# Health and Human Services

# Medical Care Advisory Committee

# November 13, 2025

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*This summary contains supplemental information from reliable sources where that information provides clarity to the issues being discussed. Power Point tables used in the presentations may also be used in this summary. Names of individuals may be misspelled but every attempt has been made to ensure accuracy. Tables and Text have been used from executive and legislative agencies and departments' presentations and publications.*

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Medical Care Advisory Committee is federally mandated to review and make recommendations to the state Medicaid director on proposed rules that involve Medicaid policy or affect Medicaid-funded programs.

The Medicaid Advisory Committee (MAC) is a federally mandated committee that reviews and makes recommendations to the state Medicaid director on proposed changes that involve Medicaid policy or affect Medicaid-funded programs.

HHSC has established a Beneficiary Advisory Council (BAC) as required by CFR § 431.12 and operates as a standing subcommittee of the MAC. As outlined in 42 CFR 431.12(f)(1) BAC members are not required to include their names in a BAC membership list and meeting minutes. Currently BAC meetings are closed to the public as outlined in 42 CFR 431.12 (f)(4). The BAC meets on a regular basis in advance of the MAC meetings. Meeting minutes will be posted upon approval by the BAC.

**Members**

**Doug Svien, MAC Chair**
Provider
Stephenville

**Mary Helen Tieken, RN, BSN, MAC Vice Chair**
Registered Nurse
Floresville

**Salil Deshpande, M.D.**
Managed Care Organization Representative
Houston

**Lou Driver**
Nursing Home Administrator
Houston

**Lisa Wright**
Community Health Choice
President/CEO

**Robert Hilliard, Jr., M.D.**
Physician, Ob/Gyn
Houston

**Sandy Crisp**
LPC Private Practice
Licensed Professional Mental Health Therapist

**Donna S. Smith**
Physical Therapist
Austin

**Christina Paz**
Centro San Vicente
Doctor of Nurse Practice/NP-CEO

**Joseph Modesto**
Dream Therapy Center
President and CEO

**Carol Daulton**
Texas Health Resources
Senior Director Supplemental Payment Program

**1. Call to order, opening remarks, introductions, and roll call**. The meeting was convened by Doug Svien, Chair. A quorum was present.

**2. Consideration of August 14, 2025, draft meeting minutes**. The minutes were approved as drafted.

**3. Medicaid and Children's Health Insurance Program (CHIP) activities update**. Emily Zulkofsky, State Medicaid Director, provided the update. Legislative support and appropriations allowed the hiring of staff for contract management, managed care oversight, and vendor drug program. There were investments made in Medicaid IT modernization, focusing on provider enrollment system improvements after feedback from numerous organizations.

There have been implemented flexibility in some enrollment deadlines due to current system challenges, and a public-facing improvement timeline is pending.

Regarding Women's health, House Bill 1575 requires health plans (and Thriving Texas Families program) to screen pregnant women for non-medical health needs. Early results indicate that top needs are related to food insecurity and childcare.

Doulas and community health workers are now allowed to deliver case management;

New maternal health dashboard launched on the Texas Healthcare Learning Collaborative website, offering plan comparison using quality measures.

The sunset review process is ongoing; public input is encouraged via the online form located on the HHSC Website. In addition, the Legislative Appropriation Request process has started, and input is open until Nov 24.

**HHSC Sunset Review**

**Sunset Advisory Commission Invites Public Input on the Health and Human Services Commission**
The Sunset Advisory Commission is reviewing the mission and performance of the Health and Human Services Commission (HHSC) and welcomes comments from the

public on whether the agency is still needed, the agency's performance in fulfilling its mission, and ideas to improve HHSC's operations and services.

The Texas Sunset Act requires the Sunset Commission to periodically review HHSC and recommend whether to continue the agency, implement Sunset staff's recommendations to improve agency efficiency and effectiveness (Sunset management directives), or change state law to improve the agency's efficiency and effectiveness. The Legislature ultimately will decide whether to continue HHSC or adopt the Sunset Commission's other statutory recommendations.

The Sunset process has three stages. First, Sunset staff will evaluate HHSC, seek public input, and issue a report recommending solutions to problems found. Second, the Sunset Commission will hold two public meetings: a hearing on the staff report and the agency, and a decision meeting to adopt recommendations based on the report and public comments. Third, the Legislature will convene in January 2027 and will consider the Sunset Commission's adopted statutory recommendations in a Sunset bill for HHSC.

**Submit Your Input**

Here are several ways to provide comments and suggestions to Sunset staff on HHSC's mission, operations, and services:

- Send an email to sunset@sunset.texas.gov, with "HHSC Review" in the subject line,
- Submit comments online at www.sunset.texas.gov/input-form,
- Send a letter to Sunset Advisory Commission, Attn: HHSC, P.O. Box 13066, Austin, Texas 78711, or
- Call (512) 463-1300 to speak to Sadie Smeck, project manager of the HHSC review.

Please provide your comments by April 2026 to ensure Sunset staff can fully consider your input while conducting their review. Comments submitted before the staff report is published in October 2026 will remain confidential.

**Regulatory Agency Solicitation of Input and Notice of Public Hearing Requirements**

Regulatory agencies, excluding river authorities, are also subject to two additional requirements, to the extent practicable, that affect individuals and entities licensed, certified, or otherwise authorized by the regulatory agency (regulated parties) to engage in an activity regulated by the agency. Regulatory agencies are required to:

- Solicit input from regulated parties on the agency's performance. In soliciting input, a regulatory agency may inform regulated parties that they can submit their input on the agency directly to Sunset staff by submitting comments online at www.sunset.texas.gov/input-form or using any of the other methods described in *Submit Your Input* above; and

- Notify regulated parties of Sunset Commission public hearings related to the agency. In its notification, a regulatory agency can inform regulated parties that information about the Sunset public hearings related to the agency can be found at: www.sunset.texas.gov/sunset-commission-meetings.

Stay informed! Members of the public and regulated parties may also visit www.sunset.texas.gov/join-mailing-list to sign up for email alerts on the Sunset staff report and the Sunset Commission's public meetings on HHSC.

**Learn About the Process**

Learn more about the Sunset review process on the Texas Sunset Advisory Commission website.

Read the Self-Evaluation Report (PDF) HHSC submitted to the Sunset Advisory Commission on Aug. 29, 2025.

**HHSC Seeks Public Input for Budget Request by Nov. 24**

The Texas Health and Human Services Commission is working on its Legislative Appropriations Request (LAR) for the 90th Texas Legislature, which starts in January 2027.

Hearing from the people we serve, and our partners is a critical part of developing our budget request and public comments are open. The deadline for comment is Nov. 24.

The LAR will outline the agency's funding needs for the 2028-2029 biennium. The due date for submission of the LAR can vary but is typically in August before the legislative session.

Let HHSC know what you believe should be in the 2028-2029 request by submitting your ideas and recommendations to CFOStakeholderFeedback@hhs.texas.gov.

Please include the following in your email:

- Your name or the name of your organization and a contact person.
- A clear, concise description of the recommendation.
- What need would be addressed by this recommendation.
- The expected impact or benefit to the state or the people we serve.

HHSC will review and consider all submissions as it develops the LAR.

**4. HHS Chief Ethics Officer presentation on conflict-of-interest requirements**. For the presentation materials please follow the link.

Kathy Montalbano introduced a new federal rule requiring committee conflict of interest disclosure. Members are expected to review agendas and disclose conflicts prior to meetings, recusing themselves as appropriate.

A video presentation by David Reisman, HHS Chief Ethics Officer, was presented and covered:

- Rules on official representation, confidential information, disclosure, misuse of government property, honoraria, lobbying, Open Meetings Act requirements, bribery, and public servant definitions.
- Emphasis on transparency, recusal for direct private/financial interests, and required completion of Open Meetings and Public Information Act training.

**~~5. Discussion and consideration of the draft revisions and updates to the MCAC bylaws~~. This item was tabled**

**6. Hospital Payment Advisory Committee (HPAC) update**.

- Nine new members were introduced;
- Rural Health Transformation Program applications have closed, and rural hospitals are awaiting funding decisions
- Updates on Medicaid supplemental programs (CHRP, AHPRCA), payment timelines, and upcoming reductions tied to federal requirements.
- Inpatient rebasing is planned for 2027 after 2025 cost reports are reviewed.
- Disproportionate Share Hospital program may see changes in payment schedule, with concerns about rural hospital cash flow.
- Next HPAC update in Feb 2026.

**7. Beneficiary Advisory Council (BAC) update**. The second meeting of the council was held Nov 4. The timing is set to precede full MCAC meetings by one week.

They discussed ways to engage Medicaid service users and their families with an ; emphasis on clear and accessible program communications. They received feedback on Medicare-Medicaid dual demo transition materials.

**8. Dual Demonstration update**. Leslie Reid Director of Program Policy Office of Policy Medicaid and CHIP Services

**In Summary**. The presentation focused on the transition from MMP (Medicare-Medicaid Plan) model to integrated D-SNP (Dual Eligible Special Needs Plan) model in select counties (Bexar, Dallas, El Paso, Harris, Hidalgo) starting Jan 1, 2026.

Integrated D-SNPs will align Medicare and Medicaid coverage under the same parent company, but not all services paid by one entity as before.

MMP ends Dec 31, 2025; affected members will be auto enrolled in new plan unless they opt out by Nov 30. Providers must ensure credentialing with new integrated D-SNPs to continue serving members.

HHSC hosting provider and member webinars (Nov 18 & 20) and updating public web resources for transition information. Lessons learned from the demonstration included: graduated implementation, focusing on member/ public education, incremental expansion after evaluation.

**Presentation.**

**Dual-Eligible Options for STAR+PLUS Members**

- Dual-eligible = Medicare + Medicaid benefits
- Medicare options for dual-eligible STAR+PLUS members in all Texas counties:
- Original (fee-for-service) Medicare
- Medicare Advantage Plan (MAP)
- Dual-Eligible Special Needs Plan (D-SNP)
- Demonstration (pilot) program for Medicare & Medicaid services in Bexar, Dallas, El Paso, Harris, and Hidalgo counties: Medicare-Medicaid Plan (MMP)

**CMS Rule & HHSC Decision** The Centers for Medicare & Medicaid Services (CMS) Contract Year 2023 Medicare Advantage and Part D Final Rule

- End Dual Demonstration MMPs on December 31, 2025
- Begin operating a new Integrated D-SNP model by January 1, 2026

Integrated D-SNP model and multi-phase implementation in the Demonstration Counties -- Bexar, Dallas, El Paso, Harris, and Hidalgo.

**Integrated D-SNP Model (In Demonstration Counties Only)**
Medicare-led exclusively aligned enrollment (EAE) model ( EAE is when a member's STAR+PLUS plan aligns with the D-SNPs affiliated Medicaid STAR+PLUS plan offered by the same organization as the D-SNP

D-SNPs and affiliated STAR+PLUS MCOs will implement integrated Medicare-Medicaid:

- Appeals and grievances processes
- Member materials

Texas-specific D-SNP-only contracts

Any organization that operates an Integrated D-SNP may not operate coordination-only (CO) D-SNPs for full duals in a demonstration county

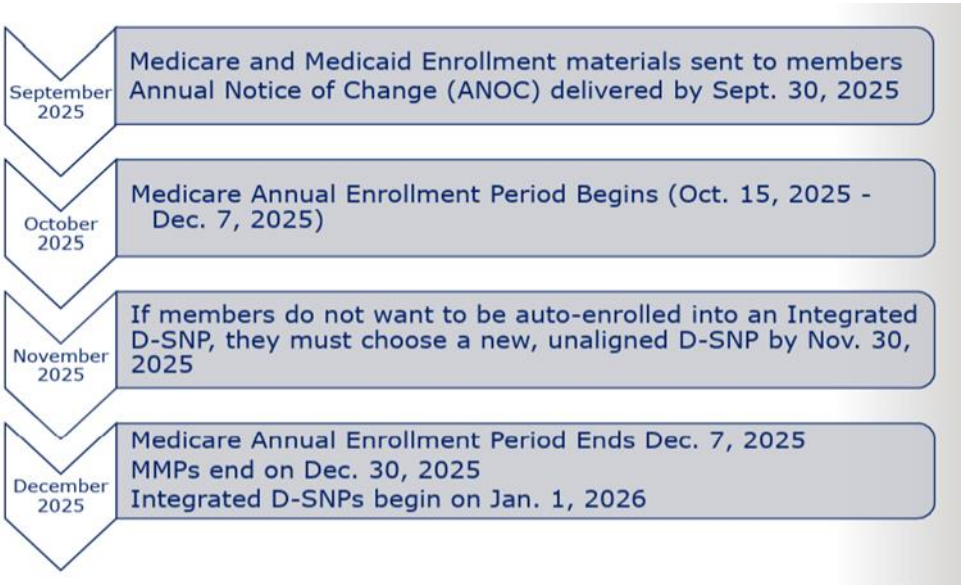
**Transition Milestones**

- Dec. 31, 2025: End Dual Demonstration and MMPs
- Jan. 1, 2026: Begin Integrated D-SNP model for former MMPs with Medicare-led EAE into STAR+PLUS
- Jan. 1, 2027: Parent companies of remaining STAR+PLUS plans begin operating Integrated D-SNP model
- Future Steps – HHSC will analyze data for the Integrated D-SNP model to inform future integration

**Member Impacts**

- Streamlined processes for Medicare and Medicaid services under one parent organization
- EAE: comprehensive and coordinated enrollment
- Integrated member materials will help enrollees to:
    - Better understand and access benefits
    - Coordinate benefits and appeals
    - Improve member outcomes
- Full duals may transfer to a new D-SNP to stay with current STAR+PLUS plan
- HHSC will allow existing members to remain in their coordination-only D-SNPs in 2026

**Timeline for Picking a Health Plan**




**Member Contacts for Questions**

Questions about Medicaid eligibility?- Call 2-1-1- Log into YourTexasBenefits.com

Questions about Medicaid enrollment?

- Log into YourTexasBenefits.com and select “Medicaid and CHIP Services”
- Call Enrollment Broker (800) 964-2777
- They are ready to help from 8 a.m. to 6 p.m. Central Time, Monday through Friday

Questions about Medicare plan changes?

- Medicare via 1-800-MEDICARE (1-800-633-4227)
- Teletypewriter users should call 1-877-486-2048

**Provider Impacts**

- Providers must be contracted and credentialed with the health plans if they wish to serve members enrolled with these plans
- Health plans have been looking into their provider networks to ensure providers are appropriately contracted − Providers are encouraged to verify credentials with the health plan
- Providers may receive questions from members impacted by a plan change

**Provider Impacts: Health Plans** The impacted health plans for the 2026 transition include:

- Bexar County: Molina Healthcare of Texas
- Dallas County: Molina Healthcare of Texas and Superior HealthPlan
- El Paso County: Molina Healthcare of Texas
- Harris County: Molina Healthcare of Texas and UnitedHealthcare Community Plan of Texas
- Hidalgo County: Molina Healthcare of Texas and Superior HealthPlan

**Crossover Claims** -- MMPs pay all crossover claims for their members. With the Integrated D-SNP model, the Texas Medicaid & Healthcare Partnership (TMHP) will pay for Medicare crossover claims when the Medicaid benefit exceeds the Medicare benefit. Integrated D-SNPs will pay for a member's Medicare cost-sharing

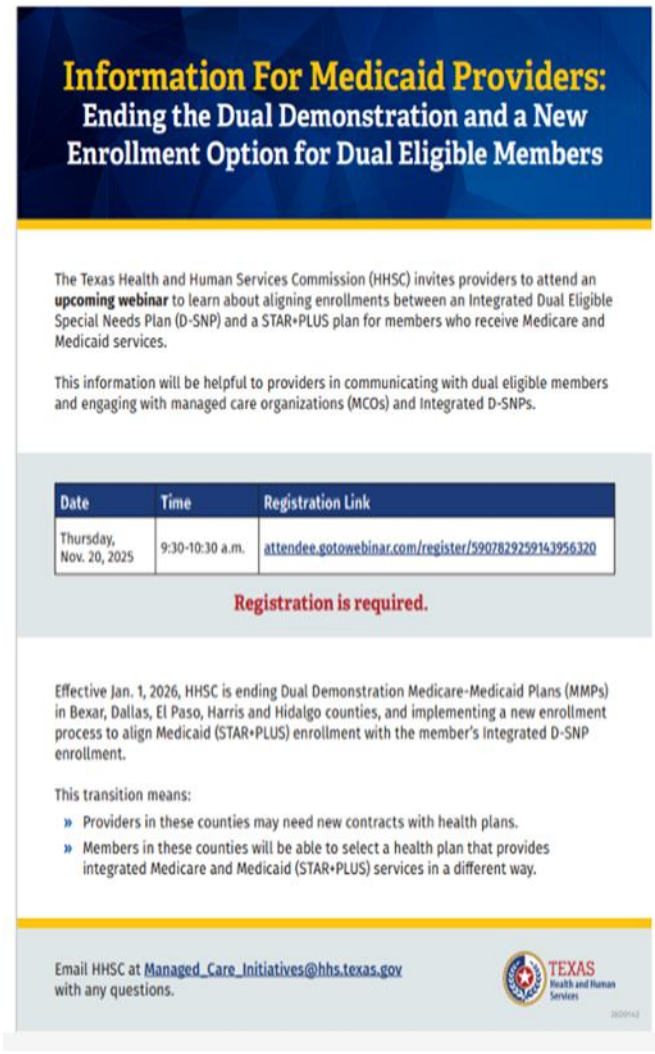
Continuity of Care As members transition out of an MMP and into a new plan, MCOs must ensure that: Current services continue without interruption at the same level of service for the shortest period of one of the following:

- up to six months after the member transfers
- until the new MCO completes all required assessments, a service plan, and issues new authorizations

Next Steps

- Complete updating HHSC IT systems
- Finalize updates to HHSC's Enrollment Broker contract
- Policy and rule changes
- HHSC public website updates
- Continue health plan workgroups
- Informational webinars for providers and members
- Continue implementation collaboration:
  - MMPs, D-SNPs, and STAR+PLUS MCOs
  - Advisory committees 13
  - Providers and members

**Provider Webinar:**



## Information For Medicaid Providers: Ending the Dual Demonstration and a New Enrollment Option for Dual Eligible Members

The Texas Health and Human Services Commission (HHSC) invites providers to attend an **upcoming webinar** to learn about aligning enrollments between an Integrated Dual Eligible Special Needs Plan (D-SNP) and a STAR+PLUS plan for members who receive Medicare and Medicaid services.

This information will be helpful to providers in communicating with dual eligible members and engaging with managed care organizations (MCOs) and Integrated D-SNPs.

| Date | Time | Registration Link |
|---|---|---|
| Thursday, Nov. 20, 2025 | 9:30-10:30 a.m. | attendee.gotowebinar.com/register/5907829259143956320 |

**Registration is required.**

Effective Jan. 1, 2026, HHSC is ending Dual Demonstration Medicare-Medicaid Plans (MMPs) in Bexar, Dallas, El Paso, Harris and Hidalgo counties, and implementing a new enrollment process to align Medicaid (STAR+PLUS) enrollment with the member's Integrated D-SNP enrollment.

This transition means:

- Providers in these counties may need new contracts with health plans.
- Members in these counties will be able to select a health plan that provides integrated Medicare and Medicaid (STAR+PLUS) services in a different way.

Email HHSC at Managed_Care_Initiatives@hhs.texas.gov with any questions.

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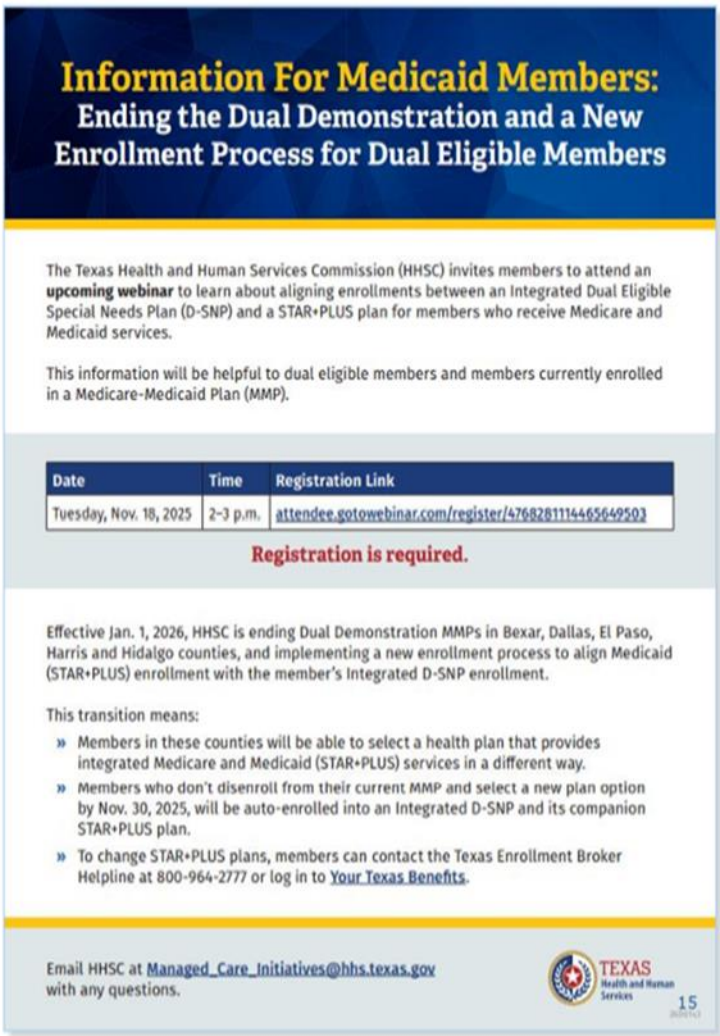
**Member Webinar:**



## Information For Medicaid Members: Ending the Dual Demonstration and a New Enrollment Process for Dual Eligible Members

The Texas Health and Human Services Commission (HHSC) invites members to attend an **upcoming webinar** to learn about aligning enrollments between an Integrated Dual Eligible Special Needs Plan (D-SNP) and a STAR+PLUS plan for members who receive Medicare and Medicaid services.

This information will be helpful to dual eligible members and members currently enrolled in a Medicare-Medicaid Plan (MMP).

| Date | Time | Registration Link |
|---|---|---|
| Tuesday, Nov. 18, 2025 | 2-3 p.m. | attendee.gotowebinar.com/register/4768281114465649503 |

**Registration is required.**

Effective Jan. 1, 2026, HHSC is ending Dual Demonstration MMPs in Bexar, Dallas, El Paso, Harris and Hidalgo counties, and implementing a new enrollment process to align Medicaid (STAR+PLUS) enrollment with the member's Integrated D-SNP enrollment.

This transition means:

- Members in these counties will be able to select a health plan that provides integrated Medicare and Medicaid (STAR+PLUS) services in a different way.
- Members who don't disenroll from their current MMP and select a new plan option by Nov. 30, 2025, will be auto-enrolled into an Integrated D-SNP and its companion STAR+PLUS plan.
- To change STAR+PLUS plans, members can contact the Texas Enrollment Broker Helpline at 800-964-2777 or log in to Your Texas Benefits.

Email HHSC at Managed_Care_Initiatives@hhs.texas.gov with any questions.

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**Discussion**.

Please speak to the "learnings" we had from the previous demonstrations. HHSC stated that the transitions should be small at first. People who have chosen an integrated model will have that and we started small before expansion. We have learned that webinars are important to inform people on how the dual system works in Texas.

## 9. Senate Bill 1, 89th Texas Legislature, Regular Session, 2025, General Appropriations Act, Article II - HHSC Rider 23 project update on Attendant Rate  Increases and Individual Cost limit changes

**In Summary.** An overview of 2026-2027 General Appropriations Act Rider 23 was presented. The rider raised average wage for personal attendants to $13/hour, ended ACRE program; and required a biannual cost reports to demonstrate compliance.

Rider 25: Increased nursing facility rates for dietary and admin costs.

SB 457: Ended Direct Care Staff Ratio Enhancement Program, with a resulting new patient care expense ratio established.

Attendant rate increases affect multiple waiver/non-waiver programs. Cost reporting was standardized to state fiscal year; providers must meet new direct care staff wage/benefits expense ratios or be publicly reported. Waiver cost limits were increased, with a new methodology and amounts for CLASS, DBMD, HCS, and Texas Home Living programs.

CMS approved related waiver and state plan amendments with effective date September 1, 2025;HHSC expedited provider communications and form updates both of which have been completed.

Consumer Directed Services plans must be revised to reflect new rates by end of January 2026.

Managed care organizations (MCOs) are required to update rates, reprocess claims as needed, and communicate changes to providers. HMOs; can create their own rate enhancement programs.

**23. Base Wage Increase for Personal Attendant Services**.

(a) Included in the amounts appropriated above in Goal A, Medicaid Client Services, Strategy D.2.3, Behavioral Health Waiver & Amendment, and Strategy F.1.2, Non-Medicaid Services, is $470,883,027 from the General Revenue Fund and $716,822,548 from Federal Funds ($1,187,705,575 from All Funds) in fiscal year 2026 and

$494,762,919 from the General Revenue Fund and $753,159,237 from Federal Funds ($1,247,922,156 from All Funds) in fiscal year 2027 to increase the base wage for personal attendant services to $13.00 per hour, increase the associated payroll costs, taxes, and benefits percentage to 15.0 percent for services provided in residential settings and 14.0 percent for services provided in non-residential settings, and increase the associated administrative rate by $0.24 per hour.

(b) The Health and Human Services Commission (HHSC) shall utilize any funds that were previously expended for the attendant compensation rate enhancement programs for the base wage increase described in subsection (a) and shall discontinue the attendant compensation rate enhancement programs for community care services, intermediate care facility services, and intellectual and developmental disability services.

(c) Out of funds appropriated in Strategy B.1.1, Medicaid & CHIP Contracts and Administration, HHSC shall continue to collect biennial cost reports from providers to monitor the average hourly wage and associated payroll costs, taxes, and benefits. HHSC shall calculate for each provider the total amount that was paid to the provider that is attributable to the direct care wages, payroll costs, taxes, and benefits, the amount expended by the provider for that purpose, and the ratio of expenses to revenue to determine a direct care wage and benefits expense ratio. HHSC shall report to the Legislative Budget Board, the Lieutenant Governor, the Speaker of the House of Representatives, and the Office of the Governor on an annual basis by November 1 of each year on the findings, including a list of providers whose calculated direct care staff wage and benefits expense ratio is less than 0.90.

Senate Bill 1 (Texas Legislature 2025) and HHSC Rider 23 provided appropriations to increase personal attendant rates and discontinue the Attendant Care Rate Enhancement (ACRE) programs. This affected waivers including CLASS, DBMD, HCS, Texas Home Living (TXHML), STAR+ HCBS, and MDCP. The rate increases also impact state plan and non-waiver services (Primary Home Care, Community Attendant Services, Family Care, HCBS ,Title 20 DAHS and Residential Care, ICFs, and Nursing Facilities).

Cost limits for IDD waivers were raised as follows:

- DBMD and CLASS: $114,736.07 → $149,774
- Texas Home Living: $17,000 → $31,684

- HCS: varied based on Level of Need (e.g., limited LON 1/5/8: $167,468 → $169,182; pervasive plus LON 9: $305,877 → $392,318)

CMS approved waiver and state plan amendments with an effective date of September 1, 2025; CLASS, DBMD, HCS, Texas Home Living, MDCP, amendments were all approved in late August 2025. Related rules in the Texas Administrative Code were updated with the new cost limits, and these became effective September 17, 2025. Information letters and provider/MCO notices were sent out to communicate these changes.

Multiple webinars were held for FMSAs, Texas Home Living HCS, local authorities, and the IDD System Redesign Advisory Committee throughout June–July 2025. Weekly updates were provided to external stakeholders during late August–early September 2025 and calls and notices were issued to providers, MCOs, and others regarding implementation status and CMS approvals. GovDelivery alerts were sent regarding form revisions.

**HHSC Communications.**

**Direction on Implementation of Medicaid Waiver Cost Limit and Rate Changes Effective Sept. 1, 2025**

On Aug. 28, 2025, HHSC published the following information letters (ILs) on the intellectual and developmental disability waiver cost limit increases, discontinuation of Attendant Care Rate Enhancement, and individual plan of care revision process to update attendant rates effective Sept. 1, 2025: Deaf Blind with Multiple Disabilities IL 2025-22, Community Living Assistance and Support Services IL 2025-23, Home and Community-based Services IL 2025-21, and Texas Home Living IL 2025-19.
Please review the ILs for more information on implementation of these changes and where to direct questions.

**Updated ICF/IID and STAR+PLUS Fee Schedules for Personal Attendant Services Payment Rates**

HHSC has published updated fee schedules for Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions (ICF/IID) and STAR+PLUS - Home and Community-Based Services Assisted Living, regarding the approved payment rates for personal attendant services in various programs.

The HHSC Provider Finance Department (PFD) webpage has more information about the approved payment rates.

If you have further questions, email HHSC PFD, Long-term Services and Supports (LTSS), Center for Information and Training, or call us at (737) 867-7817.

## Presentation

The 2026-27 General Appropriations Act (GAA), Senate Bill (S.B) 1, 89th Texas Legislature, Regular Session, 2025 did the following:

- Article II, HHSC, Rider 23 provided appropriations for the Health and Human Services Commission (HHSC) to increase the average wage for personal attendant services under Medicaid and other programs administered by HHSC and discontinue the Attendant Care Rate Enhancement (ACRE) program effective September 1, 2025.
- Article II, HHSC, Rider 25 provided appropriations for reimbursement rate increases for nursing facilities to fund dietary and administrative costs for nursing facilities.

S.B. 457, 89th Legislature, Regular Session, 2025 discontinues the Direct Care Staff Rate Enhancement program and requires the establishment of a Patient Care Expense Ratio.

The programs impacted by attendant rate increases include:

- Community Living Assistance and Support Services (CLASS)
- Deaf Blind with Multiple Disabilities (DBMD)
- Home and Community-based Services (HCS)
- Texas Home Living (TxHmL)
- STAR+PLUS Home and Community-Based Services (STAR+PLUS HCBS)
- Medically Dependent Children Program (MDCP)

The attendant rate increases also impacted the following state plan and non-waiver services:

Medicaid state plan services

- Primary Home Care, Community Attendant Services and Family Care
- Home and Community-Based Services Adult Mental Health program (HCBS-AMH)

- Intermediate Care Facility for Individuals with an Intellectual Disability or Related Condition (ICF/IID)

**Establishment of Average Hourly Wage and End Date of Personal Attendant Base Wage.** Rider 23(a) directed HHSC to implement rates for personal attendant services that support an average wage of $13.00 per attendant hour assumed in the billing unit with either a 14 or 15 percent increase for payroll taxes and Medicare/Federal Insurance Contributions Act (FICA) taxes and benefits. In addition, there was a $0.24 per hour assumed in the billing unit increase for the administrative rate component.

HHSC published fee schedules for rates effective September 1, 2025, on the HHSC Provider Finance website . HHSC also published Information Letter (IL) 2025-17, regarding "Payment Rate Actions for Attendant Services in Various Programs, effective September 1, 2025".
https://pfd.hhs.texas.gov/long-term-services-supports
Information letter: il2025-17.pdf

Providers have the flexibility to pay attendant staff through any type of compensation, subject to payroll taxes, including regular wages, overtime, and non-hourly compensation such as bonuses.

HHSC will utilize biennial cost reports to calculate the direct care staff wage and benefits expense ratio for each provider and publish a report that includes a list of providers whose calculated direct care staff wage and benefits expense ratio is less than 0.90.

**Revised Cost Reporting Requirements** HHSC adopted an amendment to 1 Texas Administrative Code (TAC) Sections 355.102, 355.105, and 355.305, which all have provisions related to cost reporting and upcoming cost reports.

HHSC requests cost reports from providers contracted to provide identified services through either HHSC or a Managed Care Organization (MCO).

HHSC collects non-Medicaid and Medicaid cost reports on a varying frequency, with some reports collected quarterly, annually, or biennially. For cost reports collected biennially, some cost reports are collected for even years, while other cost reports are collected for odd years.

**Discontinuation of the Attendant Compensation Rate Enhancement Program** Rider 23(b) discontinued the ACRE program on August 31, 2025. HHSC implemented this requirement by repealing 1 TAC 355.112. HHSC published IL 2025-11, "Discontinuation of the Attendant Compensation Rate Enhancement Program and Rate Increase for Attendant Services, Effective September 1, 2025". Note: Managed care organizations (MCOs) and Medicare Medicaid Plans (MMPs) may choose to administer their own attendant rate enhancement programs.

**Cost Limit Revisions** As part of the intellectual and developmental disabilities (IDD) waiver amendments for CLASS, DBMD, HCS, and TxHmL, HHSC increased the individual cost limits. The new cost limits for the IDD waivers are:

- For DBMD and CLASS, HHSC updated the individual cost limits from $114,736.07 to $149,774.
- For TxHmL, HHSC updated the individual cost limit from $17,000 to $31,684.

For HCS, HHSC updated the individual cost limit based on level of need (LON) as described below:

- Intermittent (LON 1), Limited (LON 5), and Extensive (LON 8) -- The amount increased from $167,468 to $169,182.
- Pervasive (LON 6) -- The amount increased from $168,615 to $211,822.
- Pervasive plus (LON 9) --The amount increased from: $305,877 to $392,318.

**1915 (c) Waiver Amendments** HHSC submitted waiver amendments to the Centers for Medicare & Medicaid Services (CMS) to amend the attendant rates with a requested effective date of September 1, 2025. HHSC received approval from CMS on the following dates:

- CLASS amendment approved on August 28, 2025
- DBMD and HCS amendments approved August 27, 2025
- TxHmL and MDCP waiver amendments approved August 22, 2025.

**State Plan Amendments** HHSC submitted the state plan amendments before the requested effective date of September 1, 2025. On August 29th, 2025, CMS approved the 1915i Adult Mental Health Home and Community-based Services (HCBSAMH) state plan amendment with a September 1, 2025, effective date.

**Rule Amendments** The Texas Administrative Code chapters 259, 260, 262 and 263 for DBMD, CLASS, HCS and TxHmL have been updated to include the new individual cost

limit dollar amount and methodology. The rules became effective on September 17, 2025.

On Aug. 28, 2025, HHSC published the following information letters:

- Deaf Blind with Multiple Disabilities IL 2025-22, il2025-22.pdf
- Community Living Assistance and Support Services IL 2025-23 il2025-23.pdf ,
- Home and Community-based Services IL 2025-21, il2025-21.pdf and
- Texas Home Living IL 2025-19 il2025-19.pdf

Form revisions were complete by September 3, 2025

**Impacts to Individuals Self Directing Services** In both fee-for-service (FFS) and managed care, service plans that include Consumer Directed Services (CDS) must be updated. In FFS, service coordinators or case managers are required to manually update the amounts, billed in dollars to reflect the updated rates.

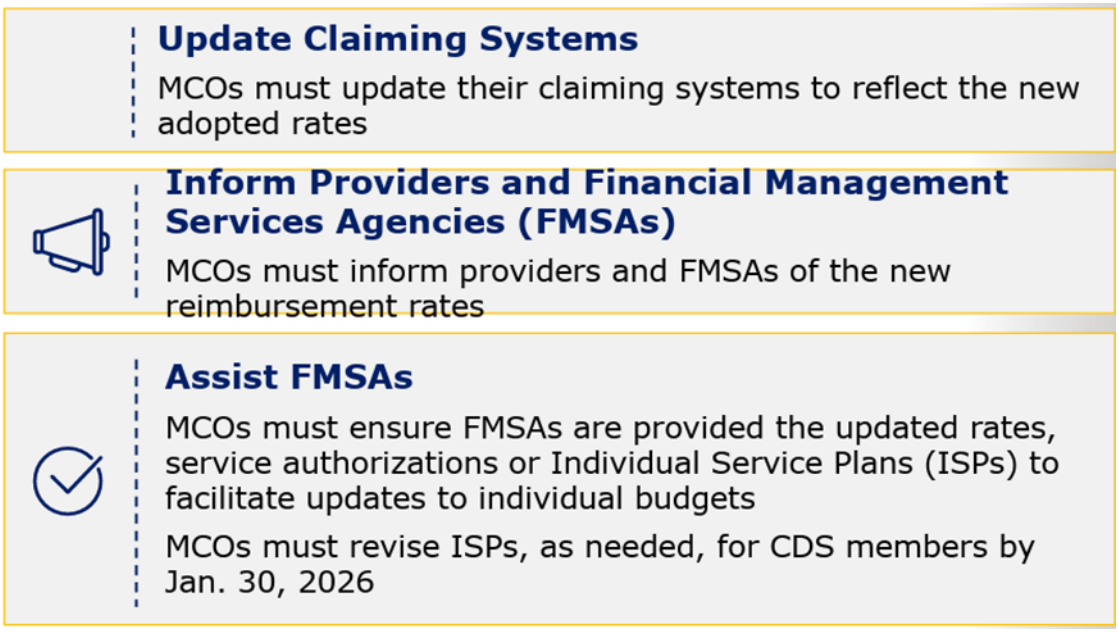
Plan revisions must be submitted by January 31, 2026 for FFS and January 30, 2026 for managed care. Individuals utilizing the CDS option must also revise the CDS budget workbook. To allow for an expedited review of changes, a plan revised to reflect increased rates must not include any other type of revision.

## Managed Care Impacts

**MCO & Provider Impacts**

- MCOs and MMPs may choose to administer their own rate enhancement program
- HHSC contract amendments
- MCO claims systems
- MCO contracts with providers
- Provider reimbursement adjustments
- STAR+PLUS HCBS and MDCP cost limits have increased

**Actions Required by MCOs**




**Discussion**

If there is a time span between a prior cost report and an upcoming cost report, the report will not be collected for that gap. The cost reports will be collected for 2025 for two provider types. For Fiscal 26 the cost reports will be collected in 2027. The timeline for these is on the HHSC website.

The cost limits and the rate increases were effective September 1.

**10. Discuss MCAC Rule Project**. Rules will be updated to align with federal regs; The MCAC committee will be renamed Medicaid Advisory Committee (MAC), and the HPAC will no longer be a subcommittee of the MAC.

The rule changes include informal and formal comment periods; rule changes clarify member requirements, travel reimbursement, and reporting.

**11. MCAC annual report discussion (report required by 42 Code of Federal Regulations Section 431.12(i))**

There is a new Annual Report Requirement. The new requirement for MAC and BACare to submit a joint annual report to HHSC, including activities, discussions, recommendations, and HHSC responses. The report is to be written by the Committee and not HHSC. A template was shared and the first report is due July 2026 and will be discussed further at Feb 2026 meeting.

Below is a possible template for the new required report.

# Medicaid Advisory Committee Annual Report Required Elements

## Annual Report

**For the period of:** Fill in time frame of the report

**1. Introduction**

A brief summary of the of the Medicaid Advisory Committee (MAC) and Beneficiary Advisory Council (BAC) yearly activities, topics discussed, and recommendations

**2. Quarterly Review**–Fill in key activities/topics that were discussed at these meetings.

**BAC August 5, 2025**
- Placeholder text

**MAC August 14, 2025**
- Placeholder text

**BAC November 4, 2025**
- Placeholder text

**MAC November 13, 2025**
- Placeholder text

**MAC February 12, 2026**
- Placeholder text

**3. Committee Recommendations**
- Placeholder text

**HHSC Responses:**

**Conclusion**

Placeholder to summarize the activities/recommendations of the committee.



**Discussion**. This can be discussed at the next meeting.

## 12. Healthy Texas Women (HTW) Post Award Forum update.

**In Summary**: The annual required public forum was conducted, and a report and comment period were provided. HTW eligibility criteria, goals, and current enrollment (395,000) were reviewed. The program covers broad preventive, reproductive, and postpartum services (HTW Plus), including mental health and chronic conditions.

HHSC received five-year approval for HTW demonstration extension (July 2025–June 2030); transitioning to managed care model to improve coordination, outcomes, and cost-effectiveness.

Evaluation is ongoing via UT Health; future reports will study service delivery changes, cost, quality, and value-based payment arrangements. In addition, CMS monitoring/reporting requirements have been updated with, new templates and annual/quarterly cadence to begin in 2025/2026.

**Presentation**.

The HTW program is dedicated to:

- Offering family planning and primary health care services at no cost to eligible Texas women.
- Enhancing women's health care services by increasing access to and participation in the HTW program.
- Providing free health and family planning services to low income women ages 15 to 44 who qualify. (15 to 17 year-old women are not part of the HTW demonstration).
- Goals of the HTW Demonstration can be found here: https://www.hhs.texas.gov/regulations/policiesrules/waivers/healthy-texas-women-1115-demonstration

**HTW Services:**

- Pregnancy testing
- Pelvic exams
- Sexually transmitted infection services
- Breast and cervical cancer screenings
- • Clinical breast examination
- Mammograms
- Screening and treatment for cholesterol, diabetes, high blood pressure
- HIV screening
- • Contraceptives

**HTW Extension Approval** HHSC submitted the HTW demonstration extension request to the Centers for Medicare and Medicaid Services (CMS) on March 28, 2024. CMS granted a six-month temporary extension of the HTW demonstration through June 30, 2025 approving the HTW demonstration extension request on June 27, 2025. The approved demonstration period is effective July 1, 2025, through June 30, 2030.

The CMS Approved Changes include: the granted authority for HHSC to transition HTW to a managed care model once HHSC fully transitions to this model; and transitioning HTW into managed care to improve continuity of care across a woman's life cycle, increase access to preventive health care, contraceptives and screenings for cancer and chronic conditions.

**Amendment Update**

**HTW Plus Amendment**

In accordance with S.B. 750, 86th Legislature, Regular Session, 2019, HHSC submitted a request to CMS, seeking to amend the HTW 1115 Demonstration to add an enhanced, cost effective, and limited postpartum care services package. HHSC implemented the new services package known as HTW Plus on September 1, 2020, and submitted an amendment in December 2020. CMS approved federal funding for these limited postpartum care services as part of the HTW extension approval.

**External Evaluation** The purpose is to examine the state's progress on the goals of the HTW demonstration. The main components include:

- Access to and utilization of covered services
- Women's health outcomes
- Provider and client experiences with HTW
- Effective use of public funds
- Impact of provider eligibility criteria

The Summative Evaluation Report for DYs 1-5 under the prior demonstration is due June 2026.

Evaluation Reports for DYs 6-11 under the approved demonstration renewal:

- Interim Evaluation Report - June 2029*
- Summative Evaluation Report - December 2031*

(*Target dates are pending based on CMS approval of evaluation design.)

**External Evaluation**

Evaluation Design Plan is due to CMS by December 23, 2025

Proposed Evaluation Changes During the Extension Period:

- Update current study design to evaluate the transition to managed care
- New evaluation components address:

- Addition of HTW Plus postpartum services;
- Use of value-based payment arrangements;
- Implementation of the overall HTW Demonstration, including client and provider experiences and Demonstration costs

**Monitoring Changes** CMS issued a new monitoring approach to section 1115 demonstrations. Updated aspects of demonstration monitoring for the HTW demonstration include:

- Reporting cadence and due date
- CMS prescribed monitoring report template
- Demonstration monitoring calls
- Budget neutrality reporting cadence

The HTW 1115 Demonstration DY5 2024 Annual Report can be found here: https://www.hhs.texas.gov/regulations/policiesrules/waivers/healthy-texas-women-1115-demonstration

HHSC will update the HTW 1115 Demonstration web page with information about future waiver amendments and public forums: https://www.hhs.texas.gov/regulations/policiesrules/waivers/healthy-texas-women-1115-demonstration

For more information about Healthy Texas Women Visit: Home | Healthy Texas Women
Submit an electronic application for HTW at: Your Texas Benefits - Learn

To learn about benefits or if you need help with your application, you may email: healthytexaswomen@hhsc.state.tx.us

**A time for public comment was offered but there was no public comment.**

**Discussion**. No discussion

## 13. Public comment. No verbal public comment was offered

## 14. Review of action items and agenda items for future meeting.

Upcoming meetings

- February 12, 2026, Public Hearing Room 125, 1st Floor 701 West 51st Street, Austin, Texas 78751
- May 19, 2026, Public Hearing Room 125, 1st Floor 701 West 51st Street Austin, Texas 78751
- August 12, 2026, Public Hearing Room 125, 1st Floor 701 West 51st Street, Austin, Texas 78751
- November 12, 2026, Public Hearing Room 125, 1st Floor 701 West 51st Street, Austin, Texas 78751

Discussion of annual report will take place at the February Meeting.

**15. Adjourn**. There being no further business, the meeting was adjourned.