PRIVATE DUTY NURSING, ADEQUACY AND ACCESS TO CARE

Assess the adequacy of reimbursement rates paid for Private Duty Nursing (PDN) relative to the cost of providing the services to include considering the reimbursement rates paid by similarly situated states and market rates in competing settings. Include in this assessment a review of acuity range for patients receiving PDN and ensure policy and reimbursement not only align with acuity but also support recruitment and retention of specialized staff, which directly affects continuity and quality of care. For example, some states use managed care payment methodologies that recognize the costs and needs of PDN within a rate cell/rate group within the capitation, using enhanced risk adjustment and other mechanisms that better align plan payment with PDN service intensity. Other approaches include increased use of modifiers within the PDN rates, more closely aligning with intensity. Any recommendations include statutory changes that ensure managed care payments support timely PDN access statewide, with reporting and oversight necessary to ensure compliance.

Additionally, addressing the adequacy of access to care, as a lack of available in-home private duty nursing services prevents some pediatric patients from receiving necessary care, resulting in higher hospitalization rates. Without sufficient access to in-home care, pediatric patients are required to receive care in hospitals or other institutions at higher rates and for prolonged periods due to the inability to discharge back into the home thus increasing the cost to the state. TAHC&H recommends examining hospitalization rates and discharge delay rates for pediatric patients due to network inadequacy.

HOME-DELIVERED PEDIATRIC THERAPY PAYMENT METHODOLOGY AND RATE ADEQUACY

Study the adequacy and structure of reimbursement for pediatric therapy delivered in the home, including whether the statewide fee schedule and payment methodology appropriately reflect the unique home-based service delivery model. Evaluate the impact of HHSC payment policy changes that shifted home-delivered therapy billing from visits to units of service, including how the change affects reimbursement in light of drive

time and other necessary service components unique to delivering therapy in the home. Assess effects on provider participation, staffing, service availability, continuity of care, and waitlist trends. Consider options to address rate adequacy, including fee schedule updates or targeted adjustments designed to reduce or eliminate waitlists. Provide recommendations for payment policy changes (including any revisions to the units-based methodology.

- **Home-Delivered Pediatric Therapy Access, Waitlists, and Reporting**

Study access to pediatric therapy services delivered in the home, including the size and growth of therapy waitlists and the length of time from assessment/authorization to initiation of treatment. Identify the primary drivers of delays (workforce capacity, provider participation, geographic barriers, administrative processes) and evaluate strategies to reduce or eliminate waitlists. Assess whether access reporting should occur more frequently than annually by requiring standardized quarterly or biannual reporting of: (1) waitlist counts, (2) time from assessment/authorization to start of care, and (3) provider capacity indicators, with consistent statewide definitions. Recommend statutory, rule, contract, and oversight changes needed to improve transparency and timely access, including an implementation timeline.

COMMUNITY CARE RATE

- **Methodology Review**

Study the Medicaid Community Care rate methodology following the 89th Legislature's termination of the attendant rate enhancement program and removal of the state required minimum wage. Evaluate the current two-part rate structure—**Attendant Cost Area (ACA)** and **Service Support**—to determine whether each component appropriately reflects required program costs and aligns with legislative intent. Review whether costs associated with direct service delivery are correctly categorized within ACA and whether the Service Support component reflects true administrative costs. Provide recommendations for statutory, rule, and rate-setting adjustments.

- **Cost Report Validity, Data Buckets, and Uncontrollable Cost Burdens**

Study whether Community Care cost reports provide a valid and complete measure of provider costs for rate-setting and oversight purposes. Evaluate whether cost reports capture:

- All attendant compensation-related costs in the correct "buckets"
- All administrative/service support costs necessary to operate the program, and
- Key cost pressures that providers cannot control

Specifically examine **Electronic Visit Verification (EVV)** cost burdens and whether costs such as **mileage, PPE, and training** that were shifted to the service support portion of the rate now further impact the provider's ability to operate. Recommend cost report revisions, rule changes, and any needed statutory direction to improve data quality and ensure rate components reflect actual allowable costs.

- **1099 Contracting Practices and Compliance with Labor Rules**

Study the use of 1099/independent contractor attendants in Community Care programs and its impact on compliance, access, and the integrity of rate funding. Evaluate the prevalence of contract attendant use, the extent to which it may conflict with U.S. Department of Labor guidance, and whether current state rules and cost reporting adequately identify and prevent inappropriate misclassification of workers. Consider updates to enforcement mechanisms, and cost report requirements to ensure attendants are treated and compensated as employees, including benefits, payroll tax, and protections intended by state and federal law.