reports to specific services. Some administrative costs are excluded from this allocation methodology as the costs are directly attributed to the

services that incur the costs, including facility-related operational expenses in the residential setting, and the Host Home/Companion Care coordinator cost.

Through interviews and workgroup sessions, the main concerns identified by providers included:

- Administrative payments are not adequate to support time spent on administrative activities for some services, including Host Home/Companion Care.
- The administrative rate component is used to help offset deficiencies in other rate assumptions, primarily the wages.
- The current allocation methodology uses fixed weights which were developed more than 20 years ago, and which providers don't believe reflect the true allocation of administrative costs across services.
- HHSC attempted to perform a time study to inform updated weights for the fixed weight allocation methodology, but the data received was not considered to be credible or reliable, and HHSC and providers both expressed concerns about attempting to perform this time study again in the future.

4.3.2 Environmental Scan Findings

In an effort to mitigate some or all of these concerns, the following alternatives were discussed with HHSC and the provider workgroup:

Table 5. Administrative Cost Methodology Environmental Scan Findings.

Alternative Approach	Description	Environmental Scan Results
Provider specific administrative costs	Texas could consider allowing providers to track their administrative costs individually by service and paying accordingly.	• New York • California • Tennessee
Fixed percentage of administrative costs	Another approach is to calculate a fixed percent, based on historical administrative spend, and apply that going forward. This percentage could vary by service or be applied across the board.	• Illinois • Ohio • Pennsylvania

Alternative Approach	Description	Environmental Scan Results
Updated weights in current allocation process	Texas could continue using the weight allocation method by updating the weights through additional research and cost analysis.	Not seen in other states profiled as part of Environmental Scan

4.3.3 Considerations

Through discussions with the provider workgroup and HHSC, it was determined that a fixed percentage allocation methodology was the preferred approach. The following section details the primary finding related to administrative cost allocation.

4.3.3.1. Evaluate alternatives to the current methodology of allocating administrative costs by fixed weights, and the appropriateness of administrative costs that have been established as a matter of policy

There are two primary methods observed in other states used to cover administrative costs. Some states with cost reports have provider-specific rates that are developed, and administrative costs are reimbursed directly to providers, with some guardrails (e.g., in New York, there is a weighted blend of the provider-specific administrative cost and geographic average administrative cost). Alternatively, other states utilize a fixed percentage methodology for allocating administrative cost.

HHSC could consider the following approaches for administrative cost allocation by service:

- Using summarized cost report data in aggregate, build up the costs that are currently included in the allocated administrative cost bucket (e.g., excluding the facility costs that are directly allocated in the RSS/SL rates, and excluding the HH/CC Coordinator fee that is also directly allocated). This summarized allocated administrative cost could then be compared to the total cost to develop an administrative cost as a proportion of the total rate, or compared to the direct care portion of the costs, to develop an administrative cost as a proportion of the direct care rate component. This percentage can be reviewed during each cost reporting cycle, or a blending

methodology could be used that takes a rolling average of multiple cost-reporting years into consideration to determine the percentage allocation.

- HHSC could adjust the cost report instructions and template to capture administrative cost by service, and use those costs with an appropriate inflator to develop the administrative cost to include in the rates. When discussing this option with HHSC and providers, there was a lot of pushback related to the difficulty in allocating those costs, and the additional administrative overhead that would be involved in preparing, tracking, and reviewing the allocation by service.
- HHSC could establish a fixed administrative expense percentage across all services as a matter of policy, and could incorporate an evaluation of administrative expense assumptions utilized in other states, as well as a review of the cost report data to inform the assumption. The environmental scan found that Maryland, for example, assumes a fixed administrative expense of 11%, and Pennsylvania assumes a fixed administrative expense of 10%.

Through the scenario modeling performed, we analyzed the impact of applying the first methodology described above and determined that, based on the costs reported in the cost report, the allocated administrative costs (which excludes facility and operations expenses) are roughly 43.8% of the reported direct care costs. Similarly, when comparing the allocated administrative costs to the total costs, the allocated administrative costs are roughly 22.7% of the total reported costs. As described above, either of these could be applied in the rate methodologies as a fixed percentage. This does result in a methodologically higher administrative component of the rate than is observed in other states, such as Pennsylvania and Maryland, as discussed above. Providers were clear that they are concerned with how they are operating today, with the relatively high administrative rate component being used to fund or offset the impact of other rate components that are perceived to be too low relative to what the providers indicate is needed, primarily the wage assumptions. As such, HHSC should consider the totality of the impact to the rates with any change in methodology.

Consideration Priority

HHSC could revisit the HCS/TxHmL administrative cost allocation methodology alongside a review of any applicable policy, regulatory, and/or billing policies. If the existing methodology for HCS/TxHmL administrative cost allocation is retained, then HHSC could consider performing another time study to inform updated cost allocation weights. If a fixed allocation methodology as described above is selected, then HHSC could evaluate the data that is available through cost reporting to evaluate the associated rate impact with a change in methodology, alongside any changes to policy and/or regulatory requirements as necessary.

4.4. Inflators and Other Adjustments

4.4.1 Current Approach and Primary Concerns

To inflate the cost reporting data from the cost reporting period to the prospective rate period, a PCE (Personal Consumption Expenditures) inflator is utilized.

In addition, within the current methodology, there is a separate mark-up applied, depending upon the service – a mark-up of 7.0% is applied to HCS and ICF/IID Residential Care, HCS Individualized Skills and Socialization (On-Site), and ICF Day Habilitation, and a 4.4% mark-up is applied to the remaining services. These mark-ups were established in TAC §355.112, and serve to increase the reimbursement rates by the indicated percentages.

No other inflators or adjustments are applied within the current methodology. Rates also do not vary by geographic region. The following concerns were identified through conversations with HHSC and provider workgroups:

- Providers expressed concern that the PCE inflator does not adequately address inflationary pressures related to wage inflation and costs of providing service.

- For the legislated 7.0% and 4.4% rate mark-ups, HHSC indicated they do not have a clear understanding as to how these mark-ups were calculated, and exactly what they were intended to address beyond increasing the level of reimbursement. Additionally, these mark-ups are established through policy and are not tied to defensible components in the rate methodology, and there is not a mechanism by which the scale of these adjustments is evaluated on a recurring basis.
- Providers expressed mixed feedback regarding geographic variation in costs, including the degree to which costs significantly vary in urban vs. rural areas, and across various regions of the state.
- Non-billable time results in providers being paid for a fraction of the time they work, with issues raised specifically in regard to non-attributable training time, implications of the 80% rule, and non-billable nursing time that is required for maintaining licensure and certifications.
- The current rate methodology does not incorporate an adjustment to account for days that a bed cannot be filled in a residential setting due to circumstances outside of the provider's control. This issue is exacerbated in Texas given the zero-reject policy that requires providers to serve individuals that choose them, which can create scenarios where there are more unfilled beds than if the zero-reject policy wasn't in place.
- The provider workgroup shared their concerns around service coordination activities, and who is responsible for performing those activities between the Local IDD Authorities (LIDDAs) and the providers. HHSC determined that there were a number of allowable but not billable service coordination and case management activities that are not currently accounted for in the existing reimbursement methodology. This list of activities can be found in **Appendix 7.2: HHSC Documentation**.

4.4.2 Environmental Scan Findings

To help mitigate these concerns, the following alternatives were discussed with HHSC and the provider workgroup:

Table 6. Inflators and Other Adjustments Environmental Scan Findings.

Alternative Approach	Description	Environmental Scan Results
PCE Inflator	Texas could consider adjusting their current PCE inflator to a different index for all components of the rate or for a subset of the rate – as well as for all services or a subset of services	The following states use the CPI index: ● New York ● Ohio ● Maryland ● California
Geographic Factor	To account for cost variations across the state, Texas could consider a geographic differential for higher and lower cost counties	● Ohio ● Florida ● New York ● Illinois ● Maryland
Productivity Adjustment	As a way of adjusting reimbursement for non-billable time, Texas could implement a productivity adjustment that inflates costs to account for said time	● Ohio ● Pennsylvania ● Maryland
Occupancy Adjustment	To account for fluctuations in Residential Care vacancy rates, Texas could add an occupancy adjustment to provide payment to providers when residential facilities are not fully occupied	● New York ● Pennsylvania
Mark Up Adjustments	Texas' implementation of the 4.4% and 7% rate mark-ups is methodologically reasonable given that the calculation of the mark-ups is understood and captures allowable impacts	Not seen in other states profiled as part of Environmental Scan.

4.4.3 Considerations

4.4.3.1. Consider rate adjustments to capture the impact of allowable but non-billable activities, or update cost reporting consistent with 4.1.2.1 as appropriate

Through the evaluation process, HHSC expressed a desire to replace the 4.4% and 7.0% rate mark-ups that exist in the current methodology with factors that are well understood, and can be updated on a repeatable basis with available or obtainable data. Given this guidance, allowable adjustments to rates, as identified in the following, were considered. As discussed in **Section 4.1.2.1 Revise cost report template and/or accompanying instructions**, HHSC could consider adding additional fields to the cost reporting to capture time spent on these non-billable activities. To the extent any of the costs as discussed below are captured in the cost report data and flow into the costs used to build up the rates, these adjustments should no longer be applied.

Productivity Adjustment

A productivity adjustment is intended to account for allowable but not billable time spent on tasks that are necessary for providing high quality care, such as staff training and quality review.

- For Direct Care staff, necessary training time that is not directly attributable to an individual is not billable, but these costs are necessary for providing quality, efficient and economical care, and thus it is appropriate to include a rate adjustment to capture these impacts. The applicability of this type of adjustment was considered by service.
- For nurses, there are a number of tasks that must be performed to retain their licensure or provide care, such as charting and documentation, or participating in meetings to aid in the transition of an individual to a home; these are all times that the current cost reporting process is not capturing as billable.

Using the information gathered through the cost reporting, it would be appropriate to adjust the rates to account for these activities. HHSC should also consider temporary rate adjustments to account for these issues in the interim until cost reports can be updated to include this information. Through the provider data request, information related to non-billable training time for direct care staff, and

the amount of time the average nurse spends on non-billable tasks per day, as well as other non-billable time, was captured; this could also be captured in future cost reporting. More detail on the data request findings is found by-service in **Section 5. HCS and TxHmL Rate Setting Methodology Review by Service** and **Section 6. ICF/IID Rate Setting Methodology Review by Service**.

Occupancy/Vacancy Adjustment

The intent of an occupancy/vacancy adjustment is to account for days that a bed cannot be filled in a residential setting due to circumstances outside of a provider's control such as a hospitalization or vacation. Occupancy/vacancy adjustments are utilized by many states to account for this issue for days that are not covered by the bed hold policy. This issue is exacerbated in Texas given the zero-reject policy that requires providers to serve individuals that choose them, which can create scenarios where there are more unfilled beds than if the zero-reject policy wasn't in place. It was noted that the billing guidelines for the RSS and SL services allow for up to 14 billable vacation days, and thus the calculation of the occupancy/vacancy adjustment should be structured so that vacation days are not included in the calculation.

There are a few ways that HHSC could consider incorporating an Occupancy/Vacancy adjustment into the reimbursement methodology.

- Through the cost reporting, HHSC could seek to gather information related to unavoidable empty bed days in the HCS residential setting, and the drivers for those empty bed days, to inform the scale of this adjustment on an ongoing basis. Through the data request, information was gathered related to these unavoidable empty bed days, including days a resident was in a hospital or nursing home, a resident was in jail, there was no client assigned, or other reasons such as weather-related issues. For no client assigned, this data was gathered to understand the impact of the Texas' zero reject policy on vacancies.
- HHSC could establish an Occupancy/Vacancy adjustment as a matter of policy, with an established assumption for the number of unavoidable empty bed days, beyond vacation, that providers would be reimbursed.

However, it is important to note that the billable policy that allows for up to 14 billable vacation days, assuming every individual utilizes all 14 billable days, would equate to an implicit 96.2% occupancy adjustment. Through the data request, information was gathered related to the average number of unavoidable empty bed

days per year, including hospitalization and vacation. The data request findings were such that the average individual spends roughly 8 days per year on vacation, which would equate to an implicit 97.8% occupancy adjustment.

This adjustment concept is not being proposed for ICF/IID, given that the billing policy for ICF allows providers to bill bed hold days, which mitigates this issue.

The following adjustments are related to policy decisions or regulatory rules for Service Coordination / Case Management cost reporting, and the 80% Direct Care rule. With discussed changes to the policy/regulatory requirements, these adjustments that could be directly addressed by revising the cost reporting consistent with consideration **4.1.2.1. Revise cost report template and accompanying instructions**, and HHSC could consider temporary rate adjustments to account for the impact of these changes, consistent with the discussion in **Appendix 7.1.1.1 Prospectively incorporate temporary rate adjustments for regulatory/policy changes**.

Service Coordination / Case Management Adjustment

Similar to the concept of the productivity adjustment, the Service Coordination/Case Management Adjustment is intended to account for time specific to these activities that are allowable but not billable, and are necessary for providing high quality care. The full list of activities can be found in the **Appendix 7.2: HHSC Documentation**, and includes activities such as processing enrollments and terminations, CARE data entry, and assisting an individual to maintain Medicaid eligibility, among others.

Through cost reporting or periodic provider surveys, HHSC could determine the average time spent per day by providers on these tasks, and the average wage of the worker performing these tasks, to develop an adjustment.

Information related to the time spent on each of these activities was gathered through the data request. After reviewing the data and removing outliers, it was estimated that providers spend roughly eight minutes per day per individual on these service coordination activities. More detail on the data request findings is found by-service in **Section 5. HCS and TxHmL Rate Setting Methodology Review by Service** and **Section 6. ICF/IID Rate Setting Methodology Review by Service**.

Consideration Priority

HHSC could consider revisiting implementing rate adjustments to capture the impact of allowable but non-billable activities alongside any applicable policy, regulatory, and/or billing rules depending on the adjustment. As described above, these assumptions could be informed by data captured through cost reporting, which would require changes to the cost report template and/or instructions.

4.5. Transportation

4.5.1 Current Approach and Primary Concerns

Transportation reimbursement is not currently captured with a standalone reimbursement methodology, and transportation costs are not explicitly identified by service within the rate methodology. Transportation costs are captured in administrative costs and subject to the fixed administrative cost allocation weights. The HCS Supported Home Living (SHL) and TxHmL Community Support Services (CSS) hourly rate is used generally for reimbursing waiver transportation reimbursement, as well as reimbursement for CFC PAS/HAB services, and the rate methodology for these services similarly incorporates the combined costs of these services. Many of the providers' concerns providers were concentrated on the calculation being too simple and not reflecting the nuances in the Transportation service. Specifically, the concerns shared were:

- Trips should be reimbursed in their totality, including the time that it takes for a provider to get to a client site before a client is in the vehicle.
- There are costs associated with maintaining the vehicle such as routine maintenance, fuel, and insurance, that providers indicated are not fully reimbursed in the current methodology.
- There may be a need for geographic variation due to longer transport times and distances in rural areas, although some providers noted that geographic

variation is likely not an issue in the aggregate because urban areas have more traffic, and the primary transportation reimbursement is on an hourly basis.

- Coordination of transportation activities, especially in the Residential Care and Day Habilitation settings, is a challenge and requires significant time and effort from providers.

4.5.2 Environmental Scan Findings

Based on the aforementioned concerns, the following approaches were considered as alternatives going forward:

Table 7. Transportation Environmental Scan Findings.

Alternative Approach	Description	Environmental Scan Results
Mileage-Based and/or trip-based Reimbursement	Texas could reimburse transportation using the IRS mileage rates and potential add-ons for gas price fluctuations, one-on-one staffing requirements, and wheelchair vans, as necessary	• Florida • Ohio • California • Illinois
Productivity Adjustment	Texas could consider implementing a productivity adjustment for time that is not currently billable, gathering information through the cost reporting process - e.g., time spent driving to/from participant's house	• Illinois • New York • Pennsylvania
Non-Emergent Medical Transportation (NEMT)	Texas could use the existing NEMT program to provide and/or reimburse for transportation services to waiver participants	• Illinois • California • Ohio

4.5.3 Considerations

Through the methodology prioritization discussions, there was significant interest in exploring mileage-based and/or trip-based methodologies for transportation reimbursement. However, there are significant policy decisions that would need to be made in establishing these methodologies, including:

- How should mileage be rounded?
- When does a trip start and stop?
- Would the methodology establish a prospective rate or reimburse actual cost?
- How does the methodology and policy address multiple people being transported, including limitations around how long an individual can be in a vehicle?
- How would reimbursement for drivers be handled? What if the direct care staff are driving?
- How are cost-drivers such as 1-on-1 direct care staff requirements and wheelchair vans addressed with the rate methodology?

The methodology prioritization discussions ultimately landed on a preferred approach of maintaining the current methodology, while seeking to enhance the information gathered through cost reporting, and continuing to evaluate other methodologies for transportation reimbursement.

4.5.3.1. Consider capturing transportation cost by service, as well as the gathering of data to evaluate transportation costs and other reimbursement methodologies

There are two separate considerations related to enhancing the cost report data gathered for transportation costs.

- First, transportation costs are not currently gathered by service. Instead, transportation costs are part of the administrative cost allocation methodology and are allocated across all services, as opposed to being targeted to the services driving those costs. Updating the cost reporting such that providers allocate their transportation costs by program would allow for the rate methodology to reflect more accurately the true costs of providing specific services.
- Second, the level of information that currently available presents another challenge when exploring other reimbursement methodology options. Information was gathered through the data request to better understand the cost implications of shifting to per-trip or per-mile methodologies. However, in reviewing the data provided, there were broad inconsistencies reported by providers, making it difficult to rely on the information for analysis. HHSC

could consider adding more specific transportation cost details to the cost reporting information gathered, including mileage per trip, number of individuals being transported per trip, and cost by vehicle type.

Consideration Priority

HHSC could consider capturing additional data related to transportation costs as an initial step in a holistic evaluation of transportation reimbursement within the HCS and TxHmL programs. Additionally, HHSC could consider capturing transportation costs by service through the cost reporting, and use those costs by service as a separate rate component in the rate methodology by service. As described above, cost report templates and/or cost report instructions could be updated to gather additional data, which could then be evaluated to better understand the cost of transportation for HCS and TxHmL.

4.6. Related Party

4.6.1 Current Approach and Primary Concerns

There are three sections of the TAC that were identified by HHSC for evaluation:

1. TAC §355.105(i) – Texas completes a related party cap on administrator, assistant administrator and owner positions based on a full-time equivalent salaried staff member. The maximum amount allowed is equal to the 90th percentile of the previously audited database. This cap applies to all cost reports collected by LTSS.
2. TAC §355.722(h) – Texas completes an additional related party cap on attendant staff for IDD providers only. This maximum amount is determined as the lesser of two calculations outlined within the rule. Since this adjustment is applied only to IDD providers, we discussed the appropriateness of applying a cap to the limited provider base or expanding the adjustment to all provider types and aligning the rules among programs.

3. TAC §355.102(i) – Texas also limits the allowable expenses of related parties to the actual costs incurred by the related party. For example, an owner of a corporation leases a building they own to their own corporation. The related party incurs $2,000 a month in expenses to own the building, but charges $3,000 to the corporation to utilize the property. Under cost reporting rules, the allowable expense would be the costs actually incurred by the related party (not the corporation) of $2,000. This adjustment applies to all programs.

Related Party is an area of concern that was identified by providers, particularly in relation to group homes that are owned by the providers. Providers also expressed concerns related to the treatment of related party through the desk review process, which is outside the scope of this report. Ultimately, providers indicated concern that the application of related party policies and resulting cost reporting implications are mis-aligned and are under-representing the true costs of the program.

4.6.2 Considerations

4.6.2.1. Standardize the related party policy across LTSS providers

Publicly available information on related party policies across the states included in the environmental scan was reviewed. Where there was information, the related party policies in TAC §355.105(i), §355.722(h), and §355.102(i) are not inconsistent with related party policies in other states, with one exception. TAC §355.722(h) is defined such that there is an additional related party cap on attendant staff for IDD providers, however this cap is not applied to other LTSS providers. In the review of related party policies in other states, other states that treat IDD providers differently than other LTSS providers for the purposes of related party policy were not identified. As such, HHSC could consider unifying the related party policy across programs.

Consideration Priority

HHSC could consider standardizing the related party policy across LTSS providers as part of a review of applicable related party policies, including the aforementioned TAC policies.

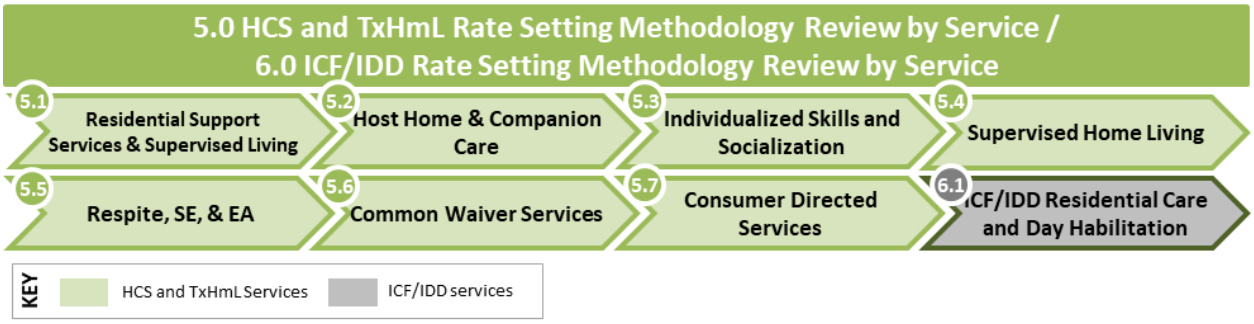
5. HCS and TxHmL Rate Setting Methodology Review by Service

The remaining sections of the report discuss the rate methodologies currently utilized for each HCS, TxHmL, and ICF/IID program, the findings of the environmental scan specific to these services, summarized stakeholder concerns and methodology considerations by rate component, and detail surrounding updated rate methodology scenario modeling and resulting rate impacts. Texas Administrative Code §355.723 defines the following cost components that are to be considered in the rate development:

- Direct care worker staffing costs (wages, benefits, and modeled staffing ratios), further specified in §355.112
- Other direct service staffing costs (wages for direct care supervisors, benefits, and modeled staffing ratios)
- Administration and operation costs, including facility costs where appropriate

Once considerations for each component were established at a high level, we then walked through each service with HHSC and the provider workgroup. For each of these services, the applicable rate components were considered to understand whether the methodology considerations would be appropriate to apply to the service. The graphic below details the services covered in the following sections, including: Residential Support Services and Supervised Living, Host Home and Companion Care, Individualized Skills and Socialization, Supported Home Living (SHL) and SHL Transportation, Respite, Supported Employment, and Employment Assistance, Common Waiver Services, Consumer Directed Services, and ICF/IID Residential Care and Day Habilitation.

Figure 3. Rate Setting Methodology Review by Service



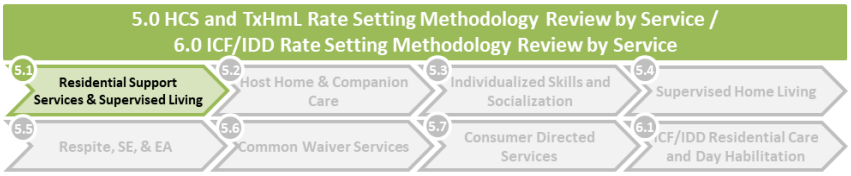
The considerations identified in **Section 4. Rate Setting Methodology Review by Component** are generally applicable to each of the services within the following sections, to the extent the contents of each consideration are relevant to the service. Within each of the services described in the remainder of the report, the considerations listed either provide necessary context relevant to the service, or introduce service-specific considerations which were not broadly applicable to other services.

The remaining sections of the report are structured by service, and within each service there is detail concerning the current rate methodology, findings from the environmental scan for states offering similar services, stakeholder concerns specific to each service and methodological considerations by rate component. The scenario modeling and potential rate impact sections provide detail on approaches by which the methodological considerations could be built into the rate methodology by service and, based on data gathered from the data request, a view of the resulting impact to the rates and budget. The table below summarizes the structure within the remaining sections of the report.

Table 8.Rate Setting Methodology Review by Service.

Item	Service	Description
1	Current Rate Methodology	Summary and visual of current rate methodology for each service.
2	Finding from Environmental Scan	High-level summary of rate methodology for states offering similar services, including similarities and differences to Texas' current methodology.
3	Stakeholder Concerns	Stakeholder concerns specific to each service and methodological considerations by rate component.
4	Scenario Modeling Approach	Approach by which scenario modeling could be conducted to evaluate the impact of the methodological considerations.
5	Potential Rate Impact Approach	Approaches by which the methodological considerations could be built into the rate methodology by service and a view of the resulting impact to the rate and budget.

5.1. Residential Support Services and Supervised Living (RSS/SL)

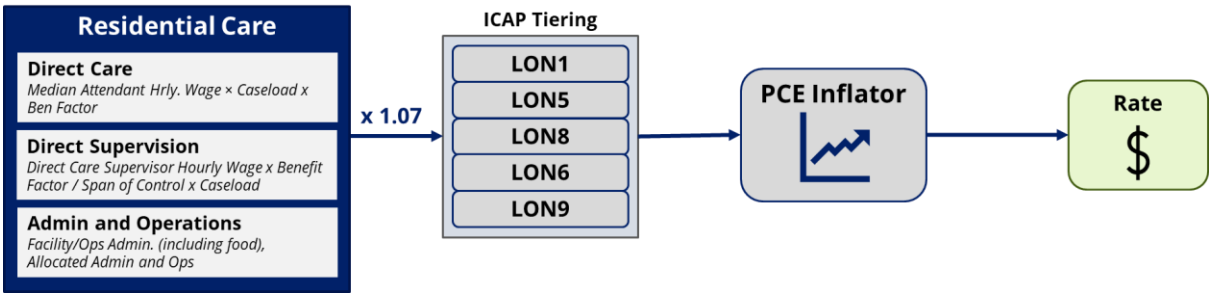


The Residential Support Services (RSS) and Supervised Living (SL) provide shared living arrangements in a group home setting; RSS is delivered in 4-bed homes serving at least one individual who requires 24-hour care, and SL is delivered in 3-bed homes for individuals who do not require 24-hour care.

5.1.1 Current Methodology

The current rate development for RSS/SL rates is depicted in the graphic below. A two-year statewide prospective per person per day (per diem) rate that varies by five levels of acuity is developed; note that RSS and SL share the same reimbursement methodology.

Figure 4. Current RSS/SL Rate Methodology.



At a high-level, the RSS/SL rate is built by separately calculating and then combining direct care, direct supervision, and administration and operations (indirect service) rate components.

- The Direct Care rate component is calculated by multiplying the median hourly residential attendant wage from the RSS/SL cost report by an attendant caseload assumption, and a benefits factor assumption, which is also derived as the median benefits factor percentage from the RSS/SL cost report. The attendant caseload assumption is a modeled direct service hours

per resident per day assumption, which varies by LON, and is calculated based on the combination of the following assumptions:

- Awake and asleep staffing ratios by LON
- The mix of awake and asleep time for the average resident in a week by LON
- The number of hours the average resident will spend outside the residence in a week
- Sick days and holidays to account for days that a resident remains at the residence in the care of attendant staff, when they otherwise would have been outside of the residence
- The modeled direct service hours per resident per day by LON is then compared against the actual units reported in the cost reporting, to proportionally increase/decrease the direct service hours per resident per day assumption within the rate methodology. It is worth noting that the assumptions underlying the development of the modeled direct service hours per resident per day by LON, particularly the staffing ratios which vary by LON, was established in a study from more than 20 years ago.

- The **Direct Supervision** rate component is calculated by multiplying medians derived from the RSS/SL cost report for direct supervisor wage, benefits factor, and supervisor span of control, by the aforementioned direct service hours per resident per day assumption which varies by LON.
- The **Indirect Service** rate component includes the median weighted residential facility and operations cost derived from the RSS/SL cost report, and the allocated administration and operations cost, which is described further in **Section 4.3 Administrative Cost Methodology**.
- The individual rate components are then added together, and multiplied by a 7% mark-up, which is described further in **Section 4.4. Inflators and Other Adjustments**. All costs derived from the cost report, as described above, also use a PCE inflator to trend the historical costs to the prospective rate period.

5.1.2 Environmental Scan

A summary of the environmental scan findings by state can be found in the table below; for more detail on the approaches utilized in other states by service, please refer to **Appendix 7.3: Environmental Scan**.

Table 9. Current RSS/SL Rate Methodology.

State	Billing Unit	Geographic Variation	Acuity Tiering	Admin	Other Comments
Texas	Daily	Not Applicable	The ICAP assessment tool classifies individuals into 5 varying Levels of Need (LON)	Allocated across the waiver based on fixed weight allocation by service	Max of either 3 or 4 residents; Additional staff needed for 4 bed
New York	Daily/Monthly (supervised/ supported)	Regional blending for provider specific rate	Acuity Assessment and protected class adjustment	Provider Specific – split by service on cost reports	Max of 14 residents for Supervised IRA and 3 for Supported IRA
California	Monthly	Not Applicable	Facilities apply to be assigned one of 14 service levels (1-4 with detailed levels within)	No detail on methodology	Max of 14 residents
Tennessee	Daily	Not Applicable	Acuity tiering into five levels based on staffing needs	Directly from cost reports	Max of 4 residents
Illinois	Daily	Housing is county-specific	Uses ICAP "smoothing" where acuity is determined on a continuous spectrum	Fixed annual fee	Max of 8 residents
Florida	Daily (capped at 24 days)	Rates vary by geography for 3 groups of counties	Approved assessment tool that classifies individuals into 4 tiers	No detail on methodology	Not Applicable

State	Billing Unit	Geographic Variation	Acuity Tiering	Admin	Other Comments
Ohio	Per 15-minute	County-level adjustment into groups CODB 1-8	Acuity assessment tool specific to Ohio - Ohio Developmental Disabilities Profile	Admin applied as an assumed percentage of the base in bottom-up rate build	Max of 4 residents
Pennsylvania	Daily	Not Applicable	Tiered by level of staffing need	The lesser of $25.00 PMPM or 10% of cost	Max of 4 residents

The sections below discuss similarities and differences in the approach for states evaluated in the environmental scan by rate structure, wages, staffing ratios, administrative costs, inflators and other adjustments, and acuity tiering.

5.1.2.1. Rate Structure

- The rate structure for these services generally follows the same direct care, supervision, and indirect cost rate components.
- All states, with the exception of Pennsylvania and Ohio, use cost reporting to establish their rates. Pennsylvania and Ohio both use a modeled rate methodology, with the former switching away from cost report-based rate setting within the last few years.
- New York is unique in that they have provider-specific rates that are developed by blending provider-specific reported costs with regional averages, and provider-specific utilization adjustments including considerations for acuity and protected classes.

5.1.2.2. Wages

- New York, California, Tennessee, and Illinois use cost reporting to determine the wage underlying the rates, similar to Texas' current methodology.
- Ohio, Pennsylvania, and Maryland rely upon BLS data to establish the wages for direct care workers.
- Florida uses a blended approach, which considers both the wages informed by cost reporting and a market analysis using the BLS data.

5.1.2.3. Staffing Ratios

The methodology used by other states to determine the staffing ratios underlying their rates was generally not publicly available. However, some states set staffing ratios as a matter of policy (Pennsylvania), and other states use studies to inform the staffing ratios (California).

- Ohio uses a Group Size Adjustment with their approach to account for this concept in a different fashion:
  - If one individual is receiving services, that individual receives 100% of the rate
  - If two individuals are receiving services, each receives 85% of the rate
  - If three individuals are receiving services, each receives 75% of the rate
  - If four individuals are receiving services, each receives 65% of the rate

5.1.2.4. Administrative Cost

- New York and Tennessee require providers to report costs by service, and the administrative cost component is based on those reported values.
- Illinois and Ohio use a fixed percentage assumption for the administrative cost component.
- Pennsylvania uses a consistent approach across waivers which is a lesser of 10% cost or $25.00 PMPM approach.

5.1.2.5. Inflators and Other Adjustments

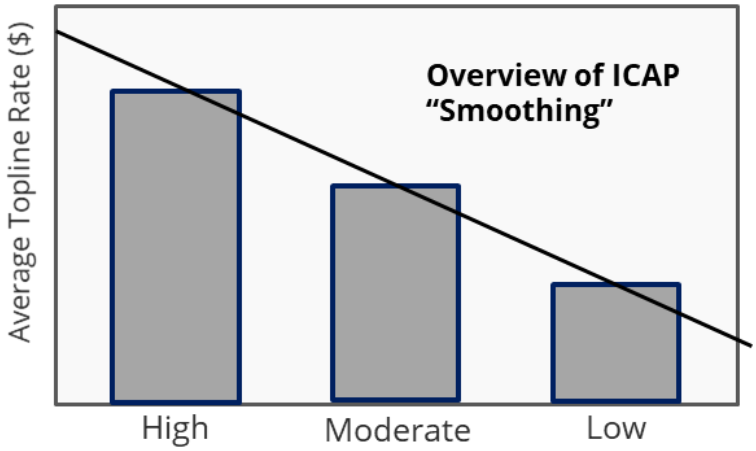
- New York, Ohio, Maryland, and California use CPI to trend the wage assumption to the prospective rate period.
- New York, Illinois, Florida, and Ohio all have geographic variation in their rates.
- New York and Pennsylvania use explicit Occupancy/Vacancy adjustments to account for bed vacancies outside of the provider's control.
- Ohio, Maryland and Pennsylvania use explicit Productivity adjustments to account for non-billable time required for quality, economical and efficient care.

- Related to Texas' implementation of the 4.4% or 7% mark-up by service, no other states were observed to have policy-driven rate increases not tied to specific components of the rate development.

5.1.2.6. Acuity Tiering

- The number of acuity tiers within the rates varies by state, ranging from 1 (Maryland) to 14 (California). New York also uses provider-specific acuities in their provider-specific reimbursement methodology.
- New York, Florida, and Ohio use state-specific assessments for establishing acuity tiers, and Tennessee uses information from each Individual Support Plan to assign an acuity tier.
- Pennsylvania uses the SIS assessment for establishing acuity tiers.
- Illinois uses the ICAP assessment for establishing acuity tiers, but has a unique approach which they call ICAP smoothing. Rather than having rates defined for specific acuity tiers (e.g., all individuals that have an ICAP score within a specific range receive the same rate), Illinois has implemented an approach where the actual score of the individual determines the rate, based on a line fit between the rates established for each acuity tier, and where the score falls within that line, as depicted within the graphic below.

Figure 5. ICAP Smoothing Example.



- California has a unique approach where they have 14 different acuity tiers, which they call service levels. Providers apply to be assigned to one of the service levels for reimbursement; this service tier then drives reimbursement, not the person-specific acuity. The variation by service level

was established by a cost-based study based on staffing ratios, service design, personnel qualifications, and consultant services.

5.1.3 Stakeholder Concerns and Methodology Considerations by Component

The following sections are structured similar to **Section 4. Rate Setting Methodology Review by Component**, and supplement with any additional relevant information for the service. The headings for each consideration identify the correlating consideration from Section 4 in parentheses as applicable. As noted, each of the considerations identified in Section 4 are generally applicable to each of the services within the following sections, to the extent the contents of each consideration are relevant to the service.

5.1.3.1. Process Improvement

5.1.3.1.1. Revise cost report template and accompanying instructions, or consider pro forma or modeled rate approaches if data cannot be obtained or is not reliable (4.1.2.1.)

Related to the noted considerations described in 4.1.2.1, to further understand the cost report consideration for identified unreported costs to the extent they are material and reasonably able to be estimated, the data request captured incremental costs associated with the identified issues. For a number of the allowable and billable items that were identified, the data was not deemed reliable for scenario modeling – please refer to the **Appendix 7.5 Data Request Findings** for additional detail. For a discussion on the adjustments related to non-billable time, please refer to **Section 5.1.3.2 Inflators and Other Adjustments**.

5.1.3.1.2. Consider the appropriateness of rate components that are based on cost report data or other data sources on a recurring basis, or define assumptions as a matter of policy (4.1.2.2)

Related to the noted considerations described in 4.1.2.2, to evaluate the appropriateness of the existing staffing ratios, the data request sent to providers captured information related to the composition of residents by LON within each home that providers currently operate, how they currently staff those homes, and how in an ideal world they believe they need to staff the homes to provide quality,

efficient and economical care. After reviewing the data and removing outliers, a range for staffing ratios was identified for consideration by LON. Based on the data provided, the staffing ratios by LON tier underlying the current rate methodology are at the low-end of the range. This approach is detailed further in **Section 5.1.4 Scenario Modeling**.

5.1.3.2. Inflators and Other Adjustments

5.1.3.2.1. Consider rate adjustments to capture the impact of allowable but non-billable activities (4.4.3.1)

Through the evaluation process, HHSC expressed a desire to replace the 7.0% rate mark-up that exists in the current RSS/SL methodology with factors that are well understood and can be updated on a repeatable basis with available or obtainable data. Given this guidance, allowable adjustments to rates were considered as described in **Section 4.4 Inflators and Other Adjustments**. As discussed in **Section 4.1.2.1 Revise cost report template and/or accompanying instructions**, HHSC could consider adding additional fields to the cost reporting to capture time spent on these non-billable activities. Additional detail on the approach used to account for identified adjustments in the scenario modeling can be found in **Section 5.1.4 Scenario Modeling**, including a Productivity Adjustment, Occupancy/Vacancy Adjustment, Service Coordination / Case Management Adjustment, and 80% Direct Care Rule Adjustment.

5.1.4 Scenario Modeling

Following discussions on alternative rate methodology considerations, in collaboration with the provider workgroup and HHSC, a methodology prioritization discussion was held, which focused on the aspects of the alternative rate methodologies discussed that the workgroup and HHSC were most interested in exploring further. A data request was developed and provided to the providers who had participated thus far in the engagement, to help inform assumptions related to the methodological changes. The contents of the data request and limitations of the data received are further discussed in previous sections. The following section contains a brief description of the methodological changes that were modeled. Please refer to the **Appendix 7.5 Data Request Findings** for additional information around the scenario modeling approach, and the adjustments listed below.

5.1.4.1. Direct Care Wages

Consistent with the discussion of direct care wages in the Methodology Prioritization section, providers expressed that current wages are not high enough to attract and retain talent in the current workforce.

It is our understanding that in Texas, changes to wage levels external to the cost reporting would need to be determined through a policy change.

For the purposes of scenario modeling, the following approach was used to assess the impact of wage changes:

- For the initial scenarios assessing the impact of the various staffing ratio levels, the direct care wage assumption was set equal to the 2020 Cost Report Direct Care wage, trended to 2024-25 using PCE.
- For the remaining scenarios, the direct care wage assumption was modeled as follows:
  - Consistent with Ohio's BLS blending approach, the average of the median wages for Home Health and Personal Care Aides, Nursing Assistants, and Social and Human Service Assistants was selected. The average of the median wages for these services in the 2020 TX BLS data is $13.58.
  - Consistent with Maryland's BLS approach which sets the direct care wages equal to the median wage for Social and Human Service Assistants which is $17.03
  - To evaluate the wage impact for an interim value, the 75th percentile of the Nursing Assistants BLS wage was selected (i.e. $15.64 per hour), a similar approach to that used in Ohio and Maryland.
- As direct care wages are increased in the scenario modeling, a proportional increase in the direct care supervisor wages was applied.

5.1.4.2. Direct Care Worker Hours per Resident per Day

Provider stakeholders expressed concern that the staffing ratios assumed in the rate methodology were not sufficient for the provision of care, particularly for higher acuity individuals. HHSC also expressed concern related to the staffing ratios because methodologically they have not been evaluated or changed since 1998.

The current rate methodology utilizes staffing ratios that assume a 4-bed home. RSS and SL services are for 4-bed and 3-bed services respectively; however, in

discussions with the provider workgroup and HHSC, stakeholders didn't indicate interest in pursuing separate rate methodologies for RSS and SL. As such, methodologically continued to assume a baseline 4-bed home for the rate methodology.

In the rate methodology, the staffing ratios are expressed through the direct care worker hours per resident per day assumption, which is built up based on underlying assumptions around staffing ratios while residents of specific acuities are awake or asleep, the relative proportion of the time a resident is awake vs. asleep, the amount of time a resident spends outside of a residence on a given week, and assumptions related to sick days and holidays where residents would be in the care of residential staff when otherwise they would be out of the home.

The data request gathered information related to each of these items, specifically:

- To evaluate the staffing ratios, the data request captured information related to the composition of residents within each home that providers currently operate, as well as how they currently staff those homes, and how in an ideal world they believe they need to staff the homes to provide quality, efficient and economical care. After reviewing the data and removing outliers, a range for staffing ratios was identified for consideration by Level of Need (LON).
- Additionally, for each home referenced above, data related to the time that residents are awake vs. asleep, and the amount of time residents spend outside of the home was collected. After reviewing the data and removing outliers, an average time awake and average time asleep for residents during the weekdays and during the weekends was estimated.

Table 10. RSS/SL Client Awake/Asleep Data Summary.

LON	Time Type	Weekday	Weekend
All	Client Awake	47	30
All	Client Asleep	39	18
All	Total	86	48

Table 11. RSS/SL Staffing Ratio Data Request Summary.

LON	Current Awake Staffing Ratios	Ideal Awake Staffing Ratios
LON1	1:4	1:4
LON5	1:3.33	1:2.35

LON	Current Awake Staffing Ratios	Ideal Awake Staffing Ratios
LON8	1:2.67	1:2
LON6	1:2	1:1.6
LON9	1:1	1:1

The average resident related to the average number of annual sick days and holidays was also collected. The findings were consistent with the existing assumption for sick days and holidays as shown in the table below.

Table 12. RSS/SL Resident Sick Leave and Holiday Assumptions.

Assumption	Days / Year
Resident Sick Leave	12
Resident Holidays	11

Using the aforementioned range of staffing ratios by LON, and the other inputs informed by the data request and outside sources, a range for the direct care worker hours per resident per day was estimated.

Table 13. RSS/SL Direct Care Hours per Resident per Day Assumption Range.

LON	Direct Care Worker Hours per Resident per Day Assumption Low Scenario	Direct Care Worker Hours per Resident per Day Assumption High Scenario
LON1	5.11	5.11
LON5	5.65	6.97
LON8	6.53	7.75
LON6	7.75	9.99
LON9	13.27	14.18

These modeled direct care worker hours per resident per day assumptions are then proportionally increased or decreased based upon the relativity of the amount of direct care time that the modeled direct care worker hours per resident per day indicate would be required to provide services to the covered individuals, and the total reported direct care time in the cost reports for these services.

5.1.4.3. 80% Direct Care Adjustment

The 80% rule for attendant care is a current policy which requires that an attendant must perform attendant functions at least 80% of his/her time worked, and staff not providing attendant services at least 80% of their total time worked are not considered attendants. An implication of this rule is that for cost reporting, direct care hours are under-reported as a result of attendant services being performed by individuals who are not meeting the 80% criteria, and as a result the direct care portion of the rates are understated. It can be argued that these costs are being captured as administrative costs or supervisor costs currently (depending on the non-attendant staff performing the direct care activities), and thus a corresponding decrease to the administrative cost could be considered as well.

However, using the supervisor as an example, the rate methodology does not simply replace those costs elsewhere on a 1:1 basis – the direct care supervisor rate component assumes a span of control in excess of 1:17, as determined by the median from cost reporting. The implication of this in the rate methodology, is that if a direct care supervisor provides 1 hour of 1:1 care for an LON 9 individual, but is unable to report that hour as direct care in the cost reporting, then the rate methodology is in essence capturing 1/17th of the impact, given the span of control and staffing assumptions, and the methodology building a person-specific daily rate.

Data provided through the data request was relied upon for this analysis, which quantified the number of hours providers estimate spending on direct care that is not billable due to the 80% rule. After reviewing the data and identifying outliers, the estimated un-reported direct care hours were divided by total direct care hours as reported in the cost reporting to develop an estimated impact for this issue.

5.1.4.4. Temporary Medication Administration Adjustment

Related to proposed policy change §565.23(h), which creates new requirements for program providers to create and implement policies and procedures around medication administration. HHSC identified this policy change as likely to be implemented at some point in the future, and as such data related to this was collected through the provider data request.

Data provided by stakeholders through the data request was relied upon, where providers estimated the number of additional direct care hours that would be required for medication administration as a result of the proposed policy change.

The estimated hours provided by stakeholders were divided by total direct care hours reported in the cost report to develop a percent adjustment, which is applied to the direct care rate component.

5.1.4.5. Fixed Administrative Percentage Adjustment

To further assess the administrative costs in the rate methodology, HHSC provided cost report information from 2020, 2018, 2017, and 2016 with separate costs by Direct Care, Admin, and Facility and Operations Expenses.

The scenario modeling used a 3-year rolling average of the administrative cost as a percentage of the direct care cost to estimate the administrative cost by service, which in this case is equal to 43.8%. This was applied in the rate methodology by multiplying the direct care rate component by the 43.8% assumption; this replaces the previous allocated administrative cost rate component. The facility and operations rate component is un-changed with this methodology.

5.1.4.6. Productivity Adjustment

The data request captured the amount of time that new and current direct care staff spends on trainings that are not directly attributable to an individual per year, and thus are not currently being captured in the cost reporting. This data, as well as an assumption related to staff turnover, was relied upon to estimate a range for the non-billable training time for the average direct care staff in a year, as shown in the table below. The estimated annual hours on non-billable trainings was divided by 2,080 (40 hours/week * 52 weeks/year) to develop a percent adjustment, which is applied as a factor to the direct care rate component.

Table 14. Productivity Adjustment Assumption Range for 2018-CR Turnover.

	New Employees	Current Employees
% of Workforce Population (based on turnover)	12%	88%
Average # of hours of training	80.00	40.00

Table 15. Productivity Adjustment Assumption Range for Mid-Point Assumption.

	New Employees	Current Employees
% of Workforce Population (based on turnover)	30%	70%
Average # of hours of training	80.00	40.00

Table 16. Productivity Adjustment Assumption Range for Data Request Driven Assumption.

	New Employees	Current Employees
% of Workforce Population (based on turnover)	49%	51%
Average # of hours of training	71.34	38.58

Table 17. Productivity Adjustment Calculation Based on Assumption Range.

Assumption Type	2018 CR Turnover	Mid-Point Assumption	Data Request Driven Assumption
Productivity Adjustment	2.16%	2.50%	2.63%

5.1.4.7. Occupancy Adjustment

Data provided by stakeholders through the data request was relied upon to quantify the total number of days that a bed is vacant in various group homes. The data request considered the following reasons for a vacancy:

- Resident in Hospital/Nursing Home, Resident in Jail, No Client Assigned, and Other.
- Days that a resident is on vacation is excluded for the purposes of this analysis, as per the billing policy, providers are able to bill for up to 14 days annually that a resident is on vacation with family.
- Resident in Jail was a datapoint gathered as a result of stakeholder feedback. However based on the data provided in the data request, this amounted to an immaterial number of days for the average RSS/SL resident.
- No Client Assigned was intended to capture the number of days a bed is empty due to a vacancy, and was an attempt to understand the degree to which Texas' zero reject policy impacts providers.
- The 'Other' reasons for unavoidable vacancies as provided by providers through the data request were generally driven by weather-related issues.
- An occupancy factor was estimated by taking the sum of the average days per year as reported in the cost reporting after data cleansing and excluding outliers, divided by 365. Based on the information provided in the data request, a range for the occupancy adjustment could fall between 94.9% and 97.4%, which is the resulting range when the average No Client Assigned days per year from the data request is included or excluded, respectively, as

shown in the table below. In the rate methodology, this adjustment is applied to the sum of all rate components.

Table 18. Occupancy Factor Assumption Range.

Occupancy Factor	Average Days/Year
Resident in Hospital/Nursing Home	7
Resident in Jail	0
No Client Assigned	9
Other	2.5
Sum of Days (including No Client Assigned)	**18.5**
Sum of Days (excluding No Client Assigned	**9.5**
Occupancy Adjustment (including No Client Assigned)	**94.9%**
Occupancy (excluding No Client Assigned)	**97.4%**

5.1.4.8. Temporary Service Coordination Adjustment

It is unclear who is responsible for performing service coordination activities between the LIDDAs and the providers. HHSC determined that there were many allowable but not billable service coordination and case management activities that are not currently accounted for in the existing reimbursement methodology. This list of activities can be found in the Appendix 7.2: HHSC Documentation.

HHSC provided a list of these activities, and through the data request, information related to the time spent by providers on these specific tasks was collected. After reviewing the data and removing outliers, an estimated daily time per individual on these service coordination and case management activities not currently captured in the cost reporting was developed to be roughly 8 minutes per resident per day.

The provider workgroup indicated that depending on the home and provider, different levels of staff were performing these activities, from supervisors to administrative and central office staff, to owners. For the purposes of the scenario modeling, the hourly wage for individuals performing these service coordination and case management activities was set at $22 per hour, which was the average administrative staff wage that providers reported through the data request.

This adjustment is proposed as a temporary rate adjustment until such time the underlying cost report instructions have been clarified to include these activities as

reported cost, and applied as an additive adjustment to the indirect care rate component.

5.1.5 Potential Rate Impact

Using the methodology adjustments described in the section above, various scenarios were created to evaluate the potential rate impacts. The budgetary impacts were developed utilizing the units as reported in the 2018 cost reports by LON.

Scenario C1a removes the 7% rate mark-up, and adjusts client awake/asleep hours which impacts the direct care hours per resident per day. This scenario also applies all of the assumptions addressed in the section above, including the occupancy adjustment, productivity adjustment, fixed administrative allocation adjustment, adjustment for direct care hours from workers who spend less than 80% of their time on direct care, temporary medication administration adjustment, and temporary service coordination adjustment. Lastly, the wage in this scenario is adjusted to the RSS/SL direct care worker wage developed from the most recent 2020 cost report, trended to years 2024-2025

Compared to Scenario C1a, **Scenario C1b** changes the staffing ratios to 'mid-levels', and maintaining all other assumptions from Scenario C1a.

Scenario C1c further increases the staffing ratio assumptions to 'high-levels', and maintaining all other assumptions from Scenario C1b.

Table 19. RSS/SL Rate Scenario Summary C1a-C1c – FTE Awake Assumption.

Level of Need	Current Rates	Scenario C1a	Scenario C1b	Scenario C1c
LON1	1	1	1	1
LON5	1.2	1.2	1.5	1.7
LON8	1.5	1.5	1.75	2
LON6	2	2	2.25	2.5
LON9	4	4	4.00	4.00

Table 20. RSS/SL Rate Scenario Summary - C1a-C1c – FTE Asleep Assumption.

Level of Need	Current Rates	Scenario C1a	Scenario C1b	Scenario C1c
LON1	1	1	1	1
LON5	1	1	1	1

Level of Need	Current Rates	Scenario C1a	Scenario C1b	Scenario C1c
LON8	1	1	1	1
LON6	1	1	1.165	1.33
LON9	1	1	1.165	1.33

Table 21. RSS/SL Rate Scenario Summary C1a-C1c - Hours/Days.

Time Metric	Current Rates	Scenario C1a	Scenario C1b	Scenario C1c
Client Awake (Hours)	82	76	76	76
Client Asleep (Hours)	56	57	57	57
Sick Leave (Days)	12	12	12	12
Holidays (Days)	11	11	11	11

Table 22. RSS/SL Rate Scenario Summary C1a-C1c - DC Hours/Resident/Day.

Level of Need	Current Rates	Scenario C1a	Scenario C1b	Scenario C1c
LON1	5.25	5.11	5.11	5.11
LON5	5.86	5.65	6.53	6.97
LON8	6.75	6.53	7.21	7.75
LON6	8.24	7.75	9.10	9.99
LON9	14.22	13.27	14.18	14.18

Table 23. RSS/SL Rate Scenario Service Summary C1a-C1c – Assumptions.*

Assumptions	Current Rates	Scenario C1a	Scenario C1b	Scenario C1c
Mark-up Assumption	7%	N/A	N/A	N/A
Occupancy Adjustment	N/A	94.9%	94.9%	94.9%
Productivity Adjustment	N/A	2.5%	2.5%	2.5%
Admin (3-year avg.)	Current Methodology	43.8%	43.8%	43.8%
80% Direct Care Adjustment	N/A	0.8%	0.8%	0.8%

Assumptions	Current Rates	Scenario C1a	Scenario C1b	Scenario C1c
Medication Admin Adjustment	N/A	0.10%	0.10%	0.10%
Service Coordination Adjustment	N/A	0.13 hours/day	0.13 hours/day	0.13 hours/day
Wage Assumption	$10.35/Hours	$11.82/Hour	$11.82/Hour	$11.82/Hour

**All assumptions are subject to change.*

Table 24. RSS/SL Rate Scenario Service Summary Rates C1a-C1c.

Level of Need	Current Rates	Scenario C1a	Scenario C1b	Scenario C1c
LON1	$137.54	$159.79	$163.16	$165.40
LON5	$146.47	$169.30	$187.64	$197.23
LON8	$159.49	$184.62	$199.30	$210.58
LON6	$181.27	$205.92	$231.96	$248.95
LON9	$268.71	$302.52	$319.50	$320.77
Budget Impact	N/A	15.4%	25.5%	31.5%

Scenario C2, C3, and **C4** maintain the high staffing ratio scenario from Scenario C1c and modify the wage assumption to other BLS levels as detailed in **Section 5.1.4.1 Direct Care Wages**.

Table 25. RSS/SL Rate Scenario Summary C2-C4 - FTE Awake Assumption.

Level of Need	Current Rates	Scenario C2	Scenario C3	Scenario C4
LON1	1	1	1	1
LON5	1.2	1.7	1.7	1.7
LON8	1.5	2.0	2.0	2.0
LON6	2	2.5	2.5	2.5
LON9	4	4.00	4.00	4.00

Table 26. RSS/SL Rate Scenario Summary C2-C4 - FTE Asleep Assumption.

Level of Need	Current Rates	Scenario C2	Scenario C3	Scenario C4
LON1	1	1	1	1
LON5	1	1	1	1
LON8	1	1	1	1
LON6	1	1.33	1.33	1.33
LON9	1	1.33	1.33	1.33

Table 27. RSS/SL Rate Scenario Summary C2-C4 - Hours/Days.

Time Metric	Current Rates	Scenario C2	Scenario C3	Scenario C4
Client Awake (Hours)	82	76	76	76
Client Asleep (Hours)	56	57	57	57
Sick Leave (Days)	12	12	12	12
Holidays (Days)	11	11	11	11

Table 28. RSS/SL Rate Scenario Summary C2-C4 - DC Hours/Resident/Day.

Level of Need	Current Rates	Scenario C2	Scenario C3	Scenario C4
LON1	5.25	5.11	5.11	5.11
LON5	5.86	6.97	6.97	6.97
LON8	6.75	7.75	7.75	7.75
LON6	8.24	9.99	9.99	9.99
LON9	14.22	14.18	14.18	14.18

Table 29. RSS/SL Rate Scenario Summary C2-C4 - Assumptions.*

Assumptions	Current Rates	Scenario C2	Scenario C3	Scenario C4
Mark-up Assumption	7%	N/A	N/A	N/A
Occupancy Adjustment	N/A	94.9%	94.9%	94.9%
Productivity Adjustment	N/A	2.5%	2.5%	2.5%
Admin (3-year avg.)	Current Methodology	43.8%	43.8%	43.8%

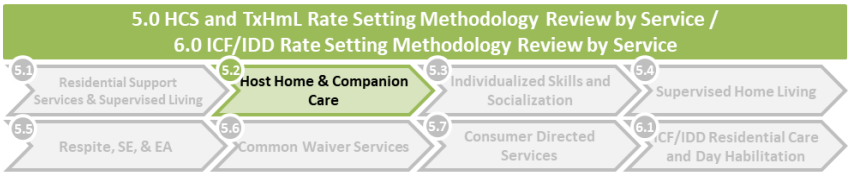
Assumptions	Current Rates	Scenario C2	Scenario C3	Scenario C4
80% Direct Care Adjustment	N/A	0.8%	0.8%	0.8%
Medication Admin Adjustment	N/A	0.10%	0.10%	0.10%
Service Coordination Adjustment	N/A	0.13 hours/day	0.13 hours/day	0.13 hours/day
Wage Assumption	$10.35/Hours	$13.58/Hour	$15.64/Hour	$17.03/Hour

**All assumptions are subject to change.*

Table 30. RSS/SL Rate Scenario Summary C2-C4 – Rates.

Level of Need	Current Rates	Scenario C2	Scenario C3	Scenario C4
LON1	$137.54	$186.57	$211.34	$228.06
LON5	$146.47	$223.13	$253.45	$273.92
LON8	$159.49	$238.48	$271.12	$293.16
LON6	$181.27	$282.55	$321.88	$348.42
LON9	$268.71	$365.09	$416.93	$451.92
Budget Impact	**N/A**	**48.8%**	**69.1%**	**82.8%**

5.2. Host Home and Companion Care (HH/CC)

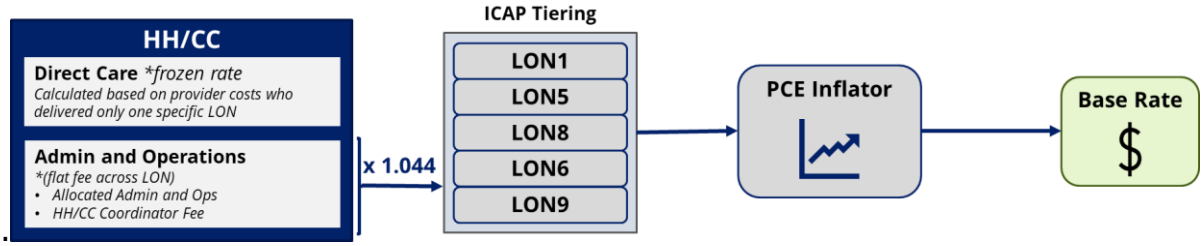


HH/CC is a service where individuals live with family or another individual, akin to a foster care arrangement.

5.2.1 Current Methodology

The current rate development for Host Home / Companion Care (HH/CC) rates is depicted in the graphic below; the HH/CC rate is a two-year statewide prospective per person per day (per diem) rate that varies by five levels of acuity.

Figure 6. Current HH/CC Rate Methodology.



At a high-level, the HH/CC rate is built by separately calculating and then combining direct care and admin and operations (indirect service) rate components.

- The **Direct Care rate component** is a rate assumption that was developed as a weighted average rate from the cost reports at a point in time in the past based on a study of providers who delivered HH/CC services only to a single LON, and is not regularly updated based upon the underlying cost reporting. The HH/CC service is unique in that most providers contract out this service, and as a result the detail that is able to be provided in cost reporting by providers is not at the granularity that is provided for other services.
- The **Indirect Service rate component** includes the allocated administration and operations cost, which is described further in Section 4.3 Administrative Cost Methodology, and the HH/CC Coordinator Fee, which is a separate rate component defined by TAC §355.723(d)(2).

All costs derived from the cost report as described above use a PCE inflator to trend the historical costs to the prospective rate period. The 4.4% mark-up is only applied to the indirect service rate component, and no mark-up is applied to the Direct Care rate component. The rate mark-up is described further in report **Section 5.2.3.2 Inflators and Other Adjustments**.

5.2.2 Environmental Scan

A summary of the environmental scan findings by state can be found in the table below; for more detail on the approaches utilized in other states by service, please refer to **Appendix 7.3: Environmental Scan**.

Table 31. HH/CC Environmental Scan Summary.

State	Rate Period	Geographic Variation	Acuity Tiering	Admin	Other Comments
Texas	Daily	Not Applicable	ICAP LON 1-5	Allocated on units of service + HH/CC Coordinator component	Not Applicable
New York	Daily	Four DOH Regions	ISPM Add-On	Provider Specific – split by service on cost reports	Max of 4 residents
Tennessee	Daily	Not Applicable	Not Applicable	Directly from cost reports	Not Applicable
Illinois	Daily	Housing is county-specific	Uses ICAP "smoothing" where acuity is determined on a continuous spectrum	Fixed annual fee	Max of 2 residents
Ohio	Daily	County-level adjustment into groups CODB 1-8	Acuity assessment tool specific to Ohio - Ohio Developmental Disabilities Profile	Admin applied as an assumed percentage of the base in bottom-up rate build	Max of 4 residents
Pennsylvania	Daily	Not Applicable	Tiered by level of staffing need	The lesser of $25.00 PMPM or 10% of cost	Max of 2 residents

The sections below discuss similarities and differences in the approach for states evaluated in the environmental scan by rate structure, wages, staffing ratios, administrative costs, inflators and other adjustments, and acuity tiering.

5.2.2.1. Rate Structure

The rate structure for these services generally follows the same direct care, supervision, and indirect cost rate components. All states, with the exception of Pennsylvania and Ohio, use cost reporting to establish their rates. Pennsylvania and Ohio both use a modeled rate methodology, with the former switching away from cost report-based rate setting within the last few years.

New York is unique in that they have provider-specific rates that are developed by blending provider-specific reported costs with regional averages, and provider-specific utilization adjustments including considerations for acuity and protected classes.

5.2.2.2. Wages

- New York, Tennessee, and Illinois use cost reporting to determine the wage underlying the rates
- Ohio and Pennsylvania rely upon BLS data to establish the wages for direct care workers

5.2.2.3. Staffing Ratios

The methodology used by other states to determine the staffing ratios underlying their rates was generally not publicly available, and the degree to which staffing ratios plays a role in the rate development for their HH/CC-analogous services was generally unclear for most states.

- Ohio uses a Group Size Adjustment with their approach to account for the concept of staffing ratios in a HH/CC-analogous setting:
  - If one individual is receiving services, that individual receives 100% of the rate
  - If two individuals are receiving services, each receives 85% of the rate
  - If three individuals are receiving services, each receives 75% of the rate
  - If four individuals are receiving services, each receives 65% of the rate

5.2.2.4. Administrative Cost

- New York and Tennessee require providers to report costs by service, and the administrative cost component is based on those reported values.
- Illinois and Ohio uses a fixed percentage assumption for the administrative cost component
- Pennsylvania uses a consistent approach across waivers which is a lesser of 10% cost or $25.00 PMPM approach.

5.2.2.5. Inflators and Other Adjustments

- New York, Illinois, and Ohio all have geographic variation in their rates

- New York and Pennsylvania use explicit Occupancy/Vacancy adjustments to account for uncompensated costs
- Ohio is the only state that is using an explicit Productivity adjustment to account for non-billable time required for economical and efficient care.
- Related to Texas' implementation of the 4.4% or 7% mark-up by service, no other states were observed to have policy-driven rate increases not tied to specific components of the rate development.

5.2.2.6. Acuity Tiering

The number of acuity tiers within the rates varies by state, ranging from 1 (Tennessee) to 9 (Ohio). New York uses provider-specific acuities in their provider-specific reimbursement methodology as well.

- New York and Ohio use state-specific assessments for establishing acuity tiers
- Pennsylvania uses the SIS assessment for establishing acuity tiers
- Tennessee is the only one of these evaluated states that had an acuity tiering methodology for residential services, but does not for host home / foster care services.
- Illinois uses the ICAP assessment for establishing acuity tiers, but has a unique approach which they call ICAP smoothing. Rather than having rates defined for specific acuity tiers (e.g., all individuals that have an ICAP score within a specific range receive the same rate), Illinois has implemented an approach where the actual score of the individual determines the rate, based on a line fit between the rates established for each acuity tier, and where the score falls within that line.

5.2.3 Stakeholder Concerns and Methodology Considerations by Component

The following sections are structured similar to **Section 4. Rate Setting Methodology Review by Component**, and supplement with any additional relevant information for HH/CC with further elaboration on HH/CC specific issues. The headings for each consideration identify the correlating consideration from Section 4 in parentheses as applicable. As noted, each of the considerations identified in Section 4 are generally applicable to each of the services within the

following sections, to the extent the contents of each consideration are relevant to the service.

An issue unique to the HH/CC service is that the majority of the service provision is contracted out by the providers. As a result, the granularity of the cost report data is not consistent with the granularity for other services, which poses challenges with the rate development. The following sections discuss this issue further, and identify some approaches that can be taken to create a data driven, repeatable rate methodology.

5.2.3.1. Process Improvement

5.2.3.1.1. Revise cost report template and accompanying instructions, or consider pro forma or modeled rate approaches if data cannot be obtained or is not reliable (4.1.2.1.)

Stakeholder Concerns

Due to the HH/CC service being contracted out by a significant portion of the providers, the cost report data that is available is not at a similar level of granularity as other services, and it would be generally difficult for providers to be able to provide more detailed information.

- The attendant wage and compensation data in the cost reporting for HH/CC is rarely populated, and as a result, relying upon the HH/CC cost report data alone to establish the direct care rate component poses a significant challenge.
- Providers of HH/CC services have an allowable, attributable portion of facility and operations costs which are not currently accounted for in the cost report or through the rate methodology. To better understand the facility and operations costs in the HH/CC setting, additional data was requested to gather specific costs in the HH/CC setting, which aligned to the costs underpinning the RSS/SL facility and operations rate component.

Through this data collection effort and through discussions with the providers, there are two core issues identified that impact providers' ability to be able to report these costs through cost reporting:

- The contracting arrangements that most providers use to provide HH/CC services do not generally allow providers to understand costs at the desired level of granularity
- Many HH/CC providers are families/guardians, and generally their ability to provide credible and complete cost report information would be a significant hurdle

Considerations

For the Direct Care portion of the rate:

- HHSC could consider comparing the average HCS only, contract non-attendant wages and compensation per day from the HH/CC cost reporting to the average attendant + non-attendant wages and compensation per day from the RSS/SL cost reporting. This would provide a proxy for the relativity in direct care costs between the services being provided in the RSS/SL setting and in the HH/CC setting. This relativity could then be applied to the RSS/SL direct care rate component, to develop an HH/CC direct care rate component with a data driven, repeatable methodology. The percentage used in this comparison could be based on the relationship in the most recent cost reporting, or methodologies such as a 3-year rolling average of the HH/CC costs as a proportion of the RSS/SL costs.
- Report **Section 5.2.4.1 Direct Care Rate Component** provides additional context related to the relationship that was established through the HH/CC Scenario Modeling.

For the Facility and Operations Costs:

- Given the identified challenges with cost reporting for the HH/CC service, if the cost report template and instructions were updated to capture this information in the HH/CC setting, the data would likely not be complete or reliable enough for the purposes of establishing a rate component assumption. As such, HHSC should consider an alternative methodology to capture these facility and operations costs in the HH/CC setting. This could include a comparative cost analysis from the cost reports to establish a relativity factor for Facility and Operations Costs relative to RSS/SL, or establishing an assumption as a matter of policy to capture the impact of these costs.

HHSC should consider revisiting these considerations alongside any applicable policy and/or regulatory requirements. As described above, providers are unlikely to be able to provide data to support these assumptions directly, and as such modeled approaches as described above could be considered.

5.2.3.2. Inflators and Other Adjustments

5.2.3.2.1. Consider rate adjustments to capture the impact of allowable but non-billable activities (4.4.3.1.)

Through the evaluation process, HHSC expressed a desire to replace the 4.4% rate mark-up that exists in the current HH/CC methodology with factors that are well understood, and can be updated on a repeatable basis with available or obtainable data. Given this guidance, allowable adjustments to rates as identified in the following were considered as described in **Section 4.4 Inflators and Other Adjustments**. As discussed in **Section 4.1.2.1 Revise cost report template and/or accompanying instructions**, HHSC could consider adding additional fields to the cost reporting to capture time spent on these non-billable activities, but due to the contracting out of HH/CC services, in many cases providers may not be able to provide relevant information. As a result, pro forma approaches, or approaches that leverage data from other services such as RSS/SL may need to be considered to determine a reasonable scale for each adjustment. Additional detail on the approach used to account for the identified adjustments can be found in **Section 5.2.4 Scenario Modeling**, including a Productivity Adjustment, Occupancy/Vacancy Adjustment, and Service Coordination / Case Management Adjustment.

5.2.3.3. Acuity Tiering

5.2.3.3.1. Consider alternative LON tiering approaches to reflect cost differences

Stakeholder Concerns

A primary issue with applying acuity tiering on the HH/CC service is aforementioned issue related to the contracting of HH/CC service by most HCS providers, and the impact that it has on the granularity of data that providers are able to provide through cost reporting. Acuity tiering considerations are also more generally discussed in **Appendix 7.1.3: Acuity Tiering**.

Considerations

Given the proposed direct care rate component methodology discussed in **Section 5.2.3.1.1**, which would establish the direct care component of the HH/CC rate as a relative proportion of the RSS/SL direct care component, HHSC could apply the resulting percentage to the direct care component by LON to retain tiered rates for HH/CC. Alternatively, if other approaches are utilized in the future to develop the direct care portion of the rate, HHSC could further explore and consider collapsing the LON tiers for the HH/CC service.

5.2.4 Scenario Modeling

Following discussions on alternative rate methodology considerations, in collaboration with the provider workgroup and HHSC, a methodology prioritization discussion was held, which focused on the aspects of the alternative rate methodologies that the workgroup and HHSC were most interested in exploring further. A data request was developed and provided to the providers who had participated thus far in the engagement, to help inform assumptions related to the methodological changes. The contents of the data request and limitations of the data received are further discussed in previous sections. The following section contains a brief description of the methodological changes that were modeled. Please refer to the **Appendix 7.5 Data Request Findings** for additional information around the scenario modeling approach, and the adjustments listed below.

5.2.4.1. Direct Care Rate Component

In evaluating the information that is available, one approach that could be utilized is comparing the average non-attendant wages and compensation per day from the HH/CC cost reporting to the average attendant + non-attendant wages and compensation per day from the RSS/SL cost reporting. This would provide a proxy for the relativity in costs as reported in the cost reporting, and a percentage could be developed from the most recent cost reporting data, or by using a rolling average of previous years' cost reporting, similar to the approach discussed for administrative costs. This percentage could then be applied to the direct care component of the RSS/SL rates to determine the direct care component of the HH/CC rates. For the scenario modeling, a 70% relativity of HH/CC direct care costs to RSS/SL direct care costs was considered.

At a high level, the idea with this adjustment is to capture corresponding costs from the cost report by cost category between the two services, and establish a point of

relativity. HHSC should evaluate whether a comparison of other cost reporting fields for the RSS/SL and HH/CC services would be better suited for the purposes of establishing this relationship.

5.2.4.2. Facility and Operation Costs

Similar to the adjustment described for the Direct Care Rate Component in 5.2.4.1, given the HH/CC contracting and cost reporting issues, HHSC could seek to establish a relativity between the Facility and Operation Costs for RSS/SL and HH/CC. For the purposes of the scenario modeling, the same identified relationship of cost between RSS/SL and HH/CC for direct care (70%) was used to model out the Facility and Operation Cost component.

5.2.4.3. Temporary Medication Administrative Adjustment

Related to proposed policy change §565.23(h), which creates new requirements for program providers to create and implement policies and procedures around medication administration. HHSC identified this policy change as likely to be implemented at some point in the future, and as such data was gathered related to this through the provider data request. Data provided by stakeholders through the data request was relied upon, where providers estimated the number of additional direct care hours that would be required for medication administration as a result of the proposed policy change.

The estimated hours provided by stakeholders were divided by total direct care hours reported in the cost report to develop a percent adjustment, which is applied to the direct care rate component.

Note that for HH/CC, an explicit adjustment to account for this adjustment was not made. However, the direct care rate component for HH/CC in the modeling was set to 70% of the RSS/SL direct care rate component, and the temporary medication administrative adjustment was applied in the build-up of the RSS/SL direct care rate component.

5.2.4.4. Fixed Administrative Percentage Adjustment

To further assess the administrative costs in the rate methodology, HHSC provided cost report information from 2020, 2018, 2017, and 2016 with separate costs by Direct Care, Admin, and Facility and Operations Expenses.

The scenario modeling used a 3-year rolling average of the administrative cost as a percentage of the direct care cost to estimate the administrative cost by service,

which in this case is equal to 43.8%. This was applied in the rate methodology by multiplying the direct care rate component by the 43.8% assumption; this replaces the previous allocated administrative cost rate component.

5.2.4.5. Productivity Adjustment

The data request captured the amount of time that new and current direct care staff spend on trainings that are not directly attributable to an individual per year, and thus are not currently being captured in the cost reporting. This data, as well as an assumption related to staff turnover, was relied upon to estimate a range for the non-billable training time for the average direct care staff in a year, as shown in the table below. The estimated annual hours on non-billable trainings was divided by 2,080 (40 hours/week * 52 weeks/year) to develop a percent adjustment, which is applied as a factor to the direct care rate component.

The same adjustment was applied across services where the concept of a productivity adjustment was appropriate to consider. This application of a similar productivity adjustment across services is consistent with the methodology observed in other states that have implemented productivity adjustments.

Note that for HH/CC, an explicit adjustment to account for this adjustment was not made. However, the direct care rate component for HH/CC in the modeling was set to 70% of the RSS/SL direct care rate component, and the productivity adjustment was applied in the build-up of the RSS/SL direct care rate component.

Table 32. Productivity Adjustment Assumption Range for 2018-CR Turnover.

	New Employees	Current Employees
% of Workforce Population (based on turnover)	12%	88%
Average # of hours of training	80	40

Table 33. Productivity Adjustment Assumption Range for Mid-Point Assumption.

	New Employees	Current Employees
% of Workforce Population (based on turnover)	30%	70%
Average # of hours of training	80	40

Table 34. Productivity Adjustment Assumption Range for Data Request Driven Assumption.

	New Employees	Current Employees
% of Workforce Population (based on turnover)	49%	51%
Average # of hours of training	71.34	38.58

Table 35. Productivity Adjustment Calculation Based on Assumption Range.

Assumption Type	2018 CR Turnover	Mid-Point Assumption	Data Request Driven Assumption
Productivity Adjustment	2.16%	2.50%	2.63%

5.2.4.6. Occupancy Adjustment

Data provided by stakeholders through the data request was relied upon to quantify the total number of days that a bed is vacant in various group homes. The data request considered the following reasons for a vacancy:

- Resident in Hospital/Nursing Home, Resident in Jail, No Client Assigned, and Other.
- Days that a resident is on vacation is excluded for the purposes of this analysis, as per the billing policy, providers are able to bill for up to 14 days annually that a resident is on vacation with family.
- The 'Other' reasons for unavoidable vacancies as provided by providers through the data request were generally driven by weather-related issues.
- An occupancy factor was estimated by taking the sum of the average days per year as reported in the cost reporting after reviewing the data and removing outliers, divided by 365. Based on the information provided in the data request and summarized below, an occupancy adjustment for HH/CC was set to 98.4%. A range was not calculated for the Occupancy Adjustment consideration for HH/CC as was calculated for RSS/SL, as the 'no client assigned' time which was used to determine the range is not relevant in the HH/CC setting. In the rate methodology, this adjustment is applied as a factor to the sum of all rate components.

Table 36. Occupancy Factor Adjustment Assumption.

Occupancy Factor	Average Days/Year
Resident in Hospital/Nursing Home	4
Other	2
Sum of Days	**6.0**
Occupancy Adjustment	**98.4%**

5.2.4.7. Service Coordination Adjustment

Through discussions with the provider workgroup, concerns around service coordination activities, and who is responsible for performing those activities between the LIDDAs and the providers, were conveyed. After discussions, HHSC determined that there were a number of allowable service coordination and case management activities, which the providers indicated they haven't been reporting time related to in the cost reporting.

HHSC provided a list of these activities, and through the data request, information related to the time spent by providers on these specific tasks was collected. After reviewing the data and removing outliers, an estimated daily time per individual on these service coordination and case management activities not currently captured in the cost reporting was developed to be roughly 8 minutes per resident per day.

The provider workgroup indicated that depending on the home and provider, different levels of staff were performing these activities. For the purposes of the scenario modeling, the hourly wage for individuals performing these service coordination and case management activities was set at $22 per hour, which was the average administrative staff wage that providers reported through the data request.

This adjustment is proposed as a temporary rate adjustment until such time the underlying cost report instructions have been clarified to include these activities as reported cost, and applied as an additive adjustment to the indirect care rate component.

5.2.4.8. Host Home Inspection

There is a proposed policy change §565.25(b) that increases the provider requirement to inspect HH/CC homes more frequently, from annually to quarterly.

Data provided by stakeholders through the data request was relied upon to assess the impact of this change, with two considerations.

- First, historically what was the cost per HH/CC home inspection under the previous one per annum policy.
- Second, what are the anticipated incremental costs associated with quarterly HH/CC home inspections.

Through the data request, providers generally expected that the cost per HH/CC inspection would be the same; there would just be three additional inspections with the related costs annually.

The average cost per inspection per HH/CC home was estimated to be $36.50 based on the data provided. The cost was annualized assuming three additional HH/CC home inspections per home per year, and compared the total estimated incremental cost to the total administrative cost by provider to develop an estimated percentage increase, which was applied to the administrative rate component.

5.2.5 Potential Rate Impact

Using the methodology adjustments described in the section above, various scenarios were created to evaluate the potential rate impacts. The budgetary impacts were developed utilizing the units as reported in the 2018 cost reports by LON.

- Scenario C1a removes the 4.4% rate mark-up, and applies all of the assumptions addressed in the section above, including the occupancy adjustment, productivity adjustment, fixed administrative allocation adjustment, temporary medication administration adjustment, temporary service coordination adjustment, and the Host Home Inspection adjustment. Additionally, this scenario applies the methodological change of calculating the direct care portion of the rate and the new facility and operations portion of the rate as 70% of the analogous RSS/SL rate component. The RSS/SL wage assumption is based on RSS/SL direct care worker wage from the 2020 cost report, trended to 2024-25, and the staffing ratio assumptions are set equal to the current staffing ratio assumptions for the RSS/SL service.
- Compared to Scenario C1a, Scenario C1b changes the RSS/SL staffing ratios to ‘mid-levels’, and maintains all other assumptions from Scenario C1a.

- Scenario C1c further increases the RSS/SL staffing ratio assumptions to 'high-levels', and maintains all other assumptions from Scenario C1b.

Table 37. HH/CC Rate Scenario Summary C1a-C1c – DC Component.

Scenario	Current Rates	Scenario C1a	Scenario C1b	Scenario C1c
Residential Staffing Assumption	Current Staffing Ratio	Current Staffing Ratio	Mid Assumption Staffing Ratio	High Assumption Staffing Ratio
Direct Care % of Residential	N/A	70%	70%	70%
LON1	$49.25	$53.42	$52.63	$52.30
LON5	$52.13	$59.11	$67.26	$71.32
LON8	$66.77	$68.26	$74.23	$79.30
LON6	$98.82	$81.00	$93.74	$102.23
LON9	$112.21	$138.71	$146.06	$145.15

Table 38. HH/CC Rate Scenario Summary C1a-C1c – Assumptions.*

Assumptions	Current Rates	Scenario C1a	Scenario C1b	Scenario C1c
Mark-up Assumption	4.40%	N/A	N/A	N/A
Occupancy Adjustment	N/A	98.40%	98.40%	98.40%
Productivity Adjustment	N/A	2.50%	2.50%	2.50%
Admin (3-year avg.)	Current Methodology	43.80%	43.80%	43.80%
Facility Admin as % of Residential	N/A	70%	70%	70%
Residential 80% Direct Care Adjustment	N/A	N/A	N/A	N/A
Medication Admin Adjustment	N/A	0.10%	0.10%	0.10%
Service Coordination Adjustment	N/A	0.13 hours/day	0.13 hours/day	0.13 hours/day
Host Home/ Companion Care Coordinator Fee	N/A	$1.60	$1.60	$1.60

Assumptions	Current Rates	Scenario C1a	Scenario C1b	Scenario C1c
Host Home Inspection Adjustment	N/A	0.87%	0.87%	0.87%
Residential Wage Assumption	$10.35/Hours	$11.82/Hour	$11.82/Hour	$11.82/Hour

**All assumptions are subject to change.*

Table 39. HH/CC Rate Scenario Summary C1a-C1c - Current Rates.

Level of Need	Current Rates	Scenario C1a	Scenario C1b	Scenario C1c
LON1	$72.56	$102.73	$104.51	$105.72
LON5	$76.14	$108.65	$119.75	$125.54
LON8	$94.07	$118.19	$127.01	$133.86
LON6	$119.18	$131.46	$147.35	$157.75
LON9	$147.84	$191.61	$201.87	$202.48
Budget Impact	**N/A**	**35.10%**	**45.50%**	**51.60%**

- Scenario C2, C3, and C4 maintain the high staffing ratio scenario from Scenario C1c and modify the wage assumption to other BLS levels as detailed in **Section 5.2.4 Scenario Modeling**.

Table 40. HH/CC Rate Scenario Summary C2-C4 – DC Component.

Scenario	Current Rates	Scenario C2	Scenario C3	Scenario C4
Residential Staffing Assumption	Current	High	High	High
Direct Care % of Residential	N/A	70%	70%	70%
LON1	$49.25	$60.10	$69.21	$75.36
LON5	$52.13	$81.94	$94.37	$102.76
LON8	$66.77	$91.11	$104.93	$114.26
LON6	$98.82	$117.45	$135.26	$147.28
LON9	$112.21	$166.76	$192.05	$209.13

Table 41. HH/CC Rate Scenario Summary C2-C4 - Assumptions.*

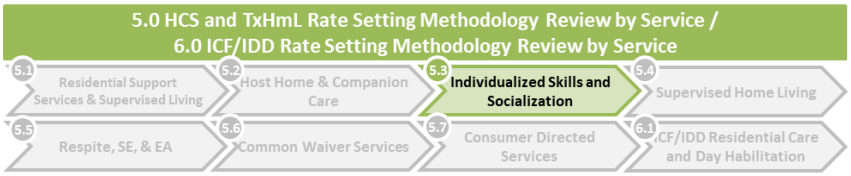
Adjustment	Current Rates	Scenario C2	Scenario C3	Scenario C4
Mark-up Assumption	4.40%	N/A	N/A	N/A
Occupancy Adjustment	N/A	98.40%	98.40%	98.40%
Productivity Adjustment	N/A	2.50%	2.5%	2.50%
Admin (3-year avg.)	Current Methodology	43.80%	43.80%	43.80%
Facility Admin as % of Residential	N/A	70%	70%	70%
Residential 80% Direct Care Adjustment	N/A	N/A	N/A	N/A
Medication Admin Adjustment	N/A	0.10%	0.10%	0.10%
Service Coordination Adjustment	N/A	0.13 hours/day	0.13 hours/day	0.13 hours/day
Host Home / Companion Care Coordinator Fee	N/A	$1.60	$1.60	$1.60
Host Home Inspection Adjustment	N/A	0.87%	0.87%	0.87%
Residential Wage Assumption	$10.35/Hours	$13.58/Hour	$15.64/Hour	$17.03/Hour

**All assumptions are subject to change.*

Table 42. HH/CC Rate Scenario Summary C2-C4 - Current Rates.

Level of Need	Current Rates	Scenario C2	Scenario C3	Scenario C4
LON1	$72.56	$118.76	$134.01	$144.31
LON5	$76.14	$141.53	$160.23	$172.87
LON8	$94.07	$151.09	$171.24	$184.85
LON6	$119.18	$178.53	$202.85	$219.26
LON9	$147.84	$229.92	$262.03	$283.71
Budget Impact	**N/A**	**70.9%**	**93.4%**	**108.7%**

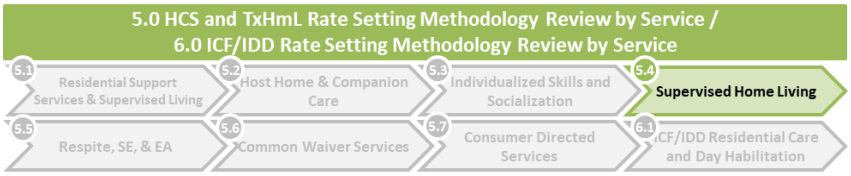
5.3. Individualized Skills and Socialization



Individualized Skills and Socialization is a new program that will be replacing the current Day Habilitation program.

At the time of preparing this report, the policies that guide Individualized Skills and Socialization were still being developed, and the rate methodology had not been finalized. Providers expressed a high degree of uncertainty related to what service delivery in this program will look like, which posed a challenge when trying to gather feedback from providers. The findings related to this service can be found in **Appendix 7.1.2.3 Individualized Skills and Socialization**, which summarizes the rate methodology being proposed at the time this report was prepared, as well as the concerns and considerations developed based on the proposed policies and feedback from providers. HHSC has been making an effort to adjust the rate methodology given the ongoing feedback that has been received, and as a result this section of the report has been shifted to the appendix. The appendix section covering Individualized Skills and Socialization should not be read as a definitive guide on the current state of the issues related to the reimbursement structure. Rather, it provides themes of stakeholder feedback related to the service based on the version of the rate methodology that was reviewed. To the extent policy changes or changes in the rate structure or reimbursement methodology are made, the considerations, data, and scenario modeling described in this section may no longer be valid.

5.4. HCS Supervised Home Living (SHL), TxHmL Community Support Services (CSS), and CFC PAS/Hab

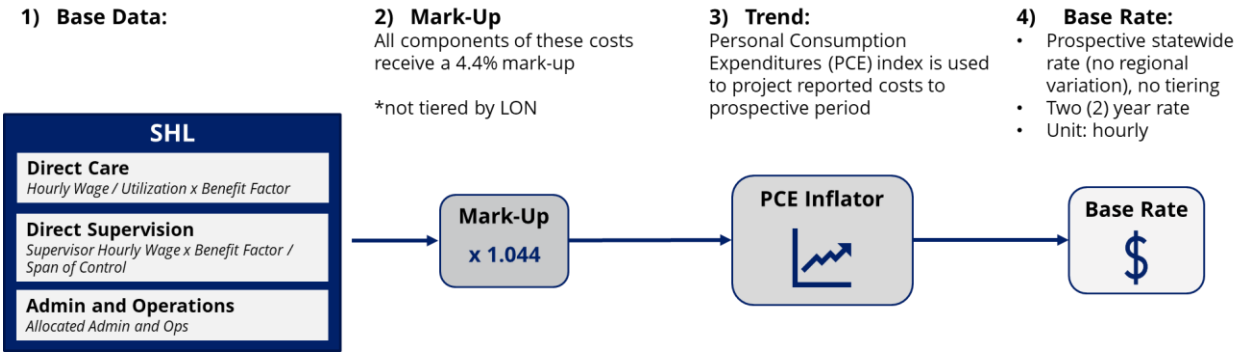


A joint reimbursement methodology is used for the HCS Supported Home Living (SHL) and SHL transportation, TxHmL CSS and CSS Transportation, and the CFC PAS/Hab services. For the sake of simplicity, SHL will be used as short-hand to refer to the combined services utilizing this shared reimbursement methodology.

5.4.1 Current Methodology

The current rate development for SHL rates is depicted in the graphic below, with the development of a two-year prospective statewide hourly rate.

Figure 7. Current SHL Rate Methodology.



At a high-level, the SHL rate is built by separately calculating and then combining direct care, direct supervision, and admin and operations (indirect service) rate components.

- The **Direct Care rate component** is calculated by multiplying the median hourly wage from the SHL cost report by a utilization factor, and a benefits factor assumption, which is also derived as the median benefits factor percentage from the RSS/SL cost report. The utilization factor is calculated as the total SHL units divided by the total SHL worker hours from the SHL cost report, and serves to convert the direct care unit basis from direct care worker hours to SHL units.
- The **Direct Supervision rate component** is calculated by multiplying medians derived from the SHL cost report for direct supervisor wage, benefits factor, and supervisor span of control.
- The **Indirect Service rate component** is established in TAC §355.723(d)(10), effective 7/1/2017, and is set equal to the administrative and facility cost component of habilitation services in the Community Living Assistance and Support Services program as specified in §355.505.

An implication of the indirect service rate component for SHL is that the previous administrative cost allocation methodology, as described further in **Section 4.3 Administrative Cost Methodology**, had applied a fixed weight to SHL. The indirect service rate component was set to a value lower than otherwise would have been calculated by the allocation methodology, and the unallocated costs were not redistributed. As such, the administrative allocation cost methodology was not distributing all administrative costs as reported in the cost reporting.

The individual rate components are then added together, and multiplied by a 4.4% mark-up, which is described further in **Section 4.4 Inflators and Other Adjustments**. All costs derived from the cost report as described above use a PCE inflator to trend the historical costs to the prospective rate period.

5.4.2 Environmental Scan

A summary of the environmental scan findings by state, which differentiates between how they reimburse for PAS/Hab services and transportation services, can be found in the table below.

Table 43. SHL, PAS/Hab and Transportation Environmental Scan Summary.

State	PAS/HAB - Description of Service	PAS/HAB - Methodology	Transportation - Description of Service	Transportation - Methodology
Texas	**CFC PAS/HAB**: Provides assistance with ADLs, health-related tasks, extension of therapy, socialization, and self-help	**Rate Period**: Hourly **Components**: Direct care staffing costs and admin. and ops (no supervision piece). Methodology: Uses biannual cost report data to build-up direct care, other direct care, and admin/ops into a rate that is trended forward using PCE index	**Supported Home Living (Transportation)**: Transportation component of the CFC PAS-HAB service that was carved out recently	Not Applicable
California	**Supported Living Services**: Broad range of services for adults who choose to remain at home: acquiring furnishings, choosing housemates, common daily tasks, participate in the community	**Rate Period**: Hourly **Methodology**: The state calculates a median rate for each regional center and uses those to calculate statewide median. New providers get the lesser of the two	**Non-Medical Transportation**: transportation within an individual's plan of care and offers private, specialized transportation when public transit is not accessible	Transportation companies get paid a rate calculated using the median methodology. Public Transit is paid at the usual and customary rate. **Unit**: Transportation Provider - Per Mile Public Transit - Monthly
Tennessee	**Personal Assistance**: Any service offering individualized services and supports that enable the person to live in the community	**Rate Period**: 15 minute Methodology: Rate build ground-up based on cost report data. Limited to 215 hours per participant per month	**Individual Transportation**: for non-medical to approved activities	**Unit**: Daily

State	PAS/HAB - Description of Service	PAS/HAB - Methodology	Transportation - Description of Service	Transportation - Methodology
Illinois	**Personal Support**: Assists the participant to implement therapies as prescribed in the person-centered plan. Provide support with adaptive skills and assistance in ADLs	**Rate Period**: Hourly Methodology: Rates are negotiated between the participant, guardian, and providers. All home-based supports are capped at a monthly cost maximum.	**Non-Medical Transportation**: offered to enable waiver participants to access to community services	Calculated using statewide mileage rates
Florida	**Supported Living Coaching**: Services that provide training and assistance, in a variety of activities, to support individuals who live in their own homes or apartments	**Rate Period**: Quarter Hour **Components**: Direct Care Staff Wages, Employment-related expenditures, Program-related expenditures, Admin	**Transportation**: Provision of rides to and from the home of the individual receiving services and community-based waiver services, when such services cannot be accessed through unpaid supports	**Rate Period**: Miles (capped at 234 miles per month)/Months/Trip (capped at 80 trips per month) **Geographic Variation**: Not Applicable **Tiering**: Not Applicable

State	PAS/HAB - Description of Service	PAS/HAB - Methodology	Transportation - Description of Service	Transportation - Methodology
Ohio	**Homemaker/Personal Care**: Services that supports a person to be more independent while meeting their daily living needs (helping people with household chores and personal care, managing money to pay household bills, getting out and being a part of the community, and helping people to get to medical and dental appointments or other health care services)	**Rate Period**: Per 15-minutes **Components**: BLS wage data, Employee-related Expenses, Administrative Overhead and Nonbillable Work Time **Geographic Variation**: County-level adjustment into groups CODB 1-8 **Tiering**: Acuity assessment tool specific to Ohio - Ohio Developmental Disabilities Profile	**Non-Medical Transportation (NMT)**: Services that enable waiver participants to get to/from a place of employment or to access to other day activities including volunteer opportunities and college or post-secondary activities.	Rate Period: Trip/Mile NMT can be billed at either a 'per-trip' rate or a 'per-mile' rate. The per-trip rate is most frequent and is used for all transportation to employment, school, etc. Per-mile is used in extenuating circumstances. **Geographic Variation**: Per-Trip: County-level adjustment into groups CODB 1-8 Per-Mile: Not Applicable **Tiering**: Per-Mile: Modified or Non-Modified and Group Size: 1, 2-3, or 4+ Individuals
Pennsylvania	**Supported Living**: Direct and indirect services provided to a participant who lives in a private home. Participants are supported in the community to learn, maintain, or improve skills to live more independently	**Rate Period**: Daily **Components**: Staff wages, expenses, productivity, occupancy, program admin costs **Tiering:** •Needs Group 1 •Needs Group 2	**Included in SL Service**: Public transit and transit provided by the SL provider is included in the cost of SL and may not be billed as a discrete service	Included in cost of SL

The high-level observations related to PAS/Hab and Transportation reimbursement methodologies used in other states includes the following.

5.4.2.1. PAS/Hab Findings:

- Generally, the approach used to determine the SHL rate is consistent with methodologies observed in other states for PAS/Hab services.
- Ohio and Pennsylvania are the only states that have acuity tiering for these services.

5.4.2.2. Transportation Findings:

- Generally, most states evaluated use a per-trip or per-mile reimbursement methodology for transportation reimbursement.
- In California, Illinois, and Ohio, reimbursement is handled through their Non-Medical Transportation programs.
- Pennsylvania and Tennessee includes transportation as part of their daily rate for the analogous SHL service.

5.4.3 Stakeholder Concerns and Methodology Considerations by Component

The following sections are structured similar to **Section 4. Rate Setting Methodology Review by Component**, and supplement with any additional relevant information for SHL and further elaborate on SHL-specific issues. The headings for each consideration identify the correlating consideration from Section 4 in parentheses as applicable. As noted, each of the considerations identified in Section 4 are generally applicable to each of the services within the following sections, to the extent the contents of each consideration are relevant to the service.

At a high level, provider concerns related to SHL centered around the fact that there are essentially two separate services (PAS/Hab and transportation) being reimbursed through a single methodology, and concerns that the methodology does not accurately reflect the nuances related to providing transportation services.

5.4.3.1. Process Improvement

5.4.3.1.1. Revise cost report template and accompanying instructions, or consider pro forma or modeled rate approaches if data cannot be obtained or is not reliable (4.1.2.1.)

Related to the noted considerations described in 4.1.2.1, to further understand the cost report consideration for identified unreported costs to the extent they are material and reasonably able to be estimated, the data request captured incremental costs associated with the identified issues. For a number of the allowable and billable items that were identified, the data was not deemed reliable for scenario modeling – please refer to the **Appendix 7.5 Data Request Findings** for additional detail. For a discussion on the adjustments related to non-billable time, please refer to **Section 5.4.3.3 Inflators and Other Adjustments**.

5.4.3.2. Administrative Cost Methodology

5.4.3.2.1. Evaluate alternatives to the current administrative cost methodology (4.3.3.1.)

Stakeholder Concerns

For SHL, the current administrative cost rate component is established in TAC §355.723(d)(10), outside of the administrative cost allocation methodology currently used for other services, and is set equal to the administrative and facility cost component of habilitation services in the Community Living Assistance and Support Services (CLASS) program as specified in §355.505. Setting the administrative rate component equal to the administrative and facility cost component of habilitation services in the CLASS program runs the risk of not accurately capturing all costs of providing the services the SHL rate is intended to reimburse for, in that the SHL service encapsulates both transportation and PAS/Hab services.

Considerations

HHSC could re-evaluate whether it is appropriate to continue to set the administrative rate component of SHL equal to the CLASS administrative and facility cost component, and consider using an administrative allocation methodology that is consistent with other HCS/TxHmL services. Additionally, as described further in **Section 5.4.3.4 Transportation**, HHSC could consider

updating the cost reporting such that providers allocate their transportation costs by program, to allow for the rate methodology to reflect the true costs of providing specific services (such as SHL) more accurately by building up a separate transportation costs component by service within the rate build methodology.

5.4.3.3. Inflators and Other Adjustments

5.4.3.3.1. Consider rate adjustments to capture the impact of allowable but non-billable activities (4.4.3.1.)

Through the evaluation process, HHSC expressed a desire to replace the 4.4% rate mark-up for SHL with factors that are well understood, and can be updated on a repeatable basis with available or obtainable data. Given this guidance, allowable adjustments to rates as identified in the following were considered as described in **Section 4.4 Inflators and Other Adjustments**. As discussed in **Section 4.1.2.1 Revise cost report template and/or accompanying instructions**, HHSC could consider adding additional fields to the cost reporting to capture time spent on these non-billable activities. Additional detail on the approach used to account for identified adjustments in the scenario modeling can be found in **Section 5.4.4 Scenario Modeling**, including the Productivity Adjustment.

5.4.3.4. Transportation

Please refer to **Appendix 7.1** for additional topics related to SHL transportation.

5.4.4 Scenario Modeling

Following discussions on alternative rate methodology considerations, in collaboration with the provider workgroup and HHSC, a methodology prioritization discussion was held, which focused on the aspects of the alternative rate methodologies discussed that the workgroup and HHSC were most interested in exploring further. A data request was developed and provided to the providers who had participated thus far in the engagement, to help inform assumptions related to the methodological changes. The contents of the data request and limitations of the data received are further discussed in previous sections. The following section contains a brief description of the methodological changes that were modeled.

5.4.4.1. Direct Care Wages

Consistent with the discussion of direct care wages in the Methodology Prioritization section, providers expressed that current wages are not high enough to attract and retain talent in the current workforce.

It's our understanding in Texas, changes to wage levels external to the cost reporting would need to be determined as a matter of policy.

For the purposes of scenario modeling, the following approach was used to assess the impact of wage changes:

- For the initial scenarios assessing the impact of the various staffing ratio levels, the direct care wage assumption was set equal to the 2020 Cost Report Direct Care wage, trended to 2024-25 using PCE.
- For the remaining scenarios, the direct care wage assumption was modeled as follows:
  - Consistent with Ohio's BLS blending approach, the average of the median wages for Home Health and Personal Care Aides, Nursing Assistants, and Social and Human Service Assistants. The average of the median wages for these services in the 2020 TX BLS data is $13.58.
  - Consistent with Maryland's BLS approach which sets the direct care wages equal to the median wage for Social and Human Service Assistants which is $17.03
  - To evaluate the wage impact for an interim value, the 75th percentile of the Nursing Assistants BLS wage was selected (i.e. $15.64 per hour), a similar approach to that used in in Ohio and Maryland.
- As direct care wages are increased in the scenario modeling, a proportional increase in the direct care supervisor wages was applied.

5.4.4.2. 80% Direct Care Adjustment

The 80% rule for attendant care is a current policy which requires that an attendant must perform attendant functions at least 80% of his/her time worked, and staff not providing attendant services at least 80% of their total time worked are not considered attendants. An implication of this rule is that for cost reporting, direct care hours are under-reported as a result of attendant services being performed by individuals who are not meeting the 80% criteria, and as a result the direct care portion of the rates are understated. It can be argued that these costs are being

captured as administrative costs or supervisor costs currently (depending on the non-attendant staff performing the direct care activities), and thus a corresponding decrease to the administrative cost could be considered as well.

However, using the supervisor as an example, the rate methodology does not simply replace those costs elsewhere on a 1:1 basis – the direct care supervisor rate component assumes a span of control in excess of 1:17, as determined by the median from cost reporting. The implication of this in the rate methodology, is that if a direct care supervisor provides 1 hour of 1:1 care for an LON 9 individual, but is unable to report that hour as direct care in the cost reporting, then the rate methodology is in essence capturing 1/17th of the impact, given the span of control and staffing assumptions, and the methodology building a person-specific daily rate.

- Data provided through the data request was relied upon for this analysis, which quantified the number of hours providers estimate spending on direct care that is not billable due to the 80% rule. After reviewing the data and removing outliers, the estimated un-reported direct care hours were divided by total direct care hours as reported in the cost reporting to develop an estimated impact for this issue.

5.4.4.3. Fixed Administrative Percentage Adjustment

To further assess the administrative costs in the rate methodology, HHSC provided cost report information from 2020, 2018, 2017, and 2016 with separate costs by Direct Care, Admin, and Facility and Operations Expenses.

The scenario modeling used a 3-year rolling average of the administrative cost as a percentage of the direct care cost to estimate the administrative cost by service, which in this case is equal to 43.8%. This was applied in the rate methodology by multiplying the direct care rate component by the 43.8% assumption; this replaces the previous allocated administrative cost rate component.

5.4.4.4. Productivity Adjustment

The data request captured to capture the amount of time that new and current direct care staff spend on trainings that are not directly attributable to an individual per year, and thus are not currently being captured in the cost reporting. This data, as well as an assumption related to staff turnover, was relied upon to estimate a range for the non-billable training time for the average direct care staff in a year, as shown in the table below. The estimated annual hours on non-billable trainings

was divided by 2,080 (40 hours/week * 52 weeks/year) to develop a percent adjustment, which is applied as a factor to the direct care rate component.

Table 44. Productivity Adjustment Assumption Range for 2018 CR Turnover.

	New Employees	Current Employees
% of Workforce Population (based on turnover)	12%	88%
Average # of hours of training	80	40

Table 45. Productivity Adjustment Assumption Range for Mid-Point Assumption.

	New Employees	Current Employees
% of Workforce Population (based on turnover)	30%	70%
Average # of hours of training	80	40

Table 46. Productivity Adjustment Assumption Range for Data Request Driven Assumption.

	New Employees	Current Employees
% of Workforce Population (based on turnover)	49%	51%
Average # of hours of training	71.34	38.58

Table 47. Productivity Adjustment Calculation Based on Assumption Range.

Assumption Type	2018 CR Turnover	Mid-Point Assumption	Data Request Driven Assumption
Productivity Adjustment	2.16%	2.50%	2.63%

5.4.5 Potential Rate Impact

Using the methodology adjustments described in the section above, various scenarios were created to evaluate the potential rate impacts. The budgetary impacts were developed utilizing the estimated units of service as established in previous analyses by TAC.

- Scenario C1 removes the 4.4% rate mark-up for SHL, and discussed the scenarios where the productivity adjustment, administrative cost allocation,

adjustment for the 80% direct care rule, and varying wage assumption. The wage assumption is based on RSS/SL direct care worker wage from the 2020 cost report, trended to 2024-25.

- Scenarios C2, C3, and C4 maintain the same assumptions as Scenario C1, with the exception of the wage assumption which is set equal to other BLS levels as detailed in the Scenario Modeling section above.

Table 48. SHL Rate Scenario Summary - Assumptions.*

Assumption	Current Rates	Scenario C1	Scenario C2	Scenario C3	Scenario C4
Mark-up Assumption	4.4%	N/A	N/A	N/A	N/A
Productivity Adjustment	N/A	2.5%	2.5%	2.5%	2.5%
Admin (3-year avg.)	Current Methodology	43.8%	43.8%	43.8%	43.8%
80% Direct Care Adjustment	N/A	0.80%	0.80%	0.80%	0.80%
Wage Assumption	$11.58/Hour	$11.82/Hour	$13.58/Hour	$15.64/Hour	$17.03/Hour

**All assumptions are subject to change.*

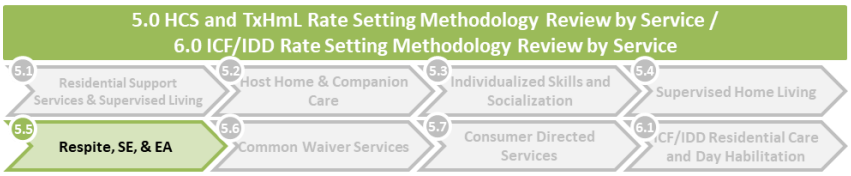
Table 49. SHL Rate Scenario Summary – Rates.

Scenario	Current Rates	Scenario C1	Scenario C2	Scenario C3	Scenario C4
Rate	$18.23	$23.62	$27.14	$31.25	$34.03
Budget Impact	**N/A**	**29.60%**	**48.90%**	**71.50%**	**86.70%**

5.5. Respite, Supported Employment, and Employment Assistance

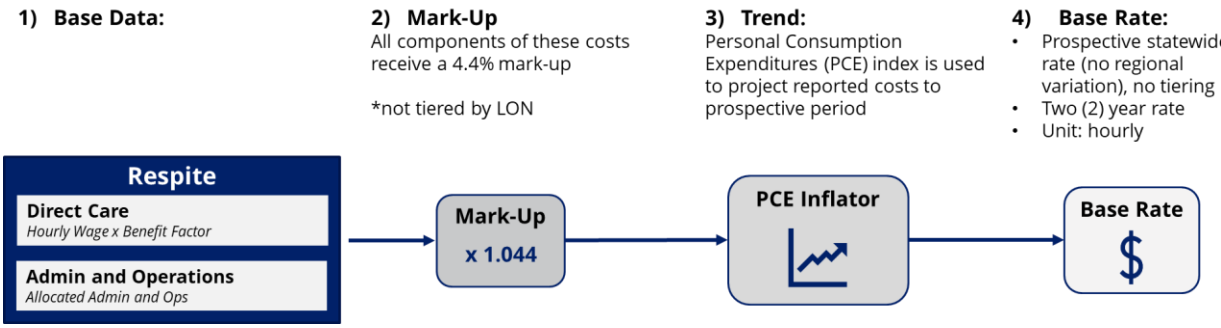
While Respite, Supported Employment, and Employment Assistance are distinct services that have differentiated rates, stakeholders had limited feedback to provide related to these services, and the proposed considerations for HHSC are consistent across services. This section will cover the nuances related to each service as appropriate, but for the sake of simplicity they are combined into the same section of the report.

5.5.1 Current Methodology



The current rate development for In-Home Respite, Supported Employment (SE), and Employment Assistance (EA) rates are as depicted in the graphics below. Each of these rates are a prospective statewide two-year hourly rate.

Figure 8. Current In-Home Respite Rate Methodology.

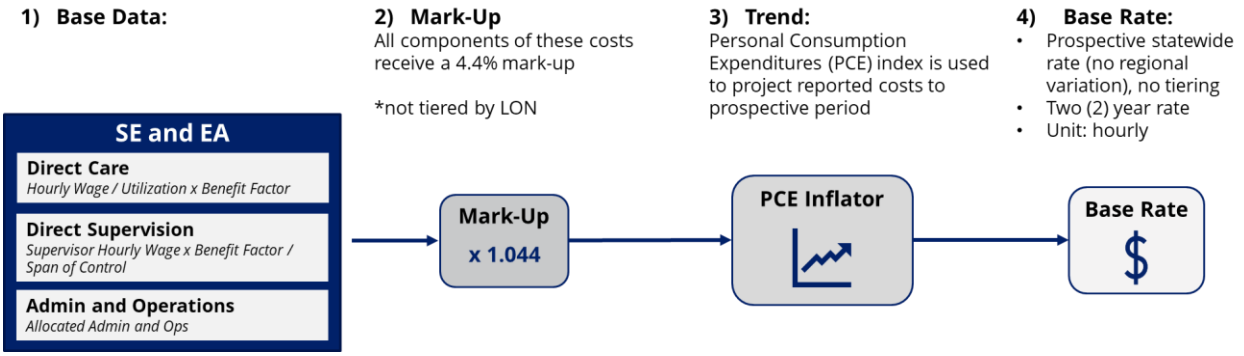


At a high-level, the **In-Home Respite** rate is built by separately calculating and then combining direct care and admin and operations (indirect service) rate components.

- The **Direct Care rate component** is calculated by multiplying medians derived from the Respite cost report for respite work hourly wage and benefits factor.
- The **Indirect Service rate component** includes the allocated administration and operations cost, which is described further in report **Section 4.3 Administrative Cost Methodology**.

For **Out-of-Home Respite**, HHSC has indicated intent to reimburse according to the setting that the Out-of-Home Respite service is delivered in. For example, if the Out-of-Home Respite service is delivered in the Individualized Skills and Socialization service setting, then the Individualized Skills and Socialization reimbursement would apply for the service. This is a reasonable approach, and given reimbursement methodologies in other settings are covered elsewhere in the report, this section of the report will focus on In-Home Respite.

Figure 9. Current EA and SE Rate Methodology.



At a high-level, the **SE and EA** rates are built by separately calculating and then combining direct care, direct supervision, and admin and operations (indirect service) rate components.

- The **Direct Care rate component** is calculated by multiplying the median hourly wage from the EA/SE cost reports respectively by a utilization factor, and a benefits factor assumption, which is also derived as the median benefits factor percentage from the RSS/SL cost report. The utilization factor is a model assumption, and serves to convert the direct care unit basis from direct care worker hours to EA/SE units.
- The **Direct Supervision rate component** is calculated by multiplying medians derived from the EA/SE cost reports respectively for direct supervisor wage, benefits factor, and supervisor span of control.
- The **Indirect Service rate component** includes the allocated administration and operations cost, which is described further in report **Section 4.3 Administrative Cost Methodology**.

All costs derived from the cost report as described above for In-Home Respite, EA, and SE use a PCE inflator to trend the historical costs to the prospective rate period. The individual rate components are then added together, and multiplied by a 4.4% mark-up, which is described further in report **Section 4.4 Inflators and Other Adjustments**.

5.5.2 Environmental Scan

5.5.2.1. Respite

The high-level observations related to In-Home Respite and Out-of-Home Respite reimbursement methodologies used in other states includes the following.

Table 50. Respite Environmental Scan Summary.

State	Rate Period	Geographic Variation	Acuity Tiering	Admin
Texas	Hourly	Not Applicable	Not Applicable	Allocated across the waiver based on fixed weight allocation by service
New York	Quarter Hour	Four DOH Regions	Not Applicable	Provider Specific – split by service on cost reports
Tennessee	Per-15 minute units capped at 8 hours	Not Applicable	Three levels of staffing time	Directly from cost report
Ohio	Daily/Partial Daily/15-minute	County-level adjustment into groups CODB 1-8	Not Applicable	Admin applied as an assumed percentage of the base in bottom-up rate build
Florida	Quarter Hour/Daily	Rates vary by geography for 3 groups of counties	Staffing ratio variation	No detail on methodology
California In-Home	Hourly	Not Applicable	Not Applicable	Directly from cost report – included in mean calculation
California Out-of-Home	1/21 of ARM (Residential) Rate	Not Applicable	Facilities apply to be assigned one of 14 service levels (1-4 with detailed levels within)	No detail on methodology

5.5.2.1.1. In-Home Respite:

The rate methodologies used by other states are generally consistent with the in-home respite methodology used in HCS.

- Florida is the only state that varies rates by staffing ratios; Tennessee has tiered rates based on the number of hours of respite care required in a day for an individual.
- Geographic variation for in-home respite is only utilized in Florida.
- Administrative cost methodologies are consistent with other services as discussed in previous sections by state.

5.5.2.1.2. Out-of-Home Respite:

California reimburses at the usual and customary rate for services provided in a day care setting, and for services provided at a licensed residential facility, either 1/21 of the established residential rate or the rate established by regional center.

New York identifies five different types of respite, including Camp, Recreational, Site-Based, Intensive, and In-Home, but uses the same provider-specific rate methodology for these services as described in previous sections.

Ohio develops Community respite rates using a methodology similar to other services with geographic variation, and uses a behavioral support rate add-on to reflect the needs of individuals requiring behavioral support in a community setting.

5.5.2.2. Supported Employment and Employment Assistance

Table 51. SE and EA Environmental Scan Summary.

State	Description of Service	Methodology	Geographic Variation	Tiering	Admin
Texas	Supported Employment: Assistance provided in order to sustain employment to an individual who requires intensive, support to be maintain employment. Employment Assistance: Assistance provided to an individual to help the individual locate paid employment in the community	Rate Period: Hourly Components: Direct care staffing costs, supervision, and admin. and ops Methodology: Uses biannual cost report data to build-up direct care, other direct care, and admin/ops into a rate that is trended forward using PCE index.	Not Applicable	Not Applicable	Allocated across the waiver based on fixed weight allocation by service (.25 for SE and EA)

State	Description of Service	Methodology	Geographic Variation	Tiering	Admin
New York	Supported Employment (SEMP): Ongoing supports to participants who need support to obtain and maintain a job or self-employment for which an individual is compensated at or above the minimum wage Pathway to Employment: Person-centered, comprehensive career planning and support service that provides assistance for participants to obtain, maintain or advance in competitive employment or self- employment	Rate Period: Hourly Components: Direct Care and Fringe, Program Support, Administrative, Clinical, Program Changes Methodology: Rates built from the ground-up, averaging provider's cost report data to determine rates by region and by group size.	3 OPWDD regions	Group size: Individual (serving 1) / Group (serving 2+)	Provider Specific – split by service on cost reports
California	Supported Employment: Paid work that is integrated in the community for IDD. Job coaching and other services with ratio of one-to-one.	Rate Period: Hourly Methodology: Rates are set in state statute	Not Applicable	Not Applicable	Directly from cost reports

State	Description of Service	Methodology	Geographic Variation	Tiering	Admin
Tennessee	Supported Employment: A program that supports an individual decide on a career path and then support them in pursuing and maintaining that path	Rate Period: 15 minute Components: Staff wages, transportation, and all "reasonable and anticipated" program costs Methodology: Prospective rate then tiered into the three tiers – quality bonuses avail.	Not Applicable	Three different tiers based upon level of need and estimated number of hours necessary to support the individual	Directly from cost report
Illinois	Supported Employment: Services to help participants obtain and maintain employment	Rate Period: Hourly Components: Job Coach wages + supervision, employment related expenditures (20% fringe), professional support staff, program related supplies, transportation, administrative costs	Not Applicable	Different tiers separated by presence/non-presence of coach and group or individual support	Fixed Annual Amount
Florida	Life Skills Development Level 2 - Supported Employment: Services that provide training and assistance to help support individuals in job development and sustaining paid employment at or above minimum wage	Rate Period: Quarter hour Components: Direct Care Staff Wages, Employment-related Expenditures, Program-related Expenditures, General/Administrative Expenditures	Rates vary by geography for 3 groups of counties	Group Size: Individual / Group (1:1, 1:2, 1:3, 1:4, 1:5, 1:6, 1:7, 1:8)	No detail on methodology

State	Description of Service	Methodology	Geographic Variation	Tiering	Admin
Ohio	Group Employment Support: Services that can help a person learn new job skills that will help them get a job they want in the community Individual Employment Support: Services that can help a person learn how to do a new job or get better at their current job.	Rate Period: Fifteen minute / Daily (between 5 and 7 hours) Components: BLS wage data, Employee-related Expenses, Administrative Overhead and Nonbillable Work Time	Group Employment Support: County-level adjustment into groups CODB 1-8 Individual Employment Support: Not Applicable	Group Employment Support: Ohio Developmental Disabilities Profile score used to determine funding range (levels 1–9) Individual Employment Support: Not Applicable	Admin applied as an assumed percentage of the base in bottom-up rate build
Pennsylvania	Small Group Employment: Direct services that provide employment opportunities in which the participant is working alongside other people with disabilities. Supported Employment: A service specific to the participant and provides the participant with ongoing support to maintain a job	Rate Period: 15 minute Components: Staff wages, staff-related expenses, productivity, occupancy program expenses and administration-related expenses Includes billable time for prospective employer relationship building	Not Applicable	Small Group Employment: Tiered by staffing ratio Supported Employment: No tiering	The lesser of $25.00 PMPM or 10% of cost

Generally, the approach used to reimburse for employment-related services across other states is similar to the approach used by HCS, with the exception of rate-tiering.

- Reimbursement is either hourly or per-15 minute unit across the states evaluated
- The rate methodology is structured similarly across states with direct care and indirect care rate components
- Geographic variation by county is observed in Florida and Ohio, while New York has a provider-specific rate methodology with regional blending.
- Tiering of rates is handled differently across states:
  - Group size is a consideration for Pennsylvania, Florida, and Illinois
  - Acuity is a consideration for Ohio
  - Illinois has separate tiers for whether a coach is present during the employment period
  - Tennessee tiers based on the number of hours of employment support are anticipated for the individual.

5.5.3 Stakeholder Concerns and Methodology Considerations by Component

The following sections are structured similar **to Section 4. Rate Setting Methodology Review by Component**. Unless otherwise indicated, each section is applicable to each of Respite, EA, and SE services.

There was limited feedback from the stakeholders related to Respite, EA, and SE, and the findings for these services were generally consistent with the considerations identified in Section 4 to the extent they are applicable to these services.

5.5.3.1. Direct Care Wages

5.5.3.1.1. Consider using wage data from the Bureau of Labor Statistics (BLS) to validate and/or set direct care wages (4.2.3.2.)

Observation

The wage assumption underlying the rates was consistently identified by the workgroup as the most significant issue across services. Providers consistently echoed the concern that current wages are not high enough to attract and retain talent in the current workforce considering the wage pressures that exist today as a result of the competitive wage options that individuals who would qualify to be attendant / direct care staff have available.

Considerations

Historically the SE and EA direct care wages have been higher than the direct care wages for other services. Anecdotally this is generally driven by higher compensated staff who are working in the community to establish relationships to allow for individuals to utilize the services, and as such with evaluating other alternatives, HHSC could consider maintaining higher relative direct care wages for the SE and EA services.

5.5.3.2. Inflators and Other Adjustments

5.5.3.2.1. Consider rate adjustments to capture the impact of allowable but non-billable activities (4.4.3.1.)

Through the evaluation process, HHSC expressed a desire to replace the 4.4% rate mark-up for Respite, SE and EA with factors that are well understood, and can be updated on a repeatable basis with available or obtainable data. Given this guidance, allowable adjustments to rates as identified in the following were considered as described in **Section 4.4 Inflators and Other Adjustments**. As discussed in **Section 4.1.2.1 Revise cost report template and/or accompanying instructions**, HHSC could consider adding additional fields to the cost reporting to capture time spent on these non-billable activities. Additional detail on the approach used to account for identified adjustments in the scenario modeling can be found in **Section 5.5.4 Scenario Modeling**, including the Productivity Adjustment.

5.5.4 Scenario Modeling

Following discussions on alternative rate methodology considerations, in collaboration with the provider workgroup and HHSC, a methodology prioritization discussion was held, which focused on the aspects of the alternative rate methodologies that the workgroup and HHSC were most interested in exploring further. A data request was developed and provided to the providers who had participated thus far in the engagement, to help inform assumptions related to the methodological changes. The contents of the data request and limitations of the data received are discussed in previous sections. The following section contains a brief description of the methodological changes that were modeled. Please refer to the **Appendix 7.5 Data Request Findings** for additional information around the scenario modeling approach, and the adjustments listed below.

5.5.4.1. Direct Care Wages

Consistent with the discussion of direct care wages in the Methodology Prioritization section, providers expressed that current wages are not high enough to attract and retain talent in the current workforce.

It's our understanding that in Texas, changes to wage levels external to the cost reporting would need to be determined as a matter of policy.

For the purposes of scenario modeling, the following approach was used to assess the impact of wage changes:

- For the initial scenarios assessing the impact of the various staffing ratio levels, the direct care wage assumption was set equal to the 2020 Cost Report Direct Care wage, trended to 2024-25 using PCE.
- For the remaining scenarios, the direct care wage assumption was modeled as follows:
  - Consistent with Ohio's BLS blending approach, the average of the median wages for Home Health and Personal Care Aides, Nursing Assistants, and Social and Human Service Assistants. The average of the median wages for these services in the 2020 TX BLS data is $13.58.
  - Consistent with Maryland's BLS approach which sets the direct care wages equal to the median wage for Social and Human Service Assistants which is $17.03

    - To evaluate the wage impact for an interim value, the 75th percentile of the Nursing Assistants BLS wage was selected (i.e. $15.64 per hour), a similar approach to that used in in Ohio and Maryland.
- As direct care wages are increased in the scenario modeling, a proportional increase in the direct care supervisor wages was applied.

For modeling wage impacts related to SE and EA, given the direct care wages from the cost reporting start at a higher level than the other services, it's assumed that the proposed increases to the direct care wages in other services, would result in a proportional increase in the SE and EA direct care wages, as well as the direct care supervisor wages.

5.5.4.2. Fixed Administrative Percentage Adjustment

To further assess the administrative costs in the rate methodology, HHSC provided cost report information from 2020, 2018, 2017, and 2016 with separate costs by Direct Care, Admin, and Facility and Operations Expenses.

The scenario modeling used a 3-year rolling average of the administrative cost as a percentage of the direct care cost to estimate the administrative cost by service, which in this case is equal to 43.8%. This was applied in the rate methodology by multiplying the direct care rate component by the 43.8% assumption; this replaces the previous allocated administrative cost rate component.

5.5.4.3. Productivity Adjustment

The data request captured to capture the amount of time that new and current direct care staff spends on trainings that are not directly attributable to an individual per year, and thus are not currently being captured in the cost reporting. This data, as well as an assumption related to staff turnover, was relied upon to estimate a range for the non-billable training time for the average direct care staff in a year, as shown in the table below. The estimated annual hours on non-billable trainings was divided by 2,080 (40 hours/week * 52 weeks/year) to develop a percent adjustment, which is applied as a factor to the direct care rate component for Respite.

Table 52. Productivity Adjustment Assumption Range for 2018 CR Turnover.

	New Employees	Current Employees
% of Workforce Population (based on turnover)	12%	88%
Average # of hours of training	80.0	40.0

Table 53. Productivity Adjustment Assumption Range for Mid-Point Assumption.

	New Employees	Current Employees
% of Workforce Population (based on turnover)	30%	70%
Average # of hours of training	80.0	40.0

Table 54. Productivity Adjustment Assumption Range for Data Request Driven Assumption.

	New Employees	Current Employees
% of Workforce Population (based on turnover)	49%	51%
Average # of hours of training	71.34	38.58

Table 55. Productivity Adjustment Calculation Based on Assumption Range.

Assumption Type	2018 CR Turnover	Mid-Point Assumption	Data Request Driven Assumption
Productivity Adjustment	2.16%	2.50%	2.63%

5.5.5 Potential Rate Impact

Using the methodology adjustments mentioned in the section above, various scenarios were created to evaluate the potential rate impacts.

For the respite impact analysis, a productivity adjustment and fixed administrative percentage allocation were applied to all scenarios.

For respite, the wage assumptions were adjusted in each scenario according to the same BLS wage categories discussed in **Section 2.2 Data Sources**.

Table 56. Respite Rate Scenario Modeling - Assumptions.

Assumptions*	Current Rates	Scenario C1	Scenario C2	Scenario C3	Scenario C4
Mark-up Assumption	4.4%	0%	0%	0%	0%
Productivity Adjustment	N/A	2.5%	2.5%	2.5%	2.5%
Admin (3-year avg.)	Current Methodology	43.8%	43.8%	43.8%	43.8%
Wage Assumption	$10.43/Hour	$11.82/Hour	$13.58/Hour	$15.64/Hour	$17.03/Hour

**All assumptions are subject to change.*

Table 57. Respite Rate Scenario Modeling.

Respite Rates	Current Rates	Scenario C1	Scenario C2	Scenario C3	Scenario C4
Rate	$18.89	$19.36	$22.24	$25.62	$27.90
Budget Impact	N/A	2.50%	17.70%	35.70%	47.70%

Supported Employment and Employment Assistance were not adjusted by a productivity factor due to the nature of the service and only received an adjustment for the fixed administrative allocation percentage

For these two services, wages were adjusted using a ratio of their current wage to the current residential direct care worker wage. This wage was applied to the BLS wage categories discussed in Section 2.2 Data Sources and Reliance to inflate the direct care worker wage accordingly. Similarly, for both these services, the ratio of the supervisor wage to the direct care worker wage in the current rates was maintained through each of the scenarios.

Table 58. SE Rate Scenario Modeling - Assumptions.

Assumptions*	Current Rates	Scenario C1	Scenario C2	Scenario C3	Scenario C4
Mark-up Assumption	4.40%	0%	0%	0%	0%
Admin (3-year avg.)	Current Methodology	43.80%	43.80%	43.80%	43.80%
Wage Assumption	$14.14/Hour	$15.80/Hour	$18.15/Hour	$20.91/Hour	$22.76/Hour

Assumptions*	Current Rates	Scenario C1	Scenario C2	Scenario C3	Scenario C4
Supervisor Wage	$18.02/Hour	$20.85/Hour	$23.95/Hour	$27.59/Hour	$30.04/Hour

**All assumptions are subject to change.*

Table 59. SE Rate Scenario Modeling - Rates.

Rates	Current Rates	Scenario C1	Scenario C2	Scenario C3	Scenario C4
Rate	$33.10	$40.90	$46.99	$54.12	$58.92
Budget Impact	N/A	23.60%	42.00%	63.50%	78.00%

Table 60. EA Rate Scenario Modeling - Assumptions.

Assumptions*	Current Rates	Scenario C1	Scenario C2	Scenario C3	Scenario C4
Mark-up Assumption	4.4%	0%	0%	0%	0%
Admin (3-year avg.)	Current Methodology	43.8%	43.8%	43.8%	43.8%
Wage Assumption	$15.64/Hour	$17.50/Hour	$20.11/Hour	$23.16/Hour	$25.21/Hour
Supervisor Wage	$15.64/Hour	$28.77/Hour	$33.05/Hour	$38.07/Hour	$41.45/Hour

**All assumptions are subject to change.*

Table 61. EA Rate Scenario Modeling - Rates.

Rates	Current Rates	Scenario C1	Scenario C2	Scenario C3	Scenario C4
Rate	$33.10	$48.33	$55.52	$63.95	$69.63
Budget Impact	N/A	46.00%	67.70%	93.20%	110.40%

5.6. Common Waiver Services

The Common Waiver Services are services which share the same rate and reimbursement methodology across HCBS waivers, and include the following services:

- Nursing (RN, Specialized RN, LVN, Specialized LVN)
- Social work
- Behavioral support
- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Audiology
- Cognitive Rehab Therapy
- Dietary

5.6.1 Current Methodology

The rate methodology for determining Common Waiver Service reimbursement includes Direct Care and Indirect Care rate components is as follows:

The Direct Care rate component is calculated separately by common waiver service by taking the allowable cost per unit by service for each cost report across applicable waivers, and combining them into service-specific arrays. The allowable costs per unit are weighted by units of service within each array, and the Direct Care component of the rate is set equal to the resulting median cost per unit of service

The Indirect Service rate component includes the allocated administration and operations cost, which is described further in **Section 4.3 Administrative Cost Methodology**.

5.6.2 Environmental Scan

In general, the findings for the common waiver services methodologically align with observations for the methodologies used by state for other services, with some

states utilizing geographic factors and administrative rate components consistently evaluated across services for the states evaluated.

5.6.3 Stakeholder Concerns and Methodology Considerations by Component

5.6.3.1. Reassess the Common Waiver Services rate methodology approach

Stakeholder Concerns

Utilization, policy, and/or billing guidance are inconsistent across waivers for the services that fall under the Common Waiver Service reimbursement methodology. The Common Waiver Services rate, on the other hand, are the same across all applicable waivers. Because of these differences in policy and billing guidance, this can potentially result in under-reimbursement for some waivers, and over-reimbursement in other waivers for the same service. In this case, the policy and billing guidance for Common Waiver Services in the HCS program tend to increase provider costs compared to other waivers, potentially resulting in an under-reimbursement to HCS providers.

One other area of concern that was identified by providers relates to the sufficiency of the rate for common waiver services. Providers indicated that when they are seeking out specific service for residents in their care, such as nurses or speech therapists, the ability to find nurses therapists willing to provide services at the reimbursed rates can be difficult and require travelling long distances in some cases for the therapies.

Considerations

This issue could be resolved by either developing waiver-specific rates for the services that fall under the Common Waiver Services, or unifying policy and/or billing guidance across waivers for each of these services. HHSC could consider whether this would involve all services, or just common waiver services that have been identified as specific areas of concern, such as nursing.

If HHSC wants to purse developing waiver-specific rates, methodologically the rate structure should be consistent with the general methodologies described across services, with consideration for wage evaluation against BLS data, exploring different administrative cost allocation methodologies such as the fixed

administrative cost approaches, applying temporary rate adjustments to account for costs providers are incurring due to policy or regulatory changes, or due to allowable and billable costs that haven't been captured in the cost reporting, and implementation of non-billable time adjustments as appropriate. For nursing specifically, these non-billable time adjustments would include activities nurses are required to perform to maintain their licensure and certifications, such as charting and documentation time.

Alternatively, if HHSC would like to maintain the existing common waiver services methodology, HHSC should evaluate whether there truly are differences in utilization, regulatory/policy, and/or billing guidance that is inconsistent across waivers and driving cost variances, and to make sure any updated guidance be communicated clearly to providers across waivers.

Additionally, HHSC could consider implementing a wage review process using BLS data as a way to validate the wages as shown in the cost reporting, or use BLS to determine the wage component of the rates.

5.6.4 Scenario Modeling

Following discussions on alternative rate methodology considerations, in collaboration with the provider workgroup and HHSC, a methodology prioritization discussion was held, which focused on the aspects of the alternative rate methodologies discussed that the workgroup and HHSC were most interested in exploring further. A data request was developed and provided to the providers who had participated thus far in the engagement, to help inform assumptions related to the methodological changes. The contents of the data request and limitations of the data received are further discussed in previous sections. The following section contains a brief description of the methodological changes that were modeled.

The Common Waiver Services were not modeled in the same fashion as other services, as agreed upon by HHSC given the rates are determined in a process outside of the HCS, TxHmL and ICF/IID rate modeling. However, a non-billable time adjustment for Nursing was developed based on the information from the data request, and holding the direct care portion of each wage constant, demonstrated the impact of the fixed administrative percentage adjustment.

5.6.4.1 Nursing Billable Time Adjustment

The nursing billable time adjustment is meant to adjust the direct care component of the rate by the number of hours that nurses spend on non-billable activities,

such as travel time, charting and documentation, and other activities such as facilitating group trainings and aiding consumers in transitions to group homes. Given Nursing is billed as an hourly service, it would be appropriate to adjust the hourly rate to account for non-billable hours that are required in the provision of care.

Data provided by stakeholders through the data request was relied upon to estimate the number of hours nurses spend on these non-billable activities.

After reviewing the data and removing outliers, the estimated hours were discussed with HHSC and the provider workgroup. It was estimated that a range of between three and four hours per day, per nurse, are spent on the identified non-billable activities. The workgroup believed roughly four hours per day of non-billable nursing time to be in alignment with their experience.

- Roughly 1 to 1.5 hours per day on non-billable travel time to and from client sites
- Roughly 1 to 1.5 hours per day on charting and other documentation activities
- Roughly 1 hour per day on other non-billable activities such as other activities such as facilitating group trainings and aiding consumers in transitions to group homes

Methodologically, to apply such a factor, the hourly rate should be increased to account for the proportion of hours that are non-billable – e.g., if the four hours per day assumption of non-billable nursing time is utilized, then the adjustment factor would be calculated as (8 hours per day of total allowable nurse time / 4 hours per day of total allowable and billable nurse time). This factor would be applied to the total of the direct and indirect portions of the rate.

5.6.4.2 Fixed Administrative Percentage Adjustment

To further assess the administrative costs in the rate methodology, HHSC provided cost report information from 2020, 2018, 2017, and 2016 with separate costs by Direct Care, Admin, and Facility and Operations Expenses.

The scenario modeling used a 3-year rolling average of the administrative cost as a percentage of the direct care cost to estimate the administrative cost by service, which in this case is equal to 43.8%. This was applied in the rate methodology by

multiplying the direct care rate component by the 43.8% assumption; this replaces the previous allocated administrative cost rate component.

5.6.5 Potential Rate Impact

As discussed, for the common waiver services the level of data to perform the same detailed rate modeling was not available from HHSC. However, using the direct care rate component from the 2022-23 rates, the impact of applying the HCS fixed administrative allocation methodology described above was modeled.

Table 62. Common Waiver Services Administrative Assumption Scenario Modeling, 2022-2023 Direct and Indirect Care Rates.

Service	Direct Care 2022/23	Indirect Care 2022/23	Total 2022/23	Direct Care (Proposed)	Indirect Care (Proposed)	Total (Proposed)	Total Rate (% Change)
Social Work	$53.21	$6.32	$59.53	$53.21	$23.32	$76.53	29%
Behavioral Support	$72.15	$7.38	$79.53	$72.15	$31.62	$103.77	30%
Physical Therapy	$73.25	$4.18	$77.43	$73.25	$32.10	$105.35	36%
Occupational Therapy	$68.97	$3.98	$72.95	$68.97	$30.23	$99.20	36%
Speech Therapy	$69.78	$6.51	$76.29	$69.78	$30.58	$100.36	32%
Audiology	$45.52	$7.21	$52.73	$45.52	$19.95	$65.47	24%
Cognitive Rehabilitation Therapy	$72.15	$7.38	$79.53	$72.15	$31.62	$103.77	30%
Dietary	$48.07	$7.21	$55.28	$48.07	$21.07	$69.14	25%
Nursing				N/A	N/A	N/A	N/A
RN	$40.98	$2.41	$43.39	$40.98	$17.96	$58.94	36%
Specialized RN	$47.13	$2.77	$49.90	$47.13	$20.66	$67.79	36%
LVN	$26.97	$2.72	$29.69	$26.97	$11.82	$38.79	31%
Specialized LVN	$31.02	$3.12	$34.14	$31.02	$13.60	$44.62	31%

5.7. Consumer Directed Services

Consumer Directed Services (CDS) allows people who receive HCBS waiver services the choice to hire and manage the people who provide their services.

CDS is an option for a sub-set of HCS Services:

- Transportation-supported home living
- Respite Services
- Nursing Services
- Cognitive rehabilitation therapy
- CFC personal assistance services/habilitation
- Supported employment
- Employment assistance
- Support consultation

5.7.1 Current Methodology

The Total CDS rate is calculated as the sum of the CDS Agency Payment and Funds for Consumer, less one dollar ($1), as described in TAC §355.114:

- The CDS Agency Payment is a monthly payment that is modeled based on the estimated cost to carry out the responsibilities of the CDS agency
- The Funds for Consumer are modeled and are based on the direct care costs plus a portion of the operating costs included in the HCS rate

There is a requirement in this section of the TAC that states, "The monthly payment to the contracted CDS agency for a 12-month period and the funds available to the consumer participating in CDS for that same 12-month period will not exceed the amount that would have been paid to an agency for the same 12 month period if the consumer was not participating in CDS." At some historical point in time, HHSC performed an analysis that calculated the portion of the administrative cost that was not related to direct care, such as building and administrative costs. This was estimated to be approximately $1.00 per hour for hourly services, and $12 per day for daily services.

5.7.2 Environmental Scan

In the environmental scan of comparable states, the findings were fairly consistent across the board: most states price their consumer directed services either equal to, or a percentage of, the rate for that service in non-CDS settings. There were no findings of other states performing functions similar to the one-dollar subtraction from the CDS Agency Payment within HHSC's reimbursement methodology.

5.7.3 Stakeholder Concerns and Methodology Considerations by Component

Stakeholder Concerns

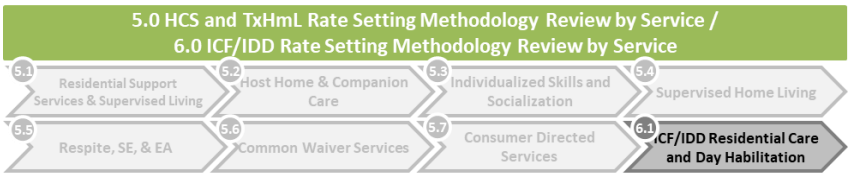
The provider workgroup had limited feedback related to CDS, as most had limited interaction with the service generally, other than in some cases providers needing to assist consumers in the coordination of obtaining their Consumer Directed Services. HHSC identified a concern related to the subtraction of $1.00 in the current rate methodology.

Considerations

In regard to the $1.00 per hour for hourly services, and $12.00 per day for daily services that is subtracted from the CDS agency rate, HHSC could consider two options. HHSC could perform an analysis similar to the previous analysis that was performed, and seek to understand the portion of administrative cost not related to direct care and whether that has changed over time. Alternatively, given the findings from the environmental scan, where there were no other states using a similar reduction methodology, HHSC could consider removing the reduction from the CDS rate methodology entirely.

6. ICF/IID Rate Setting Methodology Review by Service

6.1. Current Methodology

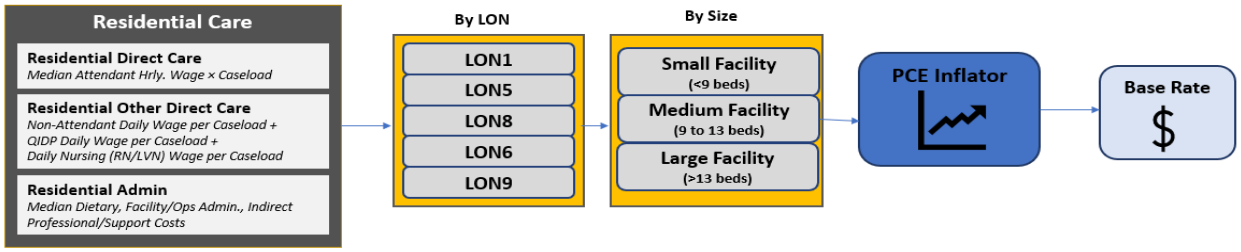


The current rate development for the ICF/IID per diem rate is depicted in the graphics below. The residential and day habilitation portions of the rate are priced separately, and then combined to create a final ICF/IID per diem rate.

6.1.1 Residential Rate

At a high-level, the ICF/IID residential rate is built by separately pricing and then combining a direct care, other direct care, and indirect service component.

Figure 10. Current ICF/IID Residential Rate Methodology.



- The **direct care component** is calculated by multiplying the median hourly residential attendant wage from the ICF/IID cost report with attendant caseload assumptions. The direct care component is varied by LON and ICF/IID facility size.
- The **other direct care component** includes the following components: non-attendant, Qualified Intellectual Disability Professional (QIDP), and nursing (RN & LVN). The pricing of the three other direct care subcomponents follows the same methodology—multiplying median hourly wage data (sourced from

the ICF/IID cost report) with case load assumptions. The other direct care component is varied by LON and ICF/IID facility size.

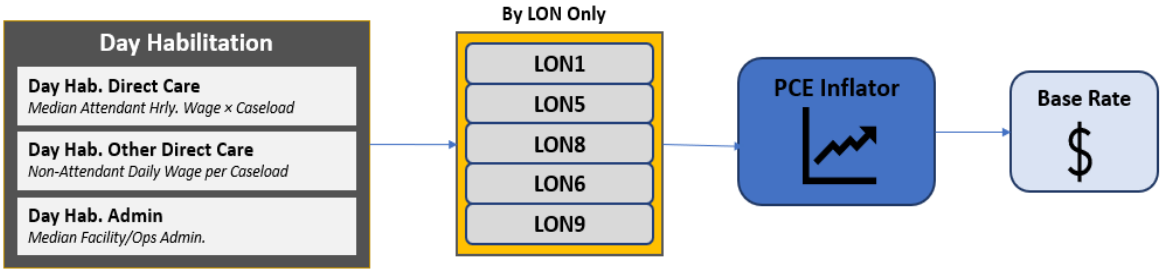
- The **indirect service component** includes the following components: Indirect Professional and Support Staff; Dietary; Facility and Operations; and Administration. Median cost report data by ICF/IID facility size is used to derive the indirect service rate, excepting the administration component which represents median cost report data across all ICF/IID sizes (i.e., is not varied by size). There is no variation by LON for this rate component. It is important to note that although HHSC prices the administrative portion of the rate, the effective administrative portion has not been updated for the last several years due to Texas statute.

The individual rate components are then added together, and multiplied by a 7% mark-up, which is described further in **Section 4.4. Inflators and Other Adjustments**. The rate is tiered into five acuity levels (LON) based on the ICAP assessment tool and is further tiered by three ICF/IID facility sizes—small (less than 9 beds), medium (9 to 13 beds), large (more than 13 beds)—resulting in 15 separate rate tiers. This tiering is effectuated in the rate build by varying staffing ratios for each LON and facility size tier combination. All costs derived from the cost report as described above also use a PCE inflator to trend the historical costs to the prospective rate period.

6.1.2 Day Habilitation Rate

At a high-level, the ICF/IID Day Habilitation rate is built by separately pricing and then combining a direct care, other direct care, and indirect service component.

Figure 11. Current ICF/IID Day Habilitation Rate Methodology.



The **direct care component** is calculated by multiplying the median hourly day hab. attendant wage from the ICF/IID cost report with attendant caseload assumptions. The direct care component is varied by LON.

The **other direct care component** is calculated by multiplying the median hourly day hab. non-attendant wage from the ICF/IID cost report with non-attendant caseload assumptions. The other direct care component is varied by LON.

The **indirect service component** includes the following components: Facility/Operations and Administration. Median cost report data is used to derive the indirect service rate. There is no variation by LON for this rate component. It is important to note that although HHSC prices the administrative portion of the rate, the effective administrative portion has not been updated for the last several years due to Texas statute.

The individual rate components are then added together, and multiplied by a 7% mark-up, which is described further in **Section 4.4. Inflators and Other Adjustments**. The rate is tiered into five acuity levels (LON) based on the ICAP assessment tool; there is no facility size tiering for ICF/IID day hab. The tiering is effectuated in the rate build by varying staffing ratios for each LON tier. All costs derived from the cost report as described above also use a PCE inflator to trend the historical costs to the prospective rate period.

6.2. Environmental Scan

Many state Medicaid programs have an ICF/IID service equivalent that could be compared to the Texas ICF/IID program. Generally, most states include a rate build with components for direct care, other direct care, and administrative costs. Consistent with Texas' approach, all selected environmental scan states use provider cost reporting data in their rate build.

A few states—including, but not limited to, Ohio, Florida, and Tennessee—utilize a "lesser of logic" in the rate methodology, whereby ICF/IID provider rate component costs are compared to either their peer group costs or historical cost report costs, and the lesser of the two costs is included in the rate build (often with an efficiency adjustment applied in cases where costs had been decreased against the comparison group, to serve as an incentive). Most states included in the scan set prospective per diem rates, but a few states instead use a cost settled approach, where an interim rate is initially set, and final reimbursement is either scaled up or down from the interim rate based on actual spend during the rate period. The level of granularity of the final rate varied from state-to-state. The level of granularity of the final rate varied from state-to-state, including varying rates by provider, geographic region, level of acuity, and/or ICF/IID size.

Of the selected states, California, Louisiana, and Ohio, include tiering in the rate methodology by ICF/IID facility bed size, similar to Texas' approach. In addition, several states address acuity either through tiering or an explicit adjustment. Florida addresses acuity by tiering rates between two levels of care: Residential/Institutional (members who are ambulatory/self-mobile) and Non-ambulatory/Medical (members who are capable of mobility only with human assistance). New Mexico applies an acuity adjustment to the direct care component of the rate, by developing a case mix index using DRG weights. Similar to Texas, Louisiana utilizes the ICAP methodology, but instead uses ICAP to develop an acuity factor that is applied to the direct care cost component.

6.3. Stakeholder Concerns and Methodology Considerations by Component

The following sections are structured similar to **Section 4. Rate Setting Methodology Review by Component**, and supplement with any additional relevant information to ICF/IID services. The headings for each consideration identify the correlating consideration from Section 4 in parentheses as applicable. As noted, each of the considerations identified in Section 4 are generally applicable within the following sections, to the extent the contents of each consideration are relevant to the ICF/IID. Concerns and considerations are differentiated to the extent specific sections apply to the ICF/IID Residential or ICF/IID Day Habilitation rates; if not otherwise specified, assume the items discussed below apply to both services.

6.3.1. Process Improvement

6.3.1.1. Revise cost report template and accompanying instructions, or consider pro forma or modeled rate approaches if data cannot be obtained or is not reliable (4.1.2.1.)

Related to the noted considerations described in 4.1.2.1, to further understand the cost report consideration for identified unreported costs to the extent they are material and reasonably able to be estimated, the data request captured incremental costs associated with the identified issues. For a number of the allowable and billable items that were identified, the data was not deemed reliable for scenario modeling – please refer to the **Appendix 7.5 Data Request Findings**

for additional detail. For a discussion on the adjustments related to non-billable time, please refer to **Section 6.3.1.3 Inflators and Other Adjustments**.

6.3.1.2. Consider the appropriateness of rate components that are based on cost report data or other data sources on a recurring basis, or define assumptions as a matter of policy (4.1.2.2)

Stakeholder Concerns

Related to the noted considerations described in 4.1.2.2, there were two identified areas of concern for ICF/IID.

- The staffing ratios underlying the rates were established as part of a study performed over 20 years ago. Providers expressed concerns that the staffing ratios do not appropriately address the reality of staffing needs given policy changes and changes in service delivery requirements that have occurred since. As a specific example, for the highest acuity tier, LON 9, the staffing ratio only assumes 1:1 staffing for 16 hours in a day. Providers indicated that in many cases, LON 9 individuals in the ICF/IID setting require 24-hour care, and in some cases, require 2:1 care for a portion of the day.
- The administrative portion of the ICF/IID rate was developed based on cost report data, but has not changed since 9/1/15 due to Texas statute, in part due to a lack of additional appropriations for administrative costs.

Considerations

To evaluate the appropriateness of the existing staffing ratios, the data request sent to providers captured information related to the composition of residents by LON within each facility that providers currently operate, how they currently staff those facilities, and how in an ideal world they believe they need to staff the facilities to provide quality, efficient and economical care. Facilities indicated in the data request were grouped according to the facility size tiers that existed in the rates, to understand if differentiation in staffing patterns existed between the facility size tiers. After reviewing the data and removing outliers, a range for staffing ratios was identified for consideration by Level of Need (LON). Based on the data provided, the staffing ratios by LON tier underlying the current rate methodology are at the low-end of a range, and the data did not indicate an appreciable difference in staffing ratios between the small and medium size ICFs.

This approach is detailed further in **Section 6.4 Scenario Modeling – ICF/IID Residential Care**.

Please see **Section 6.3.1.2 Administrative Cost Methodology** below for further discussion on the considerations related to the administrative costs rate component for ICF/IID**.**

6.3.1.3. Administrative Cost Methodology

6.3.1.3.1. Evaluate alternatives to the current methodology of allocating administrative costs by fixed weights

Stakeholder Concerns

ICF/IID does not have the same methodological issue related to the allocation of administrative costs that HCS/TxHmL does, as the costs are developed directly from the cost report data without a need to allocate across services. However, the administrative portion of the ICF/IID rate was developed based on cost report data, but has not changed since 9/1/15 due to Texas statute, in part due to a lack of additional appropriations for administrative costs, and has not been updated to keep up with the cost of the administrative load as indicated in the more recent ICF/IID cost reporting.

Consideration

HHSC could consider the following approaches for ICF/IID administrative costs:

- HHSC could consider revisiting the Texas statute and seek additional appropriations to allow the administrative costs as reported in the most recent cost reporting to inform the administrative cost component, as had been the methodology previously. This is the approach that was taken in **Section 6.4 Scenario Modeling – ICF/IID Residential Care**.
- Alternatively, if HHSC would like to consider a methodology that doesn't rely upon the reported administrative costs in the cost report, HHSC could establish a fixed percentage administrative rate component. This could be informed by the historical cost reporting for ICF/IID, findings from the administrative rate component methodologies used by other state ICF/IID programs, and what level of administrative cost HHSC would seek to fund as a matter of policy.

Further considerations related to administrative cost differential by facility tier can be found in **Appendix 7.1**.

6.3.1.4. Inflators and Other Adjustments

6.3.1.4.1. Consider rate adjustments to capture the impact of allowable but non-billable activities (4.4.3.1)

Through the evaluation process, HHSC expressed a desire to replace the 7.0% rate mark-up that exists in the current ICF/IID methodology with factors that are well understood, and can be updated on a repeatable basis with available or obtainable data. Given this guidance, allowable adjustments to rates as identified in the following were considered as described in **Section 4.4 Inflators and Other Adjustments**. As discussed in **Section 4.1.2.1 Revise cost report template and/or accompanying instructions**, HHSC could consider adding additional fields to the cost reporting to capture time spent on these non-billable activities. Additional detail on the approach used to account for the identified adjustments in the scenario modeling can be found in **Section 6.4 Scenario Modeling – ICF/IID Residential Care**, including the Productivity Adjustment and 80% Direct Care Adjustment.

6.4. Scenario Modeling – ICF/IID Residential Care

Following discussions on alternative rate methodology considerations, in collaboration with the provider workgroup and HHSC, a methodology prioritization discussion was held, which focused on the aspects of the alternative rate methodologies that the workgroup and HHSC were most interested in exploring further. A data request was developed and provided to the providers who had participated thus far in the engagement, to help inform assumptions related to the methodological changes. The contents of the data request and limitations of the data received are further discussed in previous sections. The following section contains a brief description of the methodological changes that were modeled.

6.4.1 Direct Care Caseload Assumptions

- The current case load assumptions in the ICF/IID residential care model are primarily derived from staffing ratio assumptions and client awake/asleep time assumption from a rate study conducted in the 1990s. Additionally,

stakeholders provided consistent feedback that the direct care component of the rate was underfunded, particularly for the attendant component of the rate. Because of these two factors, the direct care caseload assumptions used in the ICF/IID model were identified for further assessment. The direct care caseload assumption is expressed as direct service hours per resident per day in the rate methodology.

- Data provided by stakeholders through the data request was relied upon which provided the current staffing ratios that ICF/IIDs utilize and the ideal staffing ratios that ICF/IIDs believe should be utilized to effectively provide the service, and stakeholders provided data showing the hours by weekday and weekend that clients are awake and asleep. It is worth noting, no provider data request responses included Large ICF/IID data, presumably because Large ICF/IIDs represent such a small percentage of market share.
- For client awake time staffing ratios, the current ICF/IID awake time staffing ratios per the existing ICF/IID rate model, the current ICF/IID awake time staffing ratios per the stakeholder data request and the ideal ICF/IID awake time staffing ratios per stakeholder data request were compared. Based on the review of these data points, it became apparent that (1) the ideal ICF/IID staffing ratios closely aligned to the current staffing ratios in the HCS rate build, and that (2) ICF/IID providers were generally staffing their facilities consistent with how the current rate staffing ratio assumptions were built up. Based on this analysis, a range of awake time staffing ratios assumptions by LON were developed. The data request did not include any provider responses related to LON9; therefore, the workgroup stakeholders were engaged and an ideal staffing ratio of 1.25:1 was determined, based on the assumption that roughly 25% of LON9 staffing time is staffed at 2:1. As can be seen below, the low end of the range represents the current staffing ratios, and the high end of the range is consistent with the current HCS RSS/SL staffing ratios, with the LON9 exception as described.

Table 63. ICF/IID Awake Staffing Ratio Assumption Range by LON.

LON	Current Awake Staffing Ratios (Small ICF/IID)	Ideal Awake Staffing Ratios
LON1	1:5	1:4
LON5	1:4	1:3.3
LON8	1:3	1:2.7
LON6	1:2	1:2

LON	Current Awake Staffing Ratios (Small ICF/IID)	Ideal Awake Staffing Ratios
LON9	1:1	1.25:1

- In addition to the awake staffing ratios, Asleep staffing ratios were also assessed. Through provider feedback related to the LON6 and LON9 tiers, concerns were raised related to LON6 and LON9 members needing additional staff support during the 'asleep' hours, which was a finding consistent with the data request and the asleep staffing assumptions on the RSS/SL service. As can be seen below, the low end of the range represents the current staffing ratios, and the high end of the range represents the ideal staffing ratios.

Table 64. ICF/IID Asleep Staffing Ratio Assumption Range by LON.

LON	Current Asleep Staffing Ratios (Small ICF/IID)	Ideal Asleep Staffing Ratios
LON1	1:6	1:6
LON5	1:6	1:6
LON8	1:6	1:6
LON6	1:6	1:3
LON9	1:4.5	1:3

- For the client asleep and awake time assumptions by weekday and weekend, data provided by providers through the data request was evaluated, and the analysis resulted in an assumption of 85 weekday hours and 48 weekend hours spent in the residential facility. This equates to a total of 133 hours per week for Residential services, with the remaining 35 hours per week (or 7 hours for 5 days a week) outside of the residence. Additionally, based on workgroup stakeholder feedback, an additional four hours of weekday client awake time for LON9 was assumed, to account for the assertion that roughly 50% of LON9 members remain in a residential setting as opposed to being served in day habilitation because of their high acuity needs (i.e., assuming only 3 hours outside of residence on weekday for LON9). The table below provides the asleep and awake time assumptions used in the rate model.

Table 65. ICF/IID Awake and Asleep Hours Assumption for LON1 to LON6.

LON	Time Type	Weekday	Weekend
LON1 to LON6	Client Awake	45	32
LON1 to LON6	Client Asleep	40	16
LON1 to LON6	**Total**	**85**	**48**

Table 66. ICF/IID Awake and Asleep Hours Assumption for LON9.

LON	Time Type	Weekday	Weekend
LON9	Client Awake	49	32
LON9	Client Asleep	40	16
LON9	**Total**	**89**	**48**

- The final assumptions assessed were related to Resident Sick Leave and Resident Holidays. The Resident Holidays assumption was left at 11 days per year, which aligns with the HCS rate setting assumption, and generally converges with the values reported in the provider data request. The current Resident Sick Leave assumption of 0 days per year was instead set to 12 days per year, to align with the HCS rate setting assumption, and programmatic guidance.
- With a range of staffing ratio assumptions by LON, an awake/asleep time hour assumption, and a sick/holiday leave assumption, a range of direct care worker hours per resident per day was calculated as summarized in the table below by LON.

Table 67. ICF/IID Residential Direct Care Worker Hours per Resident per Day Assumption Range.

LON	Direct Care Worker Hours per Resident per Day Assumption Low Scenario	Direct Care Worker Hours per Resident per Day Assumption High Scenario
LON1	3.83	4.28
LON5	4.28	4.56
LON8	4.76	4.99
LON6	5.52	8.30
LON9	8.66	12.08

6.4.2 80% Direct Care Adjustment

The 80% rule for attendant care is a current policy which requires that an attendant must perform attendant functions at least 80% of his/her time worked, and staff not providing attendant services at least 80% of their total time worked are not considered attendants. An implication of this rule is that for cost reporting, direct care hours are under-reported as a result of attendant services being performed by individuals who are not meeting the 80% criteria, and as a result the direct care portion of the rates are understated. It can be argued that these costs are being captured as administrative costs or supervisor costs currently (depending on the non-attendant staff performing the direct care activities), and thus a corresponding decrease to the administrative cost could be considered as well.

However, using the supervisor as an example, the rate methodology does not simply replace those costs elsewhere on a 1:1 basis – the direct care supervisor rate component assumes a span of control in excess of 1:17, as determined by the median from cost reporting. The implication of this in the rate methodology, is that if a direct care supervisor provides 1 hour of 1:1 care for an LON 9 individual, but is unable to report that hour as direct care in the cost reporting, then the rate methodology is in essence capturing 1/17th of the impact, given the span of control and staffing assumptions, and the methodology building a person-specific daily rate.

- Data provided through the data request was relied upon for this analysis, which quantified the number of hours providers estimate spending on direct care that is not billable due to the 80% rule. After reviewing the data and removing outliers, the estimated un-reported direct care hours were divided by total direct care hours as reported in the cost reporting to develop an estimated impact for this issue.

6.4.3 Temporary Medication Administration Adjustment

Related to proposed policy change §565.23(h), which creates new requirements for program providers to create and implement policies and procedures around medication administration. HHSC identified this policy change as likely to be implemented at some point in the future, and as such data related to this was collected through the provider data request.

Data provided by stakeholders through the data request was relied upon, where providers estimated the number of additional direct care hours that would be required for medication administration as a result of the proposed policy change.

- The estimated hours provided by stakeholders were divided by total direct care hours reported in the cost report to develop a percent adjustment, which is applied to the direct care rate component.

6.4.4. Productivity Adjustment

The data request captured the amount of time that new and current direct care staff spend on trainings that are not directly attributable to an individual per year, and thus are not currently being captured in the cost reporting. This data, as well as an assumption related to staff turnover, was relied upon to estimate a range for the non-billable training time for the average direct care staff in a year, as shown in the table below. The estimated annual hours on non-billable trainings was divided by 2,080 (40 hours/week * 52 weeks/year) to develop a percent adjustment, which is applied as a factor to the direct care rate component.

Table 68. Productivity Adjustment Assumption Range for 2018 CR Turnover.

	New Employees	Current Employees
% of Workforce Population (based on turnover)	12%	88%
Average # of hours of training	80.0	40.0

Table 69. Productivity Adjustment Assumption Range for Mid-Point Assumption.

	New Employees	Current Employees
% of Workforce Population (based on turnover)	30%	70%
Average # of hours of training	80.0	40.0

Table 70. Productivity Adjustment Assumption Range for Data Request Driven Assumption.

	New Employees	Current Employees
% of Workforce Population (based on turnover)	49%	51%
Average # of hours of training	71.34	38.58

Table 71. Productivity Adjustment Calculation based on Assumption Range.

Assumption Type	2018 CR Turnover	Mid-Point Assumption	Data Request Driven Assumption
Productivity Adjustment	2.16%	2.50%	2.63%

6.4.5 Administrative Portion of Rate

- The administrative portion of the ICF/IID rate has not been updated for several years due to Texas statute and a lack of additional appropriations, and has not been updated to keep up with actual need or current cost of the administrative load.
- The rate modeling relied upon the HHSC cost report data in lieu statute-specified level of administrative load. The most recent cost report data currently calculates each of the ICF/IID administrative/indirect service rates, so the scenario modeling simply relied on the most recent cost report data.

6.4.6 Removing Facility Size Tiers

- The cost report SPSS Output found in the ICF/IID rate model captures facility costs by the facility size tiers. To develop a single ICF/IID residential care rate by LON, the following steps were taken. However, to implement this change in the rate methodology, HHSC could consider combining the tiers in the cost report output to circumvent these steps.
  - Attendant direct caseloads by ICF/IID size tier were combined by calculating a weighted average caseload using actual days of service from the cost report.
  - Non-Attendant caseloads were combined for Small and Medium ICF/IIDs only by calculating a weighted average caseload, using actual days of service from the cost report. Large ICF/IID caseloads were excluded because: (1) caseloads are based on a different methodology derived from span of control, (2): Large ICF/IIDs only represent roughly 5% of units.
  - Small ICF/IID caseloads for Nursing and QIDP were used for all ICF/IID sizes since small ICF/IIDS represent roughly 85% of units.
  - No consolidation of Direct Care and Other Care wages was necessary since the wage assumptions do not vary by ICF/IID size.

- Indirect Service Rate components (i.e., Indirect Professional & Support Staff, Dietary, Facility & Operations, and Administration) costs by ICF/IID size tier were combined by calculating a weighted average caseload using actual days of service from the cost report.

6.5 Potential Rate Impact ICF/IID Residential Rate

Using the methodology adjustments mentioned in the section above, various scenarios were created to evaluate the potential rate impacts.

- Scenario C1a adjusts client awake/asleep hours, uses the current rate model small ICF staffing ratios for all size tiers, and includes the 12-day sick leave assumption, all of which impact the direct care hours per resident per day. This scenario also applies the assumptions addressed in the section above, including the productivity adjustment, updating of the administrative portion of the rate with more recent cost report data, the adjustment for direct care hours from workers who spend less than 80% of their time on direct care, the medication administration adjustment, the nursing non-billable adjustment, and the removal of ICF size tiering. Lastly, the wage in this scenario is adjusted to the median ICF Residential direct care worker wage developed from the most recent 2020 cost report, trended to years 2024-2025
- Scenario C1b changes the staffing ratios to 'mid-levels', bringing the staffing ratio assumption to the midpoint of the "current" and "ideal" staffing ratios described in the section above
- Scenario C1c further uses the "ideal" staffing ratio assumption, as described in the section above

Table 72. ICF/IID Residential Rate Scenario Modeling C1a-C1c – Staffing Ratios Awake.

Level of Need	Current Rates – Small ICF	Current Rates – Medium ICF	Current Rates – Large ICF	Scenario C1a	Scenario C1b	Scenario C1c
LON1	1:5	1:5	1:7	1:5	1:4.5	1:4
LON5	1:4	1:4	1:6	1:4	1:3.7	1:3.3
LON8	1:3	1:3	1:5	1:3	1:2.8	1:2.7

Level of Need	Current Rates – Small ICF	Current Rates – Medium ICF	Current Rates – Large ICF	Scenario C1a	Scenario C1b	Scenario C1c
LON6	1:2	1:2.5	1:3	1:2	1:2	1:2
LON9	1:1	1:1	1:1	1:1	1:1	1.25:1

Table 73. ICF/IID Residential Rate Scenario Modeling C1a-C1c - Staffing Ratios Asleep.

Level of Need	Current Rates – Small ICF	Current Rates – Medium ICF	Current Rates – Large ICF	Scenario C1a	Scenario C1b	Scenario C1c
LON1	1:6	1:10	1:20	1:6	1:6	1:6
LON5	1:6	1:10	1:20	1:6	1:6	1:6
LON8	1:6	1:10	1:20	1:6	1:6	1:6
LON6	1:6	1:7.5	1:20	1:6	1:4.5	1:3
LON9	1:4.5	1:5	1:10	1:4.5	1:4.5	1:3

Table 74. ICF/IID Residential Rate Scenario Modeling C1a-C1c – Hours/Days.

Time Metric	Current Rates – Small ICF	Current Rates – Medium ICF	Current Rates – Large ICF	Scenario C1a	Scenario C1b	Scenario C1c
Client Awake (Hours) – Weekday	55	55	55	45	45	45
Client Asleep (Hours) – Weekday	35	35	35	40	40	40
Client Awake (Hours) – Weekend	34	34	34	32	32	32
Client Asleep (Hours) – Weekend	14	14	14	16	16	16
Sick Leave (Days)	0	0	0	12	12	12

Time Metric	Current Rates – Small ICF	Current Rates – Medium ICF	Current Rates – Large ICF	Scenario C1a	Scenario C1b	Scenario C1c
Holidays (Days)	11	11	11	11	11	11

Table 75. ICF/IID Residential Rate Scenario Modeling C1a-C1c – Direct Care Hours/Resident/Day.

Level of Need	Current Rates – Small ICF	Current Rates – Medium ICF	Current Rates – Large ICF	Scenario C1a	Scenario C1b	Scenario C1c
LON1	3.72	3.19	2.11	3.83	4.04	4.28
LON5	4.32	3.79	2.39	4.28	4.46	4.56
LON8	5.32	4.79	2.79	4.76	4.87	4.99
LON6	7.31	5.85	4.39	5.52	6.51	8.3
LON9	13.73	13.56	12.76	8.66	8.66	12.08

Table 76. ICF/IID Residential Rate Scenario Modeling C1a-C1c - Assumptions.*

Assumption	Current Rates – Small ICF	Current Rates – Medium ICF	Current Rates – Large ICF	Scenario C1a	Scenario C1b	Scenario C1c
Mark-up Assumption	7%	7%	7%	N/A	N/A	N/A
Productivity Adjustment	N/A	N/A	N/A	2.50%	2.50%	2.50%
80% Direct Care Adjustment	N/A	N/A	N/A	0.80%	0.80%	0.80%
Medication Admin Adjustment	N/A	N/A	N/A	0.10%	0.10%	0.10%
Size Tiering	Y	Y	Y	N	N	N
Direct Care Wage Assumption	$11.81/ Hour	$11.81/ Hour	$11.81/ Hour	$13.51/ Hour	$13.51/ Hour	$13.51/ Hour

**All assumptions are subject to change.*

Table 77. ICF/IID Residential Rate Scenario Modeling C1a-C1c.

Rates	Current Rates – Small ICF	Current Rates – Medium ICF	Current Rates – Large ICF	Scenario C1a	Scenario C1b	Scenario C1c
LON1	$135.35	$107.39	$104.54	$166.68	$169.63	$172.98
LON5	$149.26	$120.53	$109.54	$173.52	$175.93	$177.17
LON8	$167.15	$140.67	$118.78	$180.79	$182.16	$183.63
LON6	$199.75	$162.08	$158.25	$198.58	$213.06	$239.25
LON9	$275.81	$255.54	$257.65	$259.97	$259.97	$314.40
Budget Impact	**N/A**	**N/A**	**N/A**	**19.10%**	**21.10%**	**23.40%**

**All assumptions are subject to change.*

- Scenario C2, and C3 maintain the "ideal" staffing ratio scenario from Scenario C1c and modify the wage assumption according to the BLS data section in 'Data Sources'. Scenario C2 assumes the Nursing Assistants 75th percentile wage of $15.64. Scenario C3 assumes the Social and Human Service Assistants 50th percentile wage of $17.03.

Table 78. ICF/IID Residential Rate Scenario Modeling C2-C3 – Staffing Rations Awake.

Level of Need	Current Rates – Small ICF	Current Rates – Medium ICF	Current Rates – Large ICF	Scenario C2	Scenario C3
LON1	1:5	1:5	1:7	1:4	1:4
LON5	1:4	1:4	1:6	1:3.3	1:3.3
LON8	1:3	1:3	1:5	1:2.7	1:2.7
LON6	1:2	1:2.5	1:3	1:2	1:2
LON9	1:1	1:1	1:1	1:25.1	1:1

Table 79. ICF/IID Residential Rate Scenario Modeling C2-C3 - Staffing Ratios Asleep.

Level of Need	Current Rates – Small ICF	Current Rates – Medium ICF	Current Rates – Large ICF	Scenario C2	Scenario C3
LON1	1:6	1:10	1:20	1:6	1:6

Level of Need	Current Rates – Small ICF	Current Rates – Medium ICF	Current Rates – Large ICF	Scenario C2	Scenario C3
LON5	1:6	1:10	1:20	1:6	1:6
LON8	1:6	1:10	1:20	1:6	1:6
LON6	1:6	1:7.5	1:20	1:3.0	1:3.0
LON9	1:4.5	1:5	1:10	1:3.0	1:3.0

Table 80. ICF/IID Residential Rate Scenario Modeling C2-C3.

Hours/Days	Current Rates – Small ICF	Current Rates – Medium ICF	Current Rates – Large ICF	Scenario C2	Scenario C3
Client Awake (Hours) – Weekday	55	55	55	45	45
Client Asleep (Hours) – Weekday	35	35	35	40	40
Client Awake (Hours) – Weekend	34	34	34	32	32
Client Asleep (Hours) – Weekend	14	14	14	16	16
Sick Leave (Days)	0	0	0	12	12
Holidays (Days)	11	11	11	11	11

Table 81. ICF/IID Residential Rate Scenario Modeling C2-C3.

Direct Care Hours/ Resident/ Day	Current Rates – Small ICF	Current Rates – Medium ICF	Current Rates – Large ICF	Scenario C2	Scenario C3
LON1	3.72	3.19	2.11	4.28	4.28
LON5	4.32	3.79	2.39	4.56	4.456
LON8	5.32	4.79	2.79	4.99	4.99
LON6	7.31	5.85	4.39	8.3	8.3

Direct Care Hours/ Resident/ Day	Current Rates – Small ICF	Current Rates – Medium ICF	Current Rates – Large ICF	Scenario C2	Scenario C3
LON9	13.73	13.56	12.76	12.08	12.08

Table 82. ICF/IID Residential Rate Scenario Modeling C2-C3.*

Assumptions	Current Rates – Small ICF	Current Rates – Medium ICF	Current Rates – Large ICF	Scenario C2	Scenario C3
Mark-up Assumption	7%	7%	7%	7%	N/A
Productivity Adjustment	N/A	N/A	N/A	2.50%	2.50%
80% Direct Care Adjustment	N/A	N/A	N/A	0.80%	0.80%
Medication Admin Adjustment	N/A	N/A	N/A	0.10%	0.10%
Size Tiering	Y	Y	Y	N	N
Direct Care Wage Assumption	$11.81/ Hour	$11.81/ Hour	$11.81/ Hour	$15.64/ Hour	$17.03/ Hour

**All assumptions are subject to change.*

Table 83. ICF/IID Residential Rate Scenario Modeling C2-C3.

Rates	Current Rates – Small ICF	Current Rates – Medium ICF	Current Rates – Large ICF	Scenario C2	Scenario C3
LON1	$135.35	$107.39	$104.54	$183.61	$190.54
LON5	$149.26	$120.53	$109.54	$188.44	$195.79
LON8	$167.15	$140.67	$118.78	$195.91	$203.92
LON6	$199.75	$162.08	$158.25	$259.28	$272.35
LON9	$275.81	$255.54	$257.65	$345.35	$365.53
Budget Impact	**N/A**	**N/A**	**N/A**	**31.40%**	**36.60%**

**All assumptions are subject to change.*

6.6. Scenario Modeling – ICF/IID Day Habilitation

Following discussions on alternative rate methodology considerations, in collaboration with the provider workgroup and HHSC, a methodology prioritization discussion was held, which focused on the aspects of the alternative rate methodologies that the workgroup and HHSC were most interested in exploring further. A data request was developed and provided to the providers who had participated thus far in the engagement, to help inform assumptions related to the methodological changes. The contents of the data request and limitations of the data received are further discussed in previous sections. The following section contains a brief description of the methodological changes that were modeled.

6.6.1 Hours per Day in Day Habilitation Setting

- The current ICF/IID Day Habilitation rate methodology assumes five hours of service per day. This assumption is divided by the Day Habilitation LON staffing ratio assumptions to develop an attendant caseload assumption per LON.
- Based on HHSC feedback, and consistent with the assumed time spent outside the ICF/IID residential setting in the development of the ICF/IID residential rates, an assumption of six hours of day habilitation service per day was assumed in the scenario modeling. This change in assumption results in an increase in attendant caseload assumptions, which are represented as direct care worker hours per individual per day, as can be seen below.

Table 84. ICF/IID Day Hab Direct Care Worker Hours per Individual per Day Assumption Range.

LON	Direct Care Worker Hours per Individual per Day Assumption Low Scenario	Direct Care Worker Hours per Individual per Day Assumption High Scenario
LON1	0.50	0.60
LON5	0.63	0.75
LON8	0.83	1.00
LON6	1.25	1.50
LON9	5.00	6.00

6.6.2 Productivity Adjustment

The data request captured the amount of time that new and current direct care staff spends on trainings that are not directly attributable to an individual per year, and thus are not currently being captured in the cost reporting. This data, as well as an assumption related to staff turnover, was relied upon to estimate a range for the non-billable training time for the average direct care staff in a year, as shown in the table below. The estimated annual hours on non-billable trainings was divided by 2,080 (40 hours/week * 52 weeks/year) to develop a percent adjustment, which is applied as a factor to the direct care rate component.

Table 85. Productivity Adjustment Assumption Range for 2018 CR Turnover.

	New Employees	Current Employees
% of Workforce Population (based on turnover)	12%	88%
Average # of hours of training	80.0	40.0

Table 86. Productivity Adjustment Assumption Range for Mid-Point Assumption.

	New Employees	Current Employees
% of Workforce Population (based on turnover)	30%	70%
Average # of hours of training	80.0	40.0

Table 87. Productivity Adjustment Assumption Range for Data Request Driven Assumption.

	New Employees	Current Employees
% of Workforce Population (based on turnover)	49%	51%
Average # of hours of training	71.34	38.58

Table 88. Productivity Adjustment Calculation Based on Assumption Range.

Assumption Type	2018 CR Turnover	Mid-Point Assumption	Data Request Driven Assumption
Productivity Adjustment	2.16%	2.50%	2.63%

6.7. Potential Rate Impact ICF/IID Day Habilitation Rate

Using the methodology adjustments mentioned in the section above, various scenarios were created to evaluate the potential rate impacts.

- For ICF Day Hab., the scenarios varied by changing the productivity adjustment, increasing the hours per day in the Day Hab. setting, and varying wage assumptions.
- All assumptions, except for the wage assumptions, were applied equally throughout each scenario. The wage assumptions were increased according to the BLS data section in 'Data Sources'. Scenario C2 assumes the Nursing Assistants 50th percentile wage of $13.58. Scenario C3 assumes the Nursing Assistants 75th percentile wage of $15.64. Scenario C4 assumes the Social and Human Services 50th percentile wage of $17.03.

Table 89. ICF/IID Day Habilitation Rate Scenario Modeling.

Staffing Ratios	Current Rates	Scenario C1	Scenario C2	Scenario C3	Scenario C4
LON1	1:10	1:10	1:10	1:10	1:10
LON5	1:08	1:08	1:08	1:08	1:08
LON8	1:06	1:06	1:06	1:06	1:06
LON6	1:04	1:04	1:04	1:04	1:04
LON9	1:01	1:01	1:01	1:01	1:01

Table 90. ICF/IID Day Habilitation Rate Scenario Modeling.

Attendant Caseload	Current Rates	Scenario C1	Scenario C2	Scenario C3	Scenario C4
LON1	0.5	0.6	0.6	0.6	0.6
LON5	0.63	0.75	0.75	0.75	0.75
LON8	0.83	1	1	1	1
LON6	1.25	1.5	1.5	1.5	1.5
LON9	5	6	6	6	6

Table 91. ICF/IID Day Habilitation Rate Scenario Modeling.*

Assumptions	Current Rates	Scenario C1	Scenario C2	Scenario C3	Scenario C4
Mark-up Assumption	7%	N/A	N/A	N/A	N/A
Productivity Adjustment	N/A	2.50%	2.50%	2.50%	2.50%
80% Direct Care Adjustment	N/A	N/A	N/A	N/A	N/A
Medication Admin Adjustment	N/A	N/A	N/A	N/A	N/A
Hours per Day in Day Hab. Setting	5	6	6	6	6
Direct Care Wage Assumption	$11.24/Hour	$12.95/Hour	$13.58/Hour	$15.64/Hour	$17.03/Hour

**All assumptions are subject to change.*

Table 92. ICF/IID Day Habilitation Rate Scenario Modeling.

Rates	Current Rates	Scenario C1	Scenario C2	Scenario C3	Scenario C4
LON1	$14.88	$19.22	$19.67	$21.15	$22.15
LON5	$18.62	$21.54	$22.11	$23.95	$25.19
LON8	$24.77	$25.40	$26.16	$28.62	$30.29
LON6	$37.21	$33.14	$34.27	$37.96	$40.45
LON9	$130.30	$102.73	$107.26	$122.03	$131.99

Table 93. ICF/IID Day Habilitation Rate Scenario Modeling.

% Change from Current Rate by LON	Current Rates	Scenario C1	Scenario C2	Scenario C3	Scenario C4
LON1	N/A	29.2%	32.2%	42.1%	48.9%
LON5	N/A	15.7%	18.7%	28.6%	35.3%
LON8	N/A	2.5%	5.6%	15.5%	22.3%
LON6	N/A	-10.9%	-7.9%	2.0%	8.7%
LON9	N/A	-21.2%	-17.7%	-6.3%	1.3%

7. Appendix

7.1. Out of Scope Areas of Concern and Considerations

There were a number of identified areas of concern and considerations that were outside of the defined scope of Rider 30. The Rider directs HHSC to "evaluate the rate setting methodology for these programs…to develop reimbursement methodologies that more accurately reflect the costs of services and report back", and for the purposes of the rate methodology, HHSC defines "services" as the service description defined by Medicaid/CHIP, and as are allowable under their billable guidelines. As such items identified that would require regulatory or policy changes, or methodologies that deviated from cost report-driven approaches, were considered out of scope.

7.1.1 Out of Scope Rate Setting Methodology Review by Component

The table below contains high-level information pertaining to the out of scope areas of concern and considerations delineated by rate component, and the subsequent sections provide additional detail on the findings related to each consideration. Each of these areas of concern and considerations are applicable to a service, to the extent the rate component is applicable to the service.

Table 94. Summary of High-Level Out of Scope Considerations.

Component	Areas of Concern	Consideration	Priority
Process Improvement (a)	**Rate methodology** doesn't currently account for regulatory/policy changes that cause material changes in the cost of providing care, until many years after those costs have been incurred by providers	7.1.1.1.1 Prospectively incorporate rate adjustments for regulatory/policy changes	Revisit

Component	Areas of Concern	Consideration	Priority
Process Improvement (b)	**Common Waiver Service** utilization and billing patterns and guidance are inconsistent across waivers for these services	7.1.1.1.2 Reassess the Common Waiver Services rate methodology approach	Revisit
Transportation	**Transportation reimbursement methodology** is inconsistent with other states	7.1.1.2.1 Evaluate options for transportation reimbursement, including utilizing Non-Emergent Transportation (NET) services, or develop per-mile or per-trip rates	Revisit
Acuity Tiering	**Current tiering by LON** doesn't appropriately reflect the variation in costs to provide service	7.1.1.3.4 Consider alternative LON tiering approaches to reflect cost differences	Revisit
Direct Care Wages	**Direct care wages** were consistently identified by providers across services as their biggest concern with the current rates.	7.1.1.4.1. Consider using wage data from the Bureau of Labor Statistics (BLS) to assess and/or set direct care wages	N/A

7.1.1.1. Process Improvement

Throughout the engagement, numerous methodological concerns were discussed that apply to the overall process as a whole. Providers and HHSC expressed concerns related to information that is not being captured within the cost reporting. The following concerns were out of scope considerations, which if addressed, could lead to mitigation of many concerns expressed by providers as well as align Texas' methodology with other states.

- Providers expressed concerns about "unfunded mandates" related to regulatory and/or policy changes that, when implemented, increase the cost of care without any adjustment to rates to account for these increased costs. Given the lag between when costs are incurred by providers, and when cost reporting is used to develop the prospective rates by service, if adjustments are not made to rates in the interim, then the reimbursement methodology may not accurately reflect the costs of services. A recent example of this was the new requirement that ICFs have sprinklers. The provider workgroup also emphasized concerns related to IT requirements, and referenced the

migration of CARE to TMHP. This increased provider administrative time and the costs required to submit claims, reconcile payments, and generate reports. Providers also had concerns about EVV requirements and the upcoming Critical Incident Management System (CIMS) reporting requirements.

- Providers expressed concerns that the reimbursement under the Common Waiver Services methodology for HCS, specifically for nursing, is underfunded.

7.1.1.1.1. Prospectively incorporate temporary rate adjustments for regulatory/policy changes

The current rate methodology, which sets a prospective rate with a two-year rating period based on desk-reviewed cost report data from multiple years prior (for example, FY22-23 rates are based on 2018 cost report data trended forward), creates an issue where policy or regulatory changes that occur between the cost reporting period and the prospective rate period can cause providers to be required to provide additional services or incur additional costs that they are not being reimbursed for within the rate methodology.

- Policy or regulatory changes that result in a material change to a provider's cost to provide services, which occur between the cost reporting period and the prospective rate period, should be considered for rate adjustments equivalent to the estimated provider impact on the effective date of the change.
- Similar to the previous section, to the extent a cost can be determined and is material, methodologically these regulatory/policy change adjustments should be applied as a temporary rate adjustment effective as of the date of the change, until such time the underlying cost reporting period encompasses the effective date of the change.

To further understand these cost report considerations, the data request captured costs associated with identified regulatory changes. Through the data collected, not all costs related to the regulatory changes were considered material. Please refer to the **Appendix 7.5 Data Request Findings** for additional detail on the regulatory changes evaluated. Further discussion of the regulatory changes and impacts assessed in the scenario modeling can be found in **Section 5. HCS and TxHmL Rate Setting Methodology Review by Service** and **Section 6. ICF/IID Rate Setting Methodology Review by Service**.

Consideration Priority

HHSC should consider incorporating temporary rate adjustments to account for regulatory and/or policy changes until such time the underlying cost reporting period encompasses the effective date of the change, which would require an evaluation of the change in costs as a result of the regulatory/policy change.

7.1.1.1.2. Reassess the Common Waiver Services rate methodology approach

Utilization, policy, and/or billing guidance are inconsistent across waivers for the services that fall under the Common Waiver Service reimbursement methodology. The Common Waiver Services rate, on the other hand, is the same across all applicable waivers. Because of these differences in policy and billing guidance, this can potentially result in under-reimbursement for some waivers for the same service. In this case, the policy and billing guidance for Common Waiver Services in the HCS/TxHmL program tends to increase provider costs compared to other waivers, potentially resulting in an under-reimbursement to HCS/TxHmL providers. This issue could be resolved by either developing waiver-specific rates for the services that fall under the Common Waiver Services, or unifying policy and/or billing guidance across waivers for each of these services.

Consideration Priority

HHSC could consider revisiting the current rate methodology for Common Waiver Services alongside reviews of utilization, policy and/or billing rules across the Common Waiver Services to better inform an approach which could resolve the noted variances in costs across the Common Waiver Services.

7.1.1.2. Transportation

Through the methodology prioritization discussions, there was significant interest in exploring mileage-based and/or trip-based methodologies for transportation

reimbursement. However, there are significant policy decisions that would need to be made in establishing these methodologies, including:

- How should mileage be rounded?
- When does a trip start and stop?
- Would the methodology establish a prospective rate or reimburse actual cost?
- How does the methodology and policy address multiple people being transported, including limitations around how long an individual can be in a vehicle?
- How would reimbursement for drivers be handled? What if the direct care staff are driving?
- How are cost-drivers such as 1-on-1 direct care staff requirements and wheelchair vans addressed with the rate methodology?

The methodology prioritization discussions ultimately landed on a preferred approach of maintaining the current methodology, while seeking to enhance the information gathered through cost reporting, and continuing to evaluate other methodologies for transportation reimbursement.

7.1.1.2.1 Evaluate other options for transportation reimbursement, including utilizing Non-Emergent Medical Transportation (NEMT) services, or develop per-mile or per-trip rates.

While a time-based reimbursement methodology for transportation is not unique to Texas, and has an advantage of accounting for nuances in travel time between rural providers (longer distances, but higher average speed) and urban providers (shorter distances, but lower average speed), most other states evaluated either utilize their NEMT providers for transportation services, or develop per-mile or per-trip rates. Using the enhanced cost report transportation data described in 4.5 Transportation, HHSC could be better informed on the cost implications related to changing the reimbursement methodology to be consistent with other states.

- Transitioning to utilizing the Non-Emergent Medical Transportation services would pose a number of challenges related to service coordination. Additionally, given many HCS/TxHmL providers have purchased vehicles,

there would be other policy issues to navigate to allow these providers to be reimbursed through the NEMT service.

- Gathering additional information related to transportation costs, while maintaining the current methodology, would provide HHSC data to inform the impacts of switching to a mileage- or trip-based methodology. Data submitted by providers, where information related to these items was gathered, showed that in most cases providers are not currently tracking transportation costs at the level that would be required so it is hard to assess the impact of switching to these methodologies without additional time and data.

Consideration Priority

HHSC could consider evaluating other options for transportation reimbursement with additional data as described in the previous consideration, to allow for the evaluation of cost impacts for a shift in transportation reimbursement methodology, including mileage-based or trip-based.

7.1.1.3. Acuity Tiering

7.1.1.3.1. Current Approach and Primary Concerns

Within the current methodology, services that are tiered based on acuity use the ICAP assessment and resulting Levels of Need (LONs) to establish tiered rates. There are five LONs utilized to establish acuity tiering. Through interviews and workgroup sessions, the main concerns providers identified with the current acuity tiering methodology include:

- The scaling reimbursement by LON tier for services with acuity tiering are not always aligned with actual costs. For example, the lowest acuity tier individuals aren't necessarily less expensive to provide services for in group settings, due to individual choice and their ability to do more activities than higher acuity individuals.
- The ICAP assessment does not take into account the medical/physical needs of individuals, which have a significant bearing on the level of staff needed to

assist individuals. There is a high-medical needs rate add-on that would help account for this issue, but a review of that rate was outside the scope for this analysis.

- ICAP reassessments for individuals are challenging to obtain, and in the providers' experience, the reassessments rarely result in a change in LON due to the nature of the assessment process and how families or guardians tend to respond to the questions.
- When ICAP reassessments occur and result in a change in LON, there is a delay until the reimbursement adjustment takes effect, and there is no retroactive reimbursement.

As a reminder, evaluating alternatives to the ICAP assessment for acuity tiering was outside the scope of this analysis.

7.1.1.3.2. Environmental Scan Findings

With these concerns in mind, the following alternatives, which either address the number of tiers or how the tiers are determined, were discussed with HHSC and the provider workgroup:

Table 95. Acuity Tiering Environmental Scan Findings.

Alternative Approach	Description	Environmental Scan Results
ICAP "Smoothing" Adjustment	Instead of grouping ICAP scores into five Level of Need tiers, the "smoothing" adjustment allows each two-digit ICAP score to directly correlate to the reimbursement rate assigned for that individual's care	Illinois
Adjust Number of Tiers	Texas could choose to alter their current five Level of Need tiers into fewer tiers that would have updated reimbursement rates - Option to have two tiers (All LONs + LON9 special add-on)	California
No Tiering	For services that may show less need for cost variation based on acuity, it is possible to remove the Level of Need tiering altogether and form a standard rate across the board. Would likely still include LON9 add-on in this scenario	Maryland

Alternative Approach	Description	Environmental Scan Results
Acuity Tiering Methodology	There is an opportunity to evaluate whether there are other assessment tools or methods to assess individuals that would better define the acuity for IDD individuals in Texas	Some states (e.g., New York, Florida, Ohio) use state-specific assessment tools Pennsylvania, among other states, uses the SIS assessment

7.1.1.3.3. Consider Alternative LON Tiering Approaches to Reflect Cost Differences

During the methodology prioritization discussions, a key topic was adjusting the number of tiers for services that are currently tiered by LON. Two options were considered at a high-level: incorporating LON smoothing, similar to Illinois' approach, or collapsing LON tiers.

ICAP Smoothing Adjustment

An advantage of the ICAP Smoothing Adjustment is that it helps address disparities in rates between established acuity tiers, while also acknowledging within the rate structure that not all individuals within the same acuity tier require the same level of care. However, in discussing this option with the providers and HHSC during the methodology prioritization discussions, the complexity of implementing this methodology from a reimbursement and rate methodology perspective was considered prohibitive, and was not evaluated further.

Collapsing LON Tiers

In relation to feedback received from providers that the LON tiers aren't always indicative of costs, and general provider concerns about the validity of the ICAP assessment, methodologies of reducing the number of LON tiers were explored. Budget-neutral scenario modeling was performed to understand the provider impacts related to consolidating the LON tiers in various ways, for services that already use LON tiering. High-level findings for these analyses indicated that, regardless of the acuity tier collapsing methodology utilized, there were providers that would be disproportionately and negatively impacted relative to other providers given their relative distribution of individuals served. Ultimately, through the methodology prioritization discussions, HHSC decided not to explore this idea further.

Consideration Priority

Within the existing ICAP assessment acuity tiering structure, HHSC could revisit the considerations described above, including collapsing LON tiers. Alternatively, HHSC could evaluate, as part of a holistic review of the assessment tool used for the HCS/TxHmL and ICF/IID programs, the impact of shifting to a different assessment tool and revisit how acuity tiering of rates would work under the different assessments. This would require a significant amount of analysis and decision-making as the impacts of shifting to a different assessment are far-reaching beyond rate methodology.

7.1.1.4. Direct Care Wages

In addition to the detail related to Direct Care wages, which can be found in **Section 4.2: Direct Care Wages**, utilizing BLS wage data was discussed with HHSC and the provider workgroup.

7.1.1.4.1. Consider using wage data from the Bureau of Labor Statistics (BLS) to validate and/or set direct care wages

When discussing BLS wage data with HHSC, it was noted that using BLS wage data would provide insight on the prevailing market rate for direct care workers, but would not necessarily be reflective of the actual cost to provide services, given the number of factors that would differentiate BLS wage datapoints from the reality of service provision, such as variance in geographies and BLS occupational codes not being precisely aligned with the types of services being provided. As such, while this has not been specifically identified as a key consideration in response to Rider 30, a significant number of other states do utilize BLS wages in their rate methodologies, and doing so can avoid some pitfalls that come with solely cost report-based methodologies, as further described below.

In order to gain more insight into direct care wages, wage data from the 2020 BLS was summarized, and additional data was requested from HHSC pertaining to wages by job category and service across various other percentiles from the cost reporting. This can be found in the **Appendix 7.5 Data Request Findings**.

The tables below summarize 2020 BLS wages and occupations that are aligned with the services provided by direct care workers and that other states use in some capacity for their direct care wages (Figure 6), and the most recent direct care wage assumptions by service from the HCS/TxHmL and ICF/IID cost reports, trended to SFY2024-2024 (Figure 7).

Figure 94. Direct Care Wage Categories from the BLS used in other States.

Occupation (SOC code)[7]	Hourly Median Wage, untrended	Hourly Median Wage, Trended to SFY 2024-2025[8]	Commentary from HMA DSP Wage Study[9]
Social and Human Service Assistants (21-1093)	$17.03	$20.06	Of the 19 states evaluated in the study, the second most frequently utilized BLS Occupation used to develop the wage assumption, with weights ranging from 15%-100%
Nursing Assistants (31-1131)	$13.58	$15.99	BLS Occupation used by Ohio as part of their wage blending methodology
Recreation Workers (39-9032)	11.38	$13.40	Of the 19 states evaluated in the study, the third most frequently utilized BLS Occupation used to develop the wage assumption
Home Health and Personal Care Aides (31-1120)	$10.11	$11.91	Of the 19 states evaluated in the study, the most frequently utilized BLS Occupation used to develop the wage assumption, with weights ranging from 20%-100% and generally given at least 50% weight

[7] Bureau of Labor Statistics, U.S. Department of Labor, Occupational Employment and Wage Statistics; May 14, 2022; www.bls.gov/oes/

[8] PCE Inflation factor calculated as the projected increase from SFY2019 to SFY2024-2025

[9] "A Review of States' Approaches to Establishing Wage Assumptions for Direct Support Professionals When Setting I/DD Provider Rates"; Health Management Associates; July 6, 2022 https://www.ancor.org/sites/default/files/august_2022_dsp_wage_assumptions_in_state_idd_service_rate_setting.pdf

Figure 95. HCS/TxHmL and ICF/IID Direct Care Wages for Key Services

Service	2019/2020 Cost Report Median Wage	Hourly Median Wage, Trended to SFY 2024-2025[10]
HCS Residential Support Services / Supervised Living	$10.14	$11.94
HCS Day Habilitation	$10.24	$12.06
HCS CFC PAS HAB (SHL/CSS)	$11.84	$13.94
ICF DayHab/Residential	$11.38	$13.40

It is our understanding that in Texas, changes to the wages would need to be determined as a matter of policy. Note that the intent of this data is not to influence the minimum attendant base wage assumption; rather, to identify relevant/similar wage datapoints for individuals with similar occupations, and from which other states use to establish HCBS rate methodologies. Given that the level of direct care wages was consistently the highest priority and key pain point for providers, the scenario modeling that was performed included the impact of increasing wages on rates and budgetary needs.

Through the environmental scan, multiple states either directly use the BLS to set wages, or in the case of Florida, utilize regular wage studies to compare and validate the cost report wages against BLS wages for similar occupations and audited provider financial statements.

In addition to the environmental scan findings, Health Management Associates recently released a study[11] that evaluated the approaches used by 26 states in determining the Direct Support Professional (DSP) wage assumption for I/DD rate setting. The states evaluated in this study did not overlap with the states evaluated through the environmental scan, with the exception of Maryland. The report found that 20 of the 26 states evaluated use BLS wage data to inform the DSP wage assumption, and the study notes that while most rate studies performed by states include the collection of current DSP wages for providers, external wage benchmarks are generally relied upon given providers' costs are usually a function of the current payment rates. The study further elaborates on the BLS occupations

[10]PCE Inflation factor calculated as the projected increase from SFY2019 to SFY2024-2025
[11] "A Review of States' Approaches to Establishing Wage Assumptions for Direct Support Professionals When Setting I/DD Provider Rates"; Health Management Associates; July 6, 2022
https://www.ancor.org/sites/default/files/august_2022_dsp_wage_assumptions_in_state_idd_service_rate_setting.pdf.

that are used by other states to establish the wage assumption, including how other states are weighting the BLS occupation wage data. As noted in the study:

- 15 of the 20 states identified in the study using BLS to set their DSP wage assumption used home health and personal care aide wage data with weights ranging from 20-100%, and 14 of those used a weight greater than 50%.
- 10 of the 20 states used social and human service assistants, with weights ranging from 15%-100%.
- For all other occupations, weights generally ranged between 10%-20%.
- Most states generally use the median wage, with some opting to use the mean, and a few opting to use a higher percentile depending on the service, including Maryland.
- The study also notes that some states vary the wage assumptions based on setting, but notes that the BLS occupations used are similar across in-home, group-home, and day program settings.

HHSC could consider implementing a 'trigger' that would indicate that the wage assumptions should be re-evaluated. This could include a change in minimum wage, or comparing the inflator that was used to trend the cost report data to the prospective rate period (i.e., PCE for Direct Care wages), to the updated PCE inflator each year, or by comparing against other benchmark indices such as the CPI. If the current benchmark is greater than the original inflator, plus an established percentage, a review of the wage assumption would be triggered.

HHSC could also consider whether continuing to vary the direct care wages across services in the rate methodology is appropriate. The staff performing direct care tasks, regardless of the service setting, generally share a similar skillset and pull from the same pool of individuals. HHSC could consider setting a direct care wage assumption that is consistent across services with similar provider qualifications, which is a methodology used generally by states who utilize BLS data, including Maryland, Ohio, Pennsylvania, and Florida. The direct care portion of the rate by service, which also includes benefit factor adjustments, staffing ratio assumptions, and other utilization adjustments depending upon the service, would continue to drive appropriate differentiation in the direct portion of the rate by service.

Consideration Priority

As described above, HHSC could consider utilizing BLS wages in the direct care wage determination process, either to assess the reasonability of the cost-based wages, to inform a wage study, or to directly set the direct care portion of the rates. In addition, HHSC could consider whether direct care wages across different services should vary, given the staff across most services are generally share a similar skillset and pull from the same pool of individuals.

7.1.1.5. Inflators and Other Adjustments

In addition to the detail described in **Section 4.4: Inflators and Other Adjustments**, conversations were held with the workgroup and HHSC related to the PCE inflator that is currently used in the rate development, as well as considerations related to geographic variation of rates. These considerations have not been highlighted in the table at the beginning of this section, as they were not considerations that garnered a strong appeal from either HHSC or the provider workgroup on the whole. They are included here to document that they were discussed and considered.

7.1.1.5.1. Consider adjusting PCE inflator to a different index

Many states utilize an inflator for the purposes of trending costs forward from the cost reporting period to the prospective rate period. PCE, similarly, is intended to capture the impacts of inflation, and there is not an inherent issue with using PCE to trend the cost reporting data forward to the prospective rate period. However, HHSC could consider utilizing a standard index, such as CPI[12], that is more directly tied to inflation and wage increases.

7.1.1.5.2. Incorporate a geographic differential for higher and lower cost counties into the rate methodology

Implementing geographical factors into the rate methodology was discussed with the provider workgroup and HHSC, as well as within the provider interviews.

[12] HCBS Waiver Rate Setting Use of Inflation Factors; CMS; https://www.medicaid.gov/sites/default/files/2019-12/hcbs-1c-inflation-training.pdf.

Geographical considerations could include variation of rates by urban or rural provider setting, or variation depending on differentiated regions within the state. These regional determinations could be based on county or other regional factors. However, in discussions with the stakeholders, the general consensus was that while there may be variation to some degree geographically depending on the service, it wasn't generally a priority concern for providers interviewed, the provider workgroup, or HHSC, and thus specific geographical adjustment methodologies were not explored further.

7.1.2 Out of Scope Rate Setting Methodology Review by Service

The table below contains high-level information pertaining to the out of scope areas of concern and considerations by service, and the subsequent sections provide additional detail on the findings related to each consideration.

Table 96. Summary of Service-Specific Out of Scope Considerations.

Service	Areas of Concern	Consideration	Priority
Supported Home Living (SHL), Community Support Services (CSS), and CFC PAS/Hab	There is a **single rate for two distinct types of services**, transportation services (SHL/CSS) and CFC PAS/Hab services	7.1.2.1.1 Consider developing rates separately for CFC PAS/Hab and transportation services	Revisit
ICF/IID Residential	**Facility tiering may be overly complex** and does not capture meaningful cost differences across tiers.	7.1.2.2.1 Eliminate or simplify the facility size tiering in the rate methodology	Revisit
Individualized Skills and Socialization	At the time of preparing this report, the **rate methodology for this service was not finalized**.	7.1.2.4 General themes of stakeholder feedback related to Individualized Skills and Socialization based on the version of the rate methodology reviewed focused on accounting for offsite service costs.	Revisit

7.1.2.1. SHL, CSS, and CFC Pas/Hab Service

7.1.2.1.1. Consider developing rates separately for CFC PAS/Hab and transportation services

Stakeholder Concerns

The current SHL rate structure is built up using the costs of, and used to reimburse for, two distinct types of services – CFC PAS/Hab and transportation. This is not necessarily problematic if the relative utilization of the CFC PAS/Hab and transportation services stays consistent between the rate setting base period and the prospective rate period, or if the cost per hour for providing the CFC PAS/Hab services are in-line with the cost per hour for providing transportation services. However, if there are shifts in the relative utilization of the services between the base period and the prospective rate period, then there is the possibility that the rate will over- or under-reimburse for actual costs of providing the services in aggregate purely based on changes in the mix of services provided.

For further discussion on the SHL, CSS, and CFC Pas/Hab services, see **Section 5.4 HCS Supported Home Living (SHL), TxHmL Community Support Services (CSS), and CFC PAS/Hab**.

Considerations

HHSC could consider developing separate rates for the CFC PAS/Hab service and the SHL/CSS transportation service, which may require changes to policy, regulatory, and/or billing guidelines. This consideration could also be evaluated simultaneously with the transportation considerations identified in Section 4.5 Transportation of this report, which describes considerations related to gathering more granular transportation cost information, and how that information could be used to inform future changes to the transportation reimbursement methodology.

7.1.2.2. ICF/IID Facility Size Tiering

7.1.2.2.1. Consider eliminating facility size tiering in the rate methodology

Stakeholder Concerns

Tier Definitions: Providers expressed that the tiering definitions in the ICF/IID rate structure seemed arbitrary and did not capture meaningful cost differences between the different facility sizes. In addition, under some federal rules, a small ICF/IID is defined as a facility with 16 or fewer beds[13]. All medium sized ICF/IIDs and some large sized ICF/IIDs would be classified as a small facility if aligning with federal rules.

Economies of Scale: The original intention of implementing ICF/IID size tiering in the rate methodology was to capture the cost differential of running a small, medium, or large ICF/IID. Theoretically larger ICF/IIDs can gain efficiencies in administrative, facility, and/or operations expenses and as such have lower costs per resident served. However, when reviewing ICF/IID cost report data, Large ICF/IIDs actually have higher facility and operation costs, higher dietary costs, and higher indirect professional and support staff costs than Medium ICF/IIDs on a per person basis. In fact, the Large ICF/IID per person indirect cost profile aligns more closely to the Small ICF/IID setting.

Small ICF/IIDs Dominate Market Share: The vast majority of the Texas ICF/IID service is delivered by Small ICF/IIDs with fewer than 9 beds. This could be observed in the cost report data, which saw 86% of units delivered by Small ICF/IIDs in the 2018 cost report, and 87% of delivered by Small ICF/IIDs in the 2020 cost report. Workgroup members also mentioned that there has been a growing transition of members from larger ICF/IIDs to small ICF/IID settings.

For further discussion on ICF/IID, see **Section 6. ICF/IID Rate Setting Methodology Review by Service Rate Setting Methodology Review by Component**.

[13] https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/som107ap_j_intermcare.pdf.

Considerations

HHSC should consider eliminating the facility size tiering in their rate methodology. The differentiation in the facility tiers by individuals served appears to be arbitrary, the largest facilities are not showing economies of scale in their indirect cost reporting, and the majority of facilities are currently classified as 'small' ICF/IID facilities with less than nine beds. Additionally, the facility size doesn't conform to how the service is billed, which causes provider confusion.

An additional point of support for the consideration to eliminate facility size tiering relates to the staffing ratios. Through the data request, providers indicated the staffing ratios for how they currently staff the facilities, and under an ideal scenario for providing quality, economical and efficient care how they would staff the facilities. The staffing ratios under either scenario did not vary on average across the facility sizes when comparing facilities caring for individuals of similar levels of acuity. The proposed staffing ratios do not differ by facility size, but do continue to vary by LON.

7.1.2.3. Individualized Skills and Socialization

Individualized Skills and Socialization is a new program that will be replacing the current Day Habilitation program. This section is structured in a similar fashion as the service-specific discussion found in **Section 5. HCS and TxHmL Rate Setting Methodology Review**.

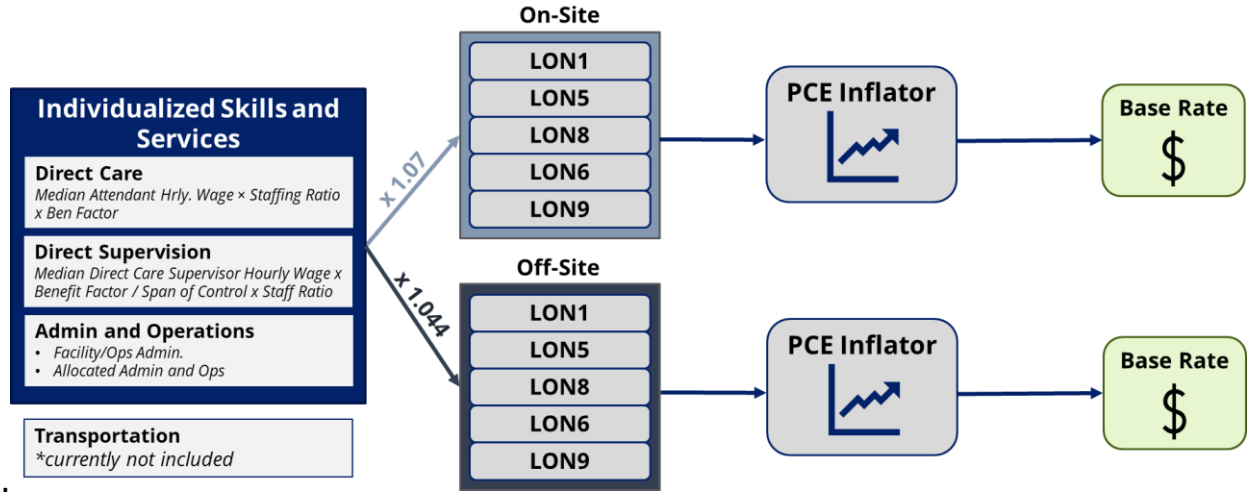
At the time of preparing this report, the policies that guide Individualized Skills and Socialization were still being developed, and the rate methodology had not been finalized. Providers expressed a high degree of uncertainty related to what service delivery in this program will look like, which posed a challenge when trying to gather feedback from providers. This section summarizes the rate methodology being proposed at the time this report was prepared, as well as the concerns and considerations developed based on the proposed policies and feedback from providers.

HHSC has been making an effort to adjust the rate methodology for Individualized Skills and Socialization given the ongoing feedback that has been received, and as a result this section of the report should not be read as a definitive guide on the current state of the issues related to the reimbursement structure. Rather, this section of the report provides themes of stakeholder feedback for the service based on the version of the rate methodology that was reviewed. To the extent policy changes or changes in the rate structure or reimbursement methodology are made, the considerations, data, and scenario modeling described in this section may no longer be valid.

7.1.2.3.1. Current Methodology

The rate development as proposed at the time this report was prepared for Individualized Skills and Socialization is depicted in the graphic below; the rate is a two-year prospective statewide hourly rate that varies by five levels of acuity as well as site of service. Note that in the current rate development methodology, many assumptions are developed leveraging the Day Habilitation (Day Hab) cost reporting, until cost reporting data would be available for this service.

Figure 12. Current ISS Rate Methodology.



At a high-level, the rate is built by separately calculating and then combining direct care, direct supervision, and admin and operations (indirect service) rate components.

- The **Direct Care rate component** is calculated by multiplying the median hourly attendant wage from the Day Hab cost report by a staffing ratio

assumption, and a benefits factor assumption, which is also derived as the median benefits factor percentage from the Day Hab cost report. The staffing ratio assumption varies by LON and site of service. Note that the staffing ratio was considered out of scope for the purposes of this analysis, given the staffing ratios have been established as a matter of policy. As a result, acuity tiering was also considered out-of-scope.

- The **Direct Supervision rate component** is calculated by multiplying medians derived from the Day Hab cost report for direct supervisor wage, benefits factor, and supervisor span of control, by the aforementioned staffing ratios which varies by LON and site of service.
- The **Indirect Service rate component** includes the median weighted facility and operations cost derived from the Day Hab cost report, and the allocated administration and operations cost, which is described further in **Section 4.3 Administrative Cost Methodology**.

The individual rate components are then added together, with the on-site rate multiplied by a 7% mark-up and the off-site rate multiplied by a 4.4% mark-up. These mark-ups are described further in report **Section 4.4. Inflators and Other Adjustments**. All costs derived from the cost report as described above use a PCE inflator to trend the historical costs to the prospective rate period.

7.1.2.3.2 Environmental Scan

A summary of the environmental scan findings by state can be found in the table below; for more detail on the approaches utilized in other states by service, please refer to Appendix 7.3: Environmental Scan.

Figure 13. Individualized Skills and Socialization /Day Hab Environmental Scan Summary.

State	Rate Period	Geographic Variation	Acuity Tiering	Admin
Texas	Hourly	Not Applicable	Level of Need tiering based on ICAP assessment – split by on-site and off-site staffing ratios	Allocated across the waiver based on fixed weight allocation by service
New York Group Day Habilitation	Half-unit or full unit	Regional blending for provider specific rate	Not Applicable	Provider Specific – split by service on cost reports

State	Rate Period	Geographic Variation	Acuity Tiering	Admin
New York Community Habilitation	Quarter hour	Upstate/Downstate	Not Applicable	Provider Specific – split by service on cost reports
California	Daily – interim rate	Not Applicable	Tiered by staffing ratios	Directly from cost report – included in mean calculation
Tennessee	Daily	Not Applicable	Acuity tiering based on staffing levels and level of supervision	Directly from cost report
Illinois	Hourly	Not Applicable	For Direct Care - Uses ICAP "smoothing" where acuity is determined on a continuous spectrum	Fixed annual fee
Florida	Hourly	Rates vary by geography for 3 groups of counties	Staffing ratio variation	No detail on methodology
Ohio	Fifteen Minutes or Daily	County-level adjustment into groups CODB 1-8	Acuity Assessment Instrument (AAI) identifies the maximum group size allowable	Admin applied as an assumed percentage of the base in bottom-up rate build
Pennsylvania	Per-15 Minute	Not Applicable	Tiered by level of staffing need	The lesser of $25.00 PMPM or 10% of cost

The sections below discuss similarities and differences in the approach for states evaluated in the environmental scan by rate structure, wages, staffing ratios, administrative costs, inflators and other adjustments, acuity tiering, and site of service variation.

7.1.2.3.3. Rate Structure

- The rate structure for these services generally follows the same direct care, supervision, and indirect cost rate components.
- All states, with the exception of Pennsylvania and Ohio, use cost reporting to establish their rates. Pennsylvania and Ohio both use a modeled rate

methodology, with the former switching away from cost report-based rate setting within the last few years.

- New York is unique in that they have provider-specific rates that are developed by blending provider-specific reported costs with regional averages, and provider-specific utilization adjustments including considerations for acuity and protected classes.
- California reimburses for actual costs, within an established range around the average vendor cost in the State.

Wages

- New York, California, Tennessee, and Illinois use cost reporting to determine the wage underlying the rates, similar to Texas' current methodology.
- Ohio and Pennsylvania rely upon BLS data to establish the wages for direct care workers.
- Florida uses a blended approach, which considers both the wages informed by cost reporting, and a market analysis using the BLS data.

Staffing Ratios

The methodology used by other states to determine the staffing ratios underlying their rates was generally not publicly available, but staffing ratios are taken into account in the rate methodology for all states.

Administrative Cost

- New York and Tennessee require providers to report costs by service, and the administrative cost component is based on those reported values.
- Illinois and Ohio uses a fixed percentage assumption for the administrative cost component
- Pennsylvania uses a consistent approach across waivers which is a lesser of 10% cost or $25.00 PMPM approach.

Inflators and Other Adjustments

- New York, Florida, and Ohio all have geographic variation in their rates.
- Ohio and Pennsylvania use explicit Productivity adjustments to account for non-billable time required for economical and efficient care.

- Related to Texas' implementation of the 4.4% or 7% mark-up by service, no other states were observed to have policy-driven rate increases not tied to specific components of the rate development.

Acuity Tiering

- The number of acuity tiers within the rates varies by state and service setting, ranging from 2 (Tennessee In-Home and Community) to 5 (Tennessee Facility). Most states have 4 acuity tiers. New York uses provider-specific acuities in their provider-specific reimbursement methodology as well.
- New York, Florida, and Ohio use state-specific assessments for establishing acuity tiers, and Tennessee uses information from each Individual Support Plan to assign an acuity tier.
- Pennsylvania uses the SIS assessment for establishing acuity tiers.
- Illinois uses the ICAP assessment for establishing acuity tiers, but has a unique approach which they call ICAP smoothing. Rather than having rates defined for specific acuity tiers (e.g., all individuals that have an ICAP score within a specific range receive the same rate), Illinois has implemented an approach where the actual score of the individual determines the rate, based on a line fit between the rates established for each acuity tier, and where the score falls within that line.

Site of Service Variation

- New York develops separate provider-specific rates for their Group Day Habilitation and Community Habilitation services.
- California has separate rates for their Activity Centers, Adult Developmental Centers, and Behavior Management Program providers.
- Pennsylvania, Ohio, and Illinois do not have separate rates developed by service setting.
- Tennessee and Florida use similar site of service variation as the proposed Individualized Skills and Services design, with variation between facility-based and off-site services. Tennessee also separately develops rates for in-home day habilitation services as well. The staffing ratios do not vary between the facility-based and off-site service acuity tiers for these states, which does differ relative to the proposed Individualized Skills and Services,

where the staffing ratios are assumed to be different by LON depending on the setting.

7.1.2.3.4 Stakeholder Concerns and Methodology Considerations by Component

The following sections are structured similar to **Section 4. Rate Setting Methodology Review by Component**, and supplement with any additional relevant information for the service with further elaboration on the general themes that arose from stakeholder feedback. The headings for each consideration identify the correlating consideration from Section 4 in parentheses as applicable. As noted, each of the considerations identified in Section 4 are generally applicable to each of the services within the following sections, to the extent the contents of each consideration are relevant to the service.

As noted, at the time of preparing this report, the policies that guide this service were still being developed, and the rate methodology was not finalized. This section summarizes the general themes of stakeholder feedback related to the service based on the version of the rate methodology reviewed. Nuances unique to Individualized Skills and Socialization in the version of the rate methodology that was evaluated include that the rate build-up is based on staffing ratios that were set as a matter of policy (and the evaluation of which was considered outside of the scope of this analysis), and the underlying costs used to build up the rates are from the Day Habilitation program that this service is replacing. The following sections discuss this issue further, and identify some approaches that can be taken to create a data driven, repeatable rate methodology.

Process Improvement

Revise cost report template and accompanying instructions, or consider pro forma or modeled rate approaches if data cannot be obtained or is not reliable (4.1.2.1.).

Related to the noted considerations described in 4.1.2.1, to further understand the cost report consideration for identified unreported costs to the extent they are material and reasonably able to be estimated, the data request captured incremental costs associated with the identified issues. For a number of the allowable and billable items that were identified, the data was not deemed reliable for scenario modeling – please refer to the **Appendix 7.5 Data Request Findings** for additional detail. For a discussion on the adjustments related to non-billable time, please refer to **Appendix 7.1.2.4 Inflators and Other Adjustments**.

Stakeholder Concerns

In addition to the noted considerations in Section 4.1.2.1., this is a new service building upon the previous Day Habilitation service, and is currently relying upon the Day Habilitation cost report data to build up rates. The concerns listed below should be considered both in the context of what costs were captured through the Day Habilitation service, and what costs need to be captured through the Individualized Skills and Socialization service.

Specific to this service, there are allowable and billable costs that were not part of the Day Habilitation service, but are part of providing the Individualized Skills and Socialization service, including offsite transportation costs and direct care staff activity fees for the provision of off-site service. The iteration of the rate methodology that was reviewed at the time of the preparation of this report does not account for these costs.

Considerations

To address the concerns related to the cost reports not capturing all necessary costs required to provide quality, economical and efficient care, HHSC should consider the following:

- Specific to this service, data was collected through the data request to understand expectation around off-site transportation costs, and direct care staff activity fees. Given these costs are not currently captured in the rate methodology, but in the future, these would be costs captured in the cost report used to build up the rates, temporary rate adjustments could be considered to account for these costs. In **Appendix 7.1.2.3.5 Scenario Modeling**, there is additional detail on the process for estimating the proposed Transportation Adjustment and Off-Site Activity Fee Adjustment to account for these costs.

Inflators and Other Adjustments

Consider rate adjustments to capture the impact of allowable but non-billable activities (4.4.3.1.)

Through the evaluation process, HHSC expressed a desire to replace the 7.0% rate mark-up for On-Site, and 4.4% rate mark-up for Off-Site that exists in the current methodology with factors that are well understood, and can be updated on a repeatable basis with available or obtainable data. Given this guidance, allowable adjustments to rates as identified in the following were considered as described in

Section 4.4 Inflators and Other Adjustments. As discussed in **Section 4.1.2.1 Revise cost report template and/or accompanying instructions**, HHSC could consider adding additional fields to the cost reporting to capture time spent on these non-billable activities. Additional detail on the approach used to account for identified adjustments in the scenario modeling can be found in **Appendix 7.1.2.3.5 Scenario Modeling**, including the Productivity Adjustment and 80% Direct Care Adjustment.

Transportation

Capture additional data to evaluate transportation costs and other reimbursement options (4.5.3.1.)

Stakeholder Concerns

Off-site transportation is a new cost consideration for Individualized Skills and Socialization, that didn't exist for the previous Day Habilitation service. The iteration of the rate methodology reviewed does not currently account for off-site transportation costs. In the future, when the service is implemented and the cost reports are being utilized to determine the rate, if transportation costs are not captured by service, then the transportation costs attributable to off-site service delivery would be allocated across all services (depending on the administrative cost rate methodology that is being utilized) as opposed to being targeted to the service driving those costs.

Considerations

HHSC could consider a temporary rate adjustment to account for estimated transportation costs associated with off-site service delivery. Through the data request, information related to transportation costs and expectation for off-site transportation needs was gathered. This information was relied upon to develop an estimated transportation cost for the provision of off-site service delivery. Please refer to **Appendix 7.1.2.3.5 Scenario Modeling** for additional information. This temporary adjustment should only be applied to the rates until such time the underlying cost report data used to develop the rates incorporates these transportation costs.

Additionally, HHSC could consider updating the cost reporting such that providers allocate their transportation costs by service. This would allow for the rate methodology to reflect the true costs of providing specific services more accurately, by building up a separate transportation costs component by service within the rate build methodology.

Alternatively, HHSC could explore alternative transportation reimbursement methodologies entirely, including per-trip or per-mile reimbursement.

7.1.2.3.5 Scenario Modeling

Following discussions on alternative rate methodology considerations, in collaboration with the provider workgroup and HHSC, a methodology prioritization discussion was held, which focused on the aspects of the alternative rate methodologies discussed that the workgroup and HHSC were most interested in exploring further. A data request was developed and provided to the providers who had participated thus far in the engagement, to help inform assumptions related to the methodological changes. The contents of the data request and limitations of the data received are further discussed in previous sections. The following section contains a brief description of the methodological changes that were modeled.

Direct Care Wages

Consistent with the discussion of direct care wages in the Methodology Prioritization section, providers expressed that current wages are not high enough to attract and retain talent in the current workforce.

It's our understanding that in Texas, changes to wage levels external to the cost reporting would need to be determined as a matter of policy.

For the purposes of scenario modeling, the following approach was used to assess the impact of wage changes:

- For the initial scenarios assessing the impact of the various staffing ratio levels, the direct care wage assumption was set equal to the 2020 Cost Report Direct Care wage, trended to 2024-25 using PCE.
- For the remaining scenarios, the direct care wage assumption was modeled as follows:
  - Consistent with Ohio's BLS blending approach, the average of the median wages for Home Health and Personal Care Aides, Nursing Assistants, and Social and Human Service Assistants. The average of the median wages for these services in the 2020 TX BLS data is $13.58.
  - Consistent with Maryland's BLS approach which sets the direct care wages equal to the median wage for Social and Human Service Assistants which is $17.03

    - To evaluate the wage impact for an interim value, the 75th percentile of the Nursing Assistants BLS wage was selected (i.e., $15.64 per hour), a similar approach to that used in in Ohio and Maryland.
- As direct care wages are increased in the scenario modeling, a proportional increase in the direct care supervisor wages was applied.

80% Direct Care Adjustment

The 80% rule for attendant care is a current policy which requires that an attendant must perform attendant functions at least 80% of his/her time worked, and staff not providing attendant services at least 80% of their total time worked are not considered attendants. An implication of this rule is that for cost reporting, direct care hours are under-reported as a result of attendant services being performed by individuals who are not meeting the 80% criteria, and as a result the direct care portion of the rates are understated. It can be argued that these costs are being captured as administrative costs or supervisor costs currently (depending on the non-attendant staff performing the direct care activities), and thus a corresponding decrease to the administrative cost could be considered as well.

However, using the supervisor as an example, the rate methodology does not simply replace those costs elsewhere on a 1:1 basis – the direct care supervisor rate component assumes a span of control in excess of 1:17, as determined by the median from cost reporting. The implication of this in the rate methodology, is that if a direct care supervisor provides 1 hour of 1:1 care for an LON 9 individual, but is unable to report that hour as direct care in the cost reporting, then the rate methodology is in essence capturing 1/17th of the impact, given the span of control and staffing assumptions, and the methodology building a person-specific daily rate.

Data provided through the data request was relied upon for this analysis, which quantified the number of hours providers estimate spending on direct care that is not billable due to the 80% rule. After reviewing the data and removing outliers, the estimated un-reported direct care hours were divided by total direct care hours as reported in the cost reporting to develop an estimated impact for this issue.

Temporary Medication Administration Adjustment

Related to proposed policy change §565.23(h), which creates new requirements for program providers to create and implement policies and procedures around medication administration. HHSC identified this policy change as likely to be

implemented at some point in the future, and as such data related to this was collected through the provider data request.

Data provided by stakeholders through the data request was relied upon, where providers estimated the number of additional direct care hours that would be required for medication administration as a result of the proposed policy change.

The estimated hours provided by stakeholders were divided by total direct care hours reported in the cost report to develop a percent adjustment, which is applied to the direct care rate component.

Fixed Administrative Percentage Adjustment

To further assess the administrative costs in the rate methodology, HHSC provided cost report information from 2020, 2018, 2017, and 2016 with separate costs by Direct Care, Admin, and Facility and Operations Expenses.

The scenario modeling used a 3-year rolling average of the administrative cost as a percentage of the direct care cost to estimate the administrative cost by service, which in this case is equal to 43.8%. This was applied in the rate methodology by multiplying the direct care rate component by the 43.8% assumption; this replaces the previous allocated administrative cost rate component. The facility and operations rate component is un-changed with this methodology.

Productivity Adjustment

The data request captured to capture the amount of time that new and current direct care staff spend on trainings that are not directly attributable to an individual per year, and thus are not currently being captured in the cost reporting. This data, as well as an assumption related to staff turnover, was relied upon to estimate a range for the non-billable training time for the average direct care staff in a year, as shown in the table below. The estimated annual hours on non-billable trainings was divided by 2,080 (40 hours/week * 52 weeks/year) to develop a percent adjustment, which is applied as a factor to the direct care rate component.

Table 97. Productivity Adjustment Assumption Range for 2018 CR Turnover.

	New Employees	Current Employees
% of Workforce Population (based on turnover)	12%	88%
Average # of hours of training	80.0	40.0

Table 98. Productivity Adjustment Assumption Range for Mid-Point Assumption.

	New Employees	Current Employees
% of Workforce Population (based on turnover)	30%	70%
Average # of hours of training	80.0	40.0

Table 99. Productivity Adjustment Assumption Range for Data Request Driven Assumption.

	New Employees	Current Employees
% of Workforce Population (based on turnover)	49%	51%
Average # of hours of training	71.34	38.58

Table 100. Productivity Adjustment Assumption Range.

Assumption Type	2018 CR Turnover	Mid-Point Assumption	Data Request Driven Assumption
Productivity Adjustment	2.16%	2.50%	2.63%

Transportation Adjustment

In the proposed Individualized Skills and Socialization service, there was no assumption related to costs associated with transporting individuals to and from the off-site activities that are proposed as a part of the service. Through the data request, information was gathered and relied upon to estimate the transportation costs for off-site activities. The development of the adjustment applied in the scenario modeling can be found in the table below.

- The Average Annual Cost for Vehicles was estimated based on data provided by providers through the data request.
- This adjustment methodology assumes the annual cost for the vehicle is 100% attributable to this service (i.e., the vehicle isn't used for the provision of other services)
- The average daily round-trip mileage was estimated based on anecdotal information from providers. The consistent average daily round-trip mileage ranged from 20 to 60 miles across provider responses, and 30 average daily mileage round-trip was assumed in the calculation.

- The IRS standard mileage rate[14] at the time of the analysis was used for the per-mile reimbursement rate.
- Individualized Skills and Socialization policy assumptions include that on average there will be four service participants transported per-vehicle to off-site activities, and that on average 25% of the service delivery time will occur off-site; these assumptions were used to develop an additional off-site transportation cost per hour assumption.

Table 101. Offsite Transportation Adjustment Assumption Development.

Calculation	Description	Amount
(a)	Average Annual Cost for Vehicles	$5,200
(b)	% Vehicle Cost Attributable to ISS	100%
(c)	Average Daily Round-trip Mileage	30
(d)	IRS Mileage Rate	$0.59
(e) = (c) x (d)	Average Daily Mileage Cost	$18
(f) = [(a) x (b) ÷ (5 x 52)] + (e)	Average Daily Transportation Cost	$38
(g)	Average # of ISS participants per Vehicle	4
(h) = (f) ÷ (g) ÷ 2*	Additional Off-site Cost per Hour	$4.70
Budgetary Impact		**+34.7%**

**2 hours/day for offisite in accordance with ISS rate build*

Off-Site Activity Fee Adjustment

- In the proposed service, there was no assumption related to costs associated with direct care staff going to off-site activities, such as zoo entrance fees, and HHSC indicated these would be allowable costs.
- In the data request, providers were asked to estimate the cost of off-site activities as well as frequency of each activity in order to get to an estimate per hour impact. The findings from the data request were discussed with the provider workgroup and HHSC, and through those discussions, it was estimated that $20 per week per direct care staff would be appropriate for these activity fees.

[14] https://www.irs.gov/newsroom/irs-issues-standard-mileage-rates-for-2022.

- An hourly adjustment to the off-site component of the rate by LON was calculated based on the staffing ratios by LON and the 25% off-site service delivery assumptions.

Potential Rate Impact

Using the methodology adjustments described in the section above, various scenarios were created to evaluate the potential rate impacts. The budgetary impacts were developed utilizing the estimated units of service as established in previous analyses by HHSC.

- Scenario C1 removes the 7.0% rate mark-up for on-site and 4.4% rate mark-up for off-site services, and applies all of the assumptions addressed in the section above, including the productivity adjustment, fixed administrative allocation adjustment, adjustment for the 80% direct care rule, medication administration adjustment, off-site transportation adjustment, off-site activity fee adjustment. The wage assumption is based on RSS/SL direct care worker wage from the 2020 cost report, trended to 2024-25. As mentioned above, varying the staffing ratios was out of scope for this service
- Scenarios C2, C3, and C4 maintain the same assumptions as Scenario C1, with the exception of the wage assumption which is set equal to other BLS levels as detailed in Appendix 7.1.2.3.5 Scenario Modeling.

Table 102. ISS Rate Scenario Summary – Staffing Ratios (Onsite).*

Level of Need	Current Rates	Scenario C1	Scenario C2	Scenario C3	Scenario C4
LON1	1:7	1:7	1:7	1:7	1:7
LON5	1:5	1:5	1:5	1:5	1:5
LON8	1:3	1:3	1:3	1:3	1:3
LON6	1:3	1:3	1:3	1:3	1:3
LON9	1:1	1:1	1:1	1:1	1:1

**All assumptions are subject to change.*

Table 103. ISS Rate Scenario Summary - Staffing Rations (Offsite).*

Level of Need	Current Rates	Scenario C1	Scenario C2	Scenario C3	Scenario C4
LON1	1:6	1:6	1:6	1:6	1:6

Level of Need	Current Rates	Scenario C1	Scenario C2	Scenario C3	Scenario C4
LON5	1:4	1:4	1:4	1:4	1:4
LON8	1:3	1:2	1:2	1:2	1:2
LON6	1:2	1:2	1:2	1:2	1:2
LON9	1:1	1:1	1:1	1:1	1:1

**All assumptions are subject to change.*

Table 104. ISS Rate Scenario Summary - Staffing Ratios (Enhanced).*

Level of Need	Current Rates	Scenario C1	Scenario C2	Scenario C3	Scenario C4
LON1	1:2*	1:2*	1:2*	1:2*	1:2*
LON5	1:2*	1:2*	1:2*	1:2*	1:2*
LON8	N/A	N/A	N/A	N/A	N/A
LON6	N/A	N/A	N/A	N/A	N/A
LON9	N/A	N/A	N/A	N/A	N/A

**All assumptions are subject to change.*

Table 105. Individualized Skills and Socialization Rate Scenario Summary – Direct Care Hours / Resident / Hour (Onsite).*

Level of Need	Current Rates	Scenario C1	Scenario C2	Scenario C3	Scenario C4
LON1	0.14	0.14	0.14	0.14	0.14
LON5	0.20	0.20	0.20	0.20	0.20
LON8	0.33	0.33	0.33	0.33	0.33
LON6	0.33	0.33	0.33	0.33	0.33
LON9	1.00	1.00	1.00	1.00	1.00

**All assumptions are subject to change.*

Table 106. Individualized Skills and Socialization Rate Scenario Summary - Direct Care Hours/Resident/Hour (Offsite).*

Level of Need	Current Rates	Scenario C1	Scenario C2	Scenario C3	Scenario C4
LON1	0.17	0.17	0.17	0.17	0.17

Level of Need	Current Rates	Scenario C1	Scenario C2	Scenario C3	Scenario C4
LON5	0.25	0.25	0.25	0.25	0.25
LON8	0.50	0.50	0.50	0.50	0.50
LON6	0.50	0.50	0.50	0.50	0.50
LON9	1.00	1.00	1.00	1.00	1.00

**All assumptions are subject to change.*

Table 107. Individualized Skills and Socialization Rate Scenario Summary - Direct Care Hours/Resident/Hour (Enhanced).*

Level of Need	Current Rates	Scenario C1	Scenario C2	Scenario C3	Scenario C4
LON1	0.50*	0.50*	0.50*	0.50*	0.50*
LON5	0.50*	0.50*	0.50*	0.50*	0.50*
LON8	N/A	N/A	N/A	N/A	N/A
LON6	N/A	N/A	N/A	N/A	N/A
LON9	N/A	N/A	N/A	N/A	N/A

**All assumptions are subject to change.*

Table 108. Individualized Skills and Socialization Rate Scenario Summary.*

Assumptions	Current Rates	Scenario C1	Scenario C2	Scenario C3	Scenario C4
Mark-up Assumption	7%	N/A	N/A	N/A	N/A
Occupancy Adjustment	N/A	N/A	N/A	N/A	N/A
Productivity Adjustment	N/A	2.5%	2.5%	2.5%	2.5%
Admin (3-year avg.)	Current Methodology	43.8%	43.8%	43.8%	43.8%
80% Direct Care Adjustment	N/A	0.8%	0.8%	0.8%	0.8%
Medication Admin Adjustment	N/A	0.10%	0.10%	0.10%	0.10%

Assumptions	Current Rates	Scenario C1	Scenario C2	Scenario C3	Scenario C4
Service Coordination Adjustment	N/A	N/A	N/A	N/A	N/A
Transportation Adjustment	N/A	$5,200/ vehicle, 30 miles/week	$5,200/ vehicle, 30 miles/week	$5,200/ vehicle, 30 miles/week	$5,200/ vehicle, 30 miles/week
Activity Fee Adjustment	N/A	$20/week	$20/week	$20/week	$20/week
Wage Assumption	$10.58 / Hour	$10.58 / Hour	$11.82 / Hour	$13.58 / Hour	$17.03 / Hour

**All assumptions are subject to change.*

Table 109. Individualized Skills and Socialization Rate Scenario Summary – Rates (Onsite).*

Level of Need	Current Rates	Scenario C1	Scenario C2	Scenario C3	Scenario C4
LON1	$4.95	$8.27	$9.11	$10.14	$12.14
LON5	$5.83	$9.08	$10.04	$11.20	$13.46
LON8	$7.85	$10.96	$12.20	$13.68	$16.57
LON6	$7.85	$10.96	$12.20	$13.68	$16.57
LON9	$17.96	$20.41	$22.97	$26.05	$32.09
Budget Impact	(compared to proposed)	24.80%	82.50%	102.00%	139.90%
Budget Impact	(compared to Day-Hab)	105.20%	125.10%	149.10%	195.80%

**All assumptions are subject to change.*

Table 110. Individualized Skills and Socialization Rate Scenario Summary – Rates (Offsite).*

Level of Need	Current Rates	Scenario C1	Scenario C2	Scenario C3	Scenario C4
LON1	$5.19	$13.65	$14.54	$15.63	$17.74
LON5	$6.42	$15.00	$16.06	$17.34	$19.84
LON8	$10.12	$19.04	$20.61	$22.49	$26.17

Level of Need	Current Rates	Scenario C1	Scenario C2	Scenario C3	Scenario C4
LON6	$17.52	$27.12	$29.69	$32.78	$38.82
LON9	$17.52	$27.12	$29.69	$32.77	$38.81
Budget Impact	(compared to proposed)	24.80%	82.50%	102.00%	139.90%
Budget Impact	(compared to Day-Hab)	105.20%	125.10%	149.10%	195.80%

**All assumptions are subject to change.*

Table 111. Individualized Skills and Socialization Rate Scenario Summary – Rates (Enhanced Offsite).*

Level of Need	Current Rates	Scenario C1	Scenario C2	Scenario C3	Scenario C4
LON1	$10.12	$18.37	$19.94	$21.83	$25.51
LON5	$10.12	$18.54	$20.11	$21.99	$25.67
LON8	N/A	N/A	N/A	N/A	N/A
LON6	N/A	N/A	N/A	N/A	N/A
LON9	N/A	N/A	N/A	N/A	N/A
Budget Impact	(compared to proposed)	24.80%	82.50%	102.00%	139.90%
Budget Impact	(compared to Day-Hab)	105.20%	125.10%	149.10%	195.80%

**All assumptions are subject to change.*

7.1.3 List of Identified Concerns from Stakeholders

The table below contains specific topics that were raised throughout the engagement, either through discussion with the workgroup, through provider interviews, or through documentation which was provided by the workgroup. In each of the cases below, HHSC provided a determination for whether the items would be considered as in-scope, and out-of-scope. The Report Coverage column provides additional context where the considerations were considered and more information on the topic can be found, if applicable.

Table 112. Topics and Details Raised During Engagement.

#	Topic	Detail from Stakeholders	Report Coverage
1	**Abuse, Neglect, Exploitation Investigations Adult Protective Services**	HHSC already has a group looking into rules related to Abuse, Neglect, and Exploitation. However, ANE investigations are currently taking extraordinarily long to close. This is financially burdensome on providers who have put staff on paid or unpaid leave	Out of Scope
2	**Adaptive Aids**	The way adaptive aids are paid makes it always seem like a one-time purchase even though they are often purchasing multiple things that add up to the max amount, which is much more admin work	No additional data was gathered related to this topic
3	**Additional Non-Billable Items**	Case Management, insurance on cyber theft, legal costs, RN on call, IT labor	Data was gathered from providers related to this topic, see **Appendix 7.5 Data Request Findings**
4	**Admin on Therapies and other common waiver services**	Admin costs built into the rates end up being paid straight to therapists in order to cover the cost of their services	**4.3 Administrative Cost**
5	**Administrative Allocation**	The current weights applied to aggregate admin amount, to distribute across services, were developed long ago and do not reflect true allocation	**4.3 Administrative Cost**
6	**Annual IPC**	If an annual renewal meeting or signing of renewal IPC is not completed by the previous IPC end-date, HHSC does not pay the provider for services rendered during the gap unless the provider can prove the delay was not the provider's fault. HHSC will only pay for services rendered during the gap if it is documented and clear that the delay is caused by the LIDDA service coordinator or the family/LAR.	Out of Scope
7	**Base Rate**	Direct Care staff is $8.11 - nobody is going to work for that. Absorbing large amount of costs and caused 50% staffing shortage.	Out of Scope

#	Topic	Detail from Stakeholders	Report Coverage
8	**Case Management**	LIDDAs and MCOs case management costs not captured on cost report	**4.4 Inflators and Other Adjustments**
9	**Consumer Directed Services**	i. PACSTX has asked for clarification regarding responsibility for CDS. i. i. More services within the waiver should be CDS including therapies, dental services, and day habilitation a. A comprehensive provider should not be required for individuals who are all CDS. ii. Providers should not be required to act as representative payee for individuals utilizing CDS iii. FMSA/LIDDA requirements should be clear for CDS. Providers should not be required to conduct training or case management for individuals receiving CDS.	Out of Scope, In-scope CDS items discussed in **5.7 Consumer Directed Goods**
10	**Corporate Taxes**	Not Applicable	Data was gathered from providers related to this topic, see **Appendix 7.5 Data Request Findings**
11	**Cost of non-reimbursable drugs / supplies not covered by Medicaid directly or reimbursable thru HCS program**	Not Applicable	Out of Scope
12	**Day Supports During the Week for People Living in an HCS Group Home**	The group home rate assumes no one is in the group home for 30 hours out of the week. If a person does not attend day habilitation due to illness, desiring to stay home, or an alternative schedule (volunteers, employment or other), there is no mechanism to reimburse providers for the extra staffing required during that time	Data was gathered from providers related to this topic, see **Appendix 7.5 Data Request Findings**

#	Topic	Detail from Stakeholders	Report Coverage
13	**Dental costs that are not covered on IPC**	Additional needs are identified during other work performed and addressed during the visit but not on the IPC in advance	Out of Scope
14	**Direct Care services for people who perform less than 80% of direct care activities**	Currently, if an admin or other employee performs ad-hoc direct care tasks, without performing direct care tasks at least 80% of the time, that time is not billable. There is nowhere on the cost report to record said time	Data was gathered from providers related to this topic, see **Appendix 7.5 Data Request Findings** and **4.2 Direct Care Wages**
15	**DME**	Create a list of DME that would not require a denial prior to billing the waiver. Denials are increasingly difficult to obtain and the process delays delivery of services	Outside of Scope
16	**Electronic Signatures**	HHSC sent out an information letter in 2015 requiring that electronic prescriptions/physician's orders be on physician/medical practitioner/hospital letterhead. These documents are not always on letterhead and are usually signed with an electronic signature. Electronic documentation requirements should be considered and limited to what is already required by HIPAA	Out of Scope
17	**EVV**	Tracking of all billing activities (especially in SHL), takes a lot of time and is non-billable	Data was gathered from providers related to this topic, see **Appendix 7.5 Data Request Findings**
18	**Geographic Areas**	Geographical concerns related to travel times in rural vs. urban areas were discussed across relevant services. Additionally, for SHL, individuals tend to live in rural areas this makes it challenging to find staff that will drive the distances required to provide services for a few hours a day, a few days a week.	Geographic variation of rates is covered in 4.4 Inflators and Other Adjustments, as well as by service as relevant in **5. HCS and TxHmL Rate Setting Methodology Review by Service**.

#	Topic	Detail from Stakeholders	Report Coverage
19	**Host Home/Companion Care In-Home Day Habilitation**	HHSC has determined that HH/CC is a 24-hour service and disallowed the ability for a HH/CC provider to offer in-home day habilitation for individuals who are medically fragile and/or living in a rural area with limited outside staff available. The HH/CC rate however assumes that a person is at day habilitation during the day. For service recipients who remain at home all day the HH/CC provider is not paid for that time	**5.2 Host Home and Companion Care**
20	**Individualized Skills and Socialization - Offsite Requirement**	In some rural areas, it is a challenge / near impossible to find enough community activities for ISS required off-site activities.	**Appendix 7.1.2.3: Individualized, Skills, and Socialization**
21	**Level of Need**	Serve individuals for LON level 9, rate is for 16 hours and sometimes folks don't sleep at night. Sometimes we have to staff LON 9 for 24 hours and graveyard staff can't deal with that. We have increased staffing ratios in homes just because of that and there is no way to recoup dollars for that specific issue.	Data related to staffing in the RSS/SL and ICF/IID setting gathered from providers related to this topic, see **Appendix 7.5 Data Request Findings**
22	**LON 9**	LON 9 – Providers are required to document delivery of services with additional staffing to justify higher level of need. Higher LON should be awarded more quickly and/or once approved funding should be back-dated to the start date of higher level of supervision	Out of Scope
23	**LON Issues**	Individuals transitioning with lower LON than historically approved HHSC does not allow LONs to follow the person, requiring providers to "prove" the need for a higher LON by delivering and documenting additional services. LONs are not backdated even after the need is proven and approved. This is particularly problematic for LON 9, (see below) which is very difficult to get approved. not cost report related	Out of Scope

#	Topic	Detail from Stakeholders	Report Coverage
24	**LON system - ICAP**	The ICAP system was not meant to be used for rate-setting purposes upon its creation. Difficult to get a LON9 one-on-one rating - "158 are LON 9 out of the entire program." Doesn't take aging population into account	Out of Scope
25	**Marketing Costs**	Marketing costs are not captured in the cost report i.e., sponsoring golf event, which is important for their fundraising efforts.	Unallowable costs out of scope; Data was gathered from providers related to the allowable costs, see **Appendix 7.5 Data Request Findings**
26	**Medicaid Eligibility**	Providers are not able to bill the waiver for services that are denied by MCOs including prescription drugs (but if prescribed by a doctor are required to be obtained by the provider, so providers must pay for the service or drug)	Out of scope
27	**Medicaid Eligibility**	Providers should be able to bill the waiver for medical services received after a person has been off Medicaid for 90 days or longer (these services cannot be back-billed in managed care). Providers can deliver services without payment for up to a year or longer if the person loses Medicaid and it is not clear why. The provider is back-billed after Medicaid is re-established but not always all the way back to the loss date. Smaller providers also cannot afford to pay staff and deliver services for such a long period of time without payment	No additional data was gathered related to this topic
28	**Nursing Travel Time**	Paying hourly wage + mileage for nurse to travel location to location but unable to recoup that cost	Data was gathered from providers related to this topic, see **Appendix 7.5 Data Request Findings**

#	Topic	Detail from Stakeholders	Report Coverage
29	**Payments made to doctors and dentists to be on retainer and/or to see service recipients who have lost Medicaid-**	Even if the service recipient's Medicaid eligibility is restored, it is often too late for the doctor or other health care providers to bill the Medicaid MCO or other insurance.	Out of Scope
30	**Recoupment**	If providers can show evidence that a service was delivered, they should not be subject to recoupment, particularly for documentation errors. If a signature is missing or other administrative error on service logs HHSC recoups for the entire day or service.	Out of Scope
31	**Regulatory should not be able to require providers to do anything not specifically required in rule including**	i. Life Safety Code requirements beyond what is expected or required by inspecting authority (should only check for inspection being performed) – sprinkler systems, industrial vent hoods, etc. ii. Recommendations by DFPS following an ANE investigation that are not feasible or are not covered by the waiver iii. Requires provider to deliver all services recommended by a host of professionals and/or family members even if the service is not listed on the IPC.	Data was gathered from providers related to this topic, see **Appendix 7.5 Data Request Findings**
32	**Related Party Transactions**	Concerns related to allowable costs for related party transactions, particularly in cases where group homes are owned by the provider.	Considerations related to Related Party can be found in **4.6 Related Party**
33	**Representative Payee/Trust Fund Management**	Providers who are forced to be representative payee or manage a trust fund should be paid to perform that service since non-provider representative payees can receive reimbursement	No additional data was gathered related to this topic

#	Topic	Detail from Stakeholders	Report Coverage
34	**Requirements Exceed Payment:**	Individuals will have service requirements beyond what is billable or approved on IPC, including: Supervision beyond what LON permits and Nursing hours beyond what is approved on IPC	Out of Scope
35	**Residential Support Services/4-bed home**	Remove requirement that 4-bed homes have at least one RS person living in the home. This requirement is challenging for providers when a single RS person moves from a home and unnecessarily limits use of sleep-over staff in a 4-bed home	Out of Scope
36	**Room and Board Agreements**	Providers are required to allow a person to choose any home with vacancies. However, room and board is not paid through the waiver. Because choices are not limited by what the individual can afford, providers are required by program rules to subsidize room and board for individuals who do not have income or SSI for that purpose. Providers cannot bill an individual for the costs related to destruction of property not cost report related	Data was gathered from providers related to this topic, see **Appendix 7.5 Data Request Findings**
37	**Room and Board Subsidies**	Not just the inability of the consumers to pay the cost for any decent home, but also problems where SSI benefits stop or are held by a Representative Payee who is not the provider, and no payment is made for room and board expenses. Step 8A allowable maybe?	Out of Scope
38	**Service Start Date Prior to Medicaid Confirmation**	State directs IDD provider to begin services prior to confirmation of Medicaid eligibility, thereby requiring providers to "front" services with no guarantee of payment	Out of Scope

#	Topic	Detail from Stakeholders	Report Coverage
39	**Services Prior to Transition or During Temporary Suspension**	All services that are required prior to a transition like a nursing assessment are currently not billable. Providers cannot bill for services rendered during a temporary discharge including hospital admission--including nurse participation in discharge planning meetings, training staff in preparation for a client who is returning home after a hospital of NF stay, etc.	Out of Scope
40	**Technology for new employees**	Money spent on technology for new employees is not billable on the cost report (no additional detail on what that 'technology' might be)	Data was gathered from providers related to this topic, see **Appendix 7.5 Data Request Findings**
41	**Timely transfer of information between providers**	Providers who are the "losing provider" in a transition do not have incentive to transfer IPC hours or appropriate information necessary to serve the individual. Providers cannot bill for services until the transitioning provider completes all of the necessary steps – the receiving provider is forced to deliver services for free until that is completed.	Out of Scope
42	**Training**	Currently, providers may only bill for staff training for the needs of a particular individual. Providers should have the ability to bill for professional staff (nurses, psychologists, BCBAs) to train direct support staff on more general topics related to the support for people with complex behavioral and medical needs not necessarily specific to one individual. Currently training must occur one-on-one more frequently due to high turn-over and there is no way to bill for that training.	Data was gathered from providers related to this topic, see **Appendix 7.5 Data Request Findings**
43	**Transportation**	The cost for nurses to travel to provide services, especially in rural areas. Additionally, transporting and waiting with consumer at medical appointment, making appointments, and transporting medications are costs not being reimbursed for.	Out of Scope

#	Topic	Detail from Stakeholders	Report Coverage
44	**Zero Reject**	Providers should not be required to put a person in a hotel or open a new home if they do not have group home capacity for a person that chooses them or filling a vacancy would be inappropriate placement (i.e., a person with history of aggression who is looking at home with individuals who are medically fragile). ii. Providers should have the ability to temporarily suspend services in certain circumstances including (but not limited to): i. Recipient loss of Medicaid eligibility ii. Aggressive/threatening/unsafe or illegal behavior by those living in the home of individual receiving SHL toward provider staff iii. Refusal of guardian or LAR to cooperate in timely signing of IPC, refusal to pay room and board.	Out of Scope

7.2. HHSC Documentation

File Tracker

HHSC provided a number of files documenting the existing rate methodology, cost reporting, and other related files. A summary of the files provided is below.

File Tracker: HHSC File Tracker.xlsx

Service Coordination / Case Management and Potential Regulatory Changes

In addition to workgroup discussions, HHSC provided additional documents that contain more detail regarding allowable but non-billable service coordination / case management activities and potential regulatory changes.

File: Case Management Activities Not Directly Billable in HCS and TxHmL_final.docx

File: Fiscal Impact CP Rules 3.1.22.docx

FY24-25 Rate Models

HHSC provided draft versions the following rate models to assist in the rate scenario modeling.

HCS Model: 2024-2025 HCS Model updated_6152022.xlsx

ICF Model: ICF Model 2020 for CB 2024-2025.xlsx

Individualized Skills and Socialization Model: ISS Model – Midlevel.xlsx

7.3 Environmental Scan

Summarized findings from the environmental scan for both HCS and ICF/IID, discussed throughout the report, are captured in the attached PowerPoint file.

File: Texas HHSC_HCS Environmental Scan Final Deliverable.pptx

7.4 Methodology Prioritization

Methodology Prioritization Summary

Throughout the study, HHSC and the provider workgroup were engaged in multiple conversations regarding potential methodology considerations for all services. The discussions and various decisions and considerations can be found in the attached Methodology Prioritization PowerPoint.

File: Texas HHSC_HCS Methodology Prioritization_Final Deliverable.pptx

Provider Interview Feedback

In addition, all feedback discussed with stakeholders in the provider interviews, is located in the following PowerPoint. Note this file is meant to be supplemental to information throughout this report and not entirely complete as a standalone document.

File: Provider Interview Feedback.pptx

7.5 Data Request Findings

As discussed throughout the report, a large portion of the scenario modeling and potential rate impacts relied upon data points collected via a data request sent to HHSC and providers. The following files include information related to this effort.

Blank Data Request File: Rider 30 ICF HCS TxHmL Data Request.xlsx

Data Request Completed by HHSC File: Data Request_HHSC.xlsx

Data Request Information: Rider 30_Data Request Timelines and Additional Information.pptx

Key Findings from Data Request: Texas HHSC Data Request Findings and Scenario Modeling.pptx

7.6 Provider Workgroup Stakeholders

The provider workgroup consisted of the providers and representatives listed below. The provider workgroup was engaged weekly over the course of the study, providing their perspectives on the current state of these programs, and feedback concerning considerations discussed within this document.

Provider Name:

- Sandy Batton, Providers Alliance for Community Services of Texas
- Isabel Casas, Texas Council of Community Centers
- Carole Smith, Private Providers Association of Texas
- Doug Svien, Rock House
- Heather Vasek, Delisi Communications
- Ben Peakes, Private Providers Association of Texas
- Ken Gray, Kenmar Residential HCS Services, Inc.
- Sandra Taylor, Community Healthcore
- Sheryl Baker, StarCare Lubbock

7.7 List of Providers Interviewed

In addition to the workgroup providers, there were several other providers that serve HCS, ICF/IID, and TxHmL services across the State of Texas. These providers were invited to interviews in which they shared their concerns regarding the current

rate methodology, and were also invited to participate in the data request process. A list of all providers invited to the series of interviews is below:

Table 113. List of All Providers Invited to Interview Series.

Provider Name	Company	Program	Responded to Data Request?
Cody Clark	Avid Quality Care	HCS	No
Jason Berry	Berry Family Services	HCS	Yes
Alfredo Cancino	Ideal	HCS	No
Tony Ritter, Joann Perry	Advantage Care Services	HCS	Yes
Carin Shuford, Lisa Moers, Tray Stavinoha, Kevin Barker	Texana Center	HCS	Yes
Clayton Pecot	Harmony Living Centers	HCS and ICF/IID	Yes
Robert Ham, Alison Petro	Mentor/Sevita	HCS and ICF/IID	Yes
Richard Thorne	Advo - Amarillo	HCS and ICF/IID	Yes
Alyssa Lopez, Hilda Garcia, Imelda Garza, Adalia Rebollar, Nayssa Flores	Tropical Texas Behavioral Health	HCS	Yes
Chris Barnhill	PermiaCare	HCS	Yes
Roger Caraway	Disability Resources Inc.	ICF/IID	No
Mark Lashley, Tiffany Moyer	Caregiver	HCS and ICF/IID	Yes
Beth Lawson, Sheryl Baker	StarCare Specialty Health System	HCS and ICF/IID	Yes
John Delany	Lakes Regional Community Center	HCS and ICF/IID	No
Lonnie Welch	Texas HCS/ICL Corp	HCS and ICF/IID	No
Jeff Head	Caring Palms Health Care Center	ICF/IID	No
Amanda Darr	Bttc Pin Oak House	ICF/IID	No
Brian Mueller	Mariah Flats	ICF/IID	No
Steve Mulkey	Pebbleshire House	ICF/IID	No
Lori Meraz, Tony Bullard	Peoplecare	HCS	No

Provider Name	Company	Program	Responded to Data Request?
Laura Mahaley	Ability Connection Texas	HCS	Yes
Genna Dunlap	Texas Panhandle Mhmr	HCS	No
Cara Mehrens	Bluebonnet Trails Community Mhmr Ce	HCS	No
Isaac Earls	Connecting Lives Services	HCS	No
Luke Kelly	Hope Horizon, Llc	HCS	No
Nicole Mays	Premier Community Care Services	HCS	No
Sergio Castillo	Life Choices Unlimited, Inc.	HCS	No
Gilbert Enriquez	Special Recreation Services, Inc.	HCS	No
Andrea Grimes	Gateway Community Partners Inc.	HCS	No
Kayla Minchew, Jana Jobe	Spectrum of Solutions	HCS	Yes
Stephanie Yates, Melanie Taylor	Burke	HCS	Yes
Susan McDaniel	Sabine Valley Regional	HCS	Yes
Carroll Rabalais, Fran Rodda, Charlene Crump	Mary Lee Foundation	HCS	Yes