Home and Community-Based Services (HCBS) American Rescue Plan Act (ARPA) Provider Retention Payments

Frequently Asked Questions

The FAQ document has been updated to reflect additional questions that were received during the June 8, 2022 webinar. Some questions were similar so HHSC combined the main themes of questions received and provided the answer/response below.

The FAQ has also been updated to reflect an extension of the deadline for the attestation and initial report. It was July 1, 2022 and has been extended to August 15, 2022.

If you have a question not addressed by this document, please contact: PFD-LTSS@hhs.texas.gov.

If you have questions about the HHSC HCBS ARPA spending plan, please contact: Medicaid_HCBS_Rule@hhsc.state.tx.us.

The webinar recording, which includes a step-by-step walk through of the attestation and reporting, is available here: https://attendee.gotowebinar.com/recording/8631581217532733954

HHSC is providing a temporary rate add-on for certain home and community-based services delivered between March 1, 2022 and August 31, 2022. Information regarding the temporary rate add-ons can be viewed here: https://pfd.hhs.texas.gov/long-term-services-supports.

Home and Community-Based Services (HCBS) American Rescue Plan Act (ARPA) Provider Retention Payments

Frequently Asked Questions

For questions related to HCBS ARPA payments made in managed care, please reach out to your managed care organization (MCO) directly. MCO contact information is provided below:

- Aetna – Linda Graves at gravesl@aetna.com
- Amerigroup – Provider Services - 800-454-3730

  Provider Experience Consultants:
  - Deidre Haynie - DFW (Wise, Hood, Denton, Parker, Collin, and Dallas counties) - 682-321-8207
  - Leslie Goffney - Harris - 346-347-2063
  - Jennifer Pena - Bexar/Travis - 210-319-9964
  - Kristal Babino - Jefferson/Harris - 469-984-8671
  - Maribel Martinez - El Paso - 915-330-0004
  - Nancy Belcher - West Rural Service Area/Lubbock/Amarillo/ DFW (Johnson, Dallas, and Tarrant counties) - 325-514-8909

- BlueCross and Blue Shield - TexasMedicaidNetworkDepartment@bcbstx.com or (855) 212-1615
- Community First – ProviderRelations@CFHP.com
- Cook Children's – CCHPProviderRelations@cookchildrens.org
- Driscoll - DHP Provider relations – (956) 632-8308
- Molina – MHTXHomeHealth@MolinaHealthcare.com
- Superior - AM.LTSS@SuperiorHealthPlan.com
- Texas Children's – providerrelations@texaschildrens.org or contact the provider's TCHP Provider Relations Liaison or account representative
- United - Customer Service at 888-787-4107, 8 a.m.–4 p.m. CT, Monday–Friday, or contact their provider advocate

Home and Community-Based Services (HCBS) American Rescue Plan Act (ARPA) Provider Retention Payments

Frequently Asked Questions

The intent of the HCBS ARPA temporary rate add-on is for employers, such as provider agencies and consumer-directed services (CDS) employers, to accrue the additional funds and use the accrued funds for one-time financial compensation for the recruitment and retention of their employees providing direct care services. Providers, as the employers of the direct care staff, must attest they will use the funds for the purpose of one-time financial compensation for recruitment and retention of direct care staff. HHSC considers, for the purposes of the HCBS ARPA Spending Plan, direct care staff to be the attendants and nurses delivering the services for which the add-on is applied and as defined in Texas Administrative Code (TAC) §355.207.

The temporary rate add-on is being applied directly to claims. As system updates are made, paid claims are reprocessed to apply the add-on payment. Claims submitted and processed after the system update will have the add-on applied automatically. Providers and employers do not need to apply for this funding. Providers do not need to include the add-on amounts when entering information for individual plans of care (IPCs) or individual service plans (ISPs). Below are the timelines for system updates:

- Texas Medicaid & Healthcare Partnership (TMHP) Long Term Care (LTC Online Portal - Provider remittance notices will identify the add-on payment by referencing the Information Letter announcing the funding.
    - Day Activity and Health Services (DAHS), Community Living and Support Services Waiver (CLASS), Deaf-Blind with Multiple Disabilities Waiver (DBMD), Home and Community-Based Services Waiver (HCS), and Texas Home Living Waiver (TxHmL) Primary Home Care (PHC) and Community Attendant Services (CAS)- Claims completed reprocessing and the add-on will be applied to claims as they are processed
        - Due to the volume of claims for CAS level 1, non-priority, the claims for this service will complete reprocessing by the end of July 2022.
- Client Assignment and Registration (CARE) System - Due to system limitations, HHSC is not able to identify the add-on amounts in the CARE system. To determine the amount of the add-on, the provider can reference the HHSC fee schedule or subtract the base rate from the total.
    - HCS and TxHmL claims with a date of service March 1, 2022 through April 30, 2022 will be reprocessed by July 31, 2022. Claims filed after July 31, 2022 will have the add-on applied as they are processed.
- TMHP acute care system (Compass 21)
    - Personal Care Services (PCS), Community First Choice (CFC) (non-waiver), and HCBS Adult Mental Health claims will be reprocessed by August 2022. HHSC is working to expedite this process and will provide an update if the date for the system updates is any sooner.
- Managed Care
    - HHSC did not direct MCOs to make payments using a specific

methodology. MCOs must provide the funds to eligible providers. Please work with the MCO you contract with if you have questions about their methodology. STAR+PLUS and Dual Demonstration MCOs will receive a capitation adjustment to reflect the additional of state plan attendant care in August 2022.

Do I have to attest and report for each program and contract I have with HHSC?

A provider delivering services in any of the programs eligible for the provider retention payments must provide an attestation and reports on their level of staffing.

For the attestation and initial report, a provider may need to submit more than once, depending on which program(s) they deliver services through. A provider may submit using their NPI, and the contract(s) associated with the NPI will be deemed in compliance with the attestation and reporting requirement. A provider delivering services in managed care must use their NPI for their attestation and initial report, and all managed care programs will be deemed in compliance with the attestation and reporting requirements. A provider must attest and submit the initial report by August 15, 2022.

The above information will apply to the final report as well, which will be due later in 2022. Pursuant to 1 TAC §355.207, HHSC will provide at least thirty calendar day notice prior to the required deadline for each report.

HHSC will not use the required reports to hold providers accountable on how funds are spent. HHSC is using the reports to gather information regarding providers and CDS employer staff retention rates. Later in this document is information about what attestation is required for each program, including whether a provider needs to attest for multiple locations or multiple contracts. There is additional information available here.

Why does the CDS employer or CDS participant's Legally Authorized Representative (LAR) have to attest and report?

As the employer of record, the CDS employer or their LAR is responsible for determining how the funds will be distributed for recruitment and retention of their employees.

The CDS participant, as the employer of record, may choose to submit the required attestation and reports or work with their Financial Management Services Agency (FMSA) to submit the attestation and reports on the CDS participant's behalf. An attestation does not have to be submitted for each employee of the CDS participant/employer. More information regarding the FMSA's submission template will be provided on the HHSC PFD website by June 24, 2022.

Home and Community-Based Services (HCBS) American Rescue Plan Act (ARPA) Provider Retention Payments

Frequently Asked Questions

How will funds be disbursed to the CDS employer?

CDS employers or their LAR will receive the funds in the same process as provider agencies, the funds will be applied to their claims as they are processed.

ARPA funding was not directed toward FMSA as it was provided as a rate add-on for eligible CDS HCBS claims. Employers must ensure that ninety percent of HCBS ARPA funds are used for one-time financial compensation for recruitment and retention for their direct care staff. CDS employers may choose how to spend the remaining funds including payment to FMSAs to assist in administrative duties related to use of funds.

Will I get confirmation you received my attestation?

HHSC will reach out to all providers and CDS employers who have completed the attestation within 5 business days to confirm the attestation was received correctly. Providers and CDS employers must fill out the attestation completely and click the submit button on the last page to complete submission.

HHSC will provide information listing the providers who have completed the attestation on the HHSC Provider Finance website by June 24, 2022. The list of providers who have submitted will be updated on a regularly basis.

When I provide reporting, is it for all of my contracts?

The report should include information about the entity attesting. For example, if you have a single NPI and are using your single NPI to attest for 9 contracts across 3 programs, you are reporting aggregate information for 9 contracts across 3 programs. If you have 3 NPIs, you will attest once for each NPI and will provide a report about the staffing levels for each NPI.

Do I need to report these funds on my cost report?

The Medicaid cost report collects allowable costs for applicable services and does not collect revenue information. The cost incurred for one-time financial compensation to direct care staff funded by the HCBS ARPA provider recruitment and retention payments can be reported on the 2022 Medicaid cost report. A provider will not have to offset the HCBS ARPA revenue prior to reporting costs on their Medicaid cost report. HHSC will be providing additional guidance in the Medicaid cost report instructions.

By when do the funds have to be spent?

There is no required deadline to expend these funds. HHSC recognizes providers may use different strategies to distribute these funds but encourages payments to go to their direct care workforce quickly.

Home and Community-Based Services (HCBS) American Rescue Plan Act (ARPA) Provider Retention Payments

Frequently Asked Questions

How can I use these funds?

Providers and employers may use multiple strategies to distribute the funds. In the spending plan approved by CMS, HHSC described funds would be used for "one-time financial compensation." Payroll and unemployment taxes and worker's compensation may be included in the 90% spending requirements. Examples of strategies that comply with 1 TAC 355.207 include, but are not limited to:

- Paid time off for a COVID-19 vaccine, COVID-19 exposure, or as a recruitment or retention incentive
- Lump sum bonuses for recruitment and/ or retention
- One-time incentives for recruitment and/ or retention
- A recruitment and retention bonus where one time compensation is provided for recruitment and incentives are provided for retention
- Other strategies provide compensation that will not result in future reductions to hourly wages when the payments are discontinued

There is no restriction on the use of 10 percent of the funds. Providers are prohibited from using 90 percent of ARPA funds to increase hourly wages, including overtime, paid to direct care staff on an ongoing basis.

I contract to provide some of the eligible services, like Day Habilitation. How does this work for contracted services?

Providers may use these funds to provide contracted entities delivering the direct care services with recruitment and retention bonuses.

What about non-Medicaid programs?

Providers and employers in non-Medicaid programs may be eligible for grants appropriated by Senate Bill 8 (87th Legislature, Third Called Session). For more information, please visit https://www.hhs.texas.gov/business/grants/covid-19-healthcare-relief-grants.

Do these payments affect Attendant Care Rate Enhancement?

No. These funds are applied to claims in addition to the rate enhancement add-on. Providers and employers do not need to change any billing activities to receive these funds. HHSC will not hold providers accountable for how funds were used as they do for rate enhancement participants on the Medicaid cost report.

Questions Related to Purpose of the ARPA HCBS Funding

What is the HHSC's ARPA Spending Plan?

Home and Community-Based Services (HCBS) American Rescue Plan Act (ARPA) Provider Retention Payments

Frequently Asked Questions

Section 9817 of the ARPA temporarily increases the Federal Medical Assistance Percentage by 10 percentage points, up to 95 percent, for certain allowable HCBS medical assistance expenditures under the Medicaid program beginning April 1, 2021, and ending March 31, 2022. The Texas Health and Human Services Commission (HHSC) submitted an initial spending plan and narrative to the Centers for Medicare and Medicaid Services on July 12, 2021, and received partial approval on August 19, 2021.

HHSC's HCBS ARPA spending plan, including quarterly updates, can be viewed here.

What are the ARPA HCBS Provider Retention Payments?

HHSC's ARPA HCBS spending plan included recruitment and retention payments for providers delivering attendant and direct care HCBS for retention bonuses or other activities.

HHSC's spending plan requires providers to use at least 90 percent of HCBS ARPA funds for one-time financial compensation for their direct care workforce, including, but not limited to, lump-sum bonuses, retention bonuses, and paid time off to receive a COVID-19 vaccination or to isolate after receiving a positive COVID-19 test.

What Services are eligible for Provider Retention Payments?

HCBS ARPA temporary rate add-on will be applied to HCBS personal attendant and nursing services as defined in 1 TAC 355.207. A list of eligible services are is defined in Section 355.207(b)(1).

An updated service list and fee schedule is available on the Provider Finance Homepage.

What methodology did HHSC use to calculate the HCBS ARPA Temporary Add-on rates?

The methodology is defined in 1 TAC 355.207. HHSC divided the total funds amount for the provider retention payments and allocated it proportionally on a per service basis using HHSC estimate for all service claims to be delivered between March 1, 2022 and August 31, 2022. Rates vary based on service utilization and do not represent a uniform rate increased across all eligible services.

Questions regarding Attestation and Reporting Requirements

What identifying information do I need to include with my attestation and

required reports?

Each attestation and required report must include the following information:

- Provider Doing Business (DBA) Name
- Address
- Contact information (including email and phone number)
- Required unique identifiers (see below for a list by program)

Since different provider types have various unique identifiers, HHSC has developed the following list to aid providers in submitting their required attestation and reports.

HHSC requests that all providers submit two unique identifiers to ensure your organization gets credit for the required attestation and reporting. Please include any two of the following identifiers: HHSC contract number or component code, National Provider Identifier (NPI), or Taxpayer Identification Number (TIN) with the submission. For Consumer Directed Services (CDS) employers, please include your Medicaid Identification number.

If an organization has multiple fee-for-service HHSC contracts, you may only have to complete the required attestation or initial report if you report using NPI. If reporting using NPI, please enter "000000000" into the HHSC contract number or component code field and proceed with entering in an NPI in the appropriate field. (updated 6.2022)

PHC/CAS providers with multiple HHSC contracts must complete an attestation and required reports for each HHSC contract under which services are being delivered between March 1, 2022, and August 31, 2022 unless providers submit identifiers shared by all contracts within an organization (for example NPI).

HCS/TxHmL providers must complete an attestation and required reports for each component code unless providers submit identifiers shared by all component codes/contracts within an organization (for example NPI).

Fee for Service Providers (updated 6.2022)

Program	Unique Identifiers

Home and Community-Based Services (HCBS) American Rescue Plan Act (ARPA) Provider Retention Payments

Frequently Asked Questions

1915(c) Community Living Assistance and Support Services Waiver (CLASS) Provider Agency	**Required (if reporting using NPI, please enter 000000000 in the HHSC contract field and provide an NPI as the identifier in the NPI field)** • HHSC Contract Number **Optional but recommended** • NPI • TIN
CLASS Consumer Directed Services (CDS) Employer	**Required** • HHSC Medicaid Identification number
1915(c) Deaf-Blind with Multiple Disabilities Waiver (DBMD) Provider Agency	**Required (if reporting using NPI, please enter 000000000 in the HHSC contract field and provide an NPI as the identifier in the NPI field)** • HHSC Contract Number **Optional but recommended** • NPI • TIN
DBMD CDS Employer	**Required** • HHSC Medicaid Identification number
1915(c) Home and Community-Based Services Waiver (HCS) Provider Agency	**Required (if reporting using NPI, please enter 000000000 in the HHSC contract field and provide an NPI as the identifier in the NPI field)** • HHSC Component Code **Optional but recommended** • NPI • TIN
HCS CDS Employer	**Required** • HHSC Medicaid Identification number

Primary Home Care/Community Attendant Services (PHC/CAS) Provider Agency	**Required (if reporting using NPI, please enter 000000000 in the HHSC contract field and provide an NPI as the identifier in the NPI field)** • HHSC Contract Number **Optional but recommended** • NPI • TIN
PHC/CAS CDS Employer	**Required** • HHSC Medicaid Identification number
1915(c) Texas Home Living Waiver (TxHmL) Provider Agency	**Required (if reporting using NPI, please enter 000000000 in the HHSC component code field and provide an NPI as the identifier in the NPI field)** • HHSC Component Code **Optional but recommended** • NPI • TIN
1915(c) TxHmL CDS Employer	**Required** • HHSC Medicaid Identification number
1915(i) Home and Community-Based Services – Adult Mental Health (HCBS – AMH) Providers	**Required (if reporting using NPI, please enter 000000000 in the HHSC contract field and provide an NPI as the identifier in the NPI field)** • HHSC Contract Number **Optional but recommended** • NPI • TIN

For providers contracted to deliver HCBS services through STAR+PLUS, STAR Kids and STAR Health, each provider must submit NPI and TIN.

Managed Care Providers

Program	Unique Identifier
STAR+PLUS Day Activity and Health Services (DAHS) or STAR Kids Adult Day Care Provider Agency	**Required** • NPI • TIN • Facility ID
STAR+PLUS Assisted Living Provider	**Required** • NPI • TIN • Facility ID
STAR+PLUS Personal Attendant Services and Nursing - HCBS (S+P Waiver) and Non-HCBS (non-waiver) Provider Agency	**Required** • NPI • TIN
STAR+PLUS Personal Attendant Services and Nursing - HCBS (S+P Waiver) and Non-HCBS (non-waiver) CDS Employer	**Required** • HHSC Medicaid Identification number
STAR Kids or STAR Health Personal Attendant Services and Nursing services (including Medically Dependent Children's Program [MDCP] and Personal Care Services [PCS]) Provider Agency	**Required** • NPI • TIN
STAR Kids or STAR Health Personal Attendant Services and Nursing services (including MDCP and PCS) CDS Employer	**Required** • HHSC Medicaid Identification number

What attestation is required?

All providers who deliver eligible HCBS services with service dates between Match 1, 2022 and August 31, 2022, are required to complete an attestation to describe how they will use funds or face recoupment. The attestation is due by ~~Friday July 1, 2022~~ Monday, August 15, 2022.

Providers must attest to the following:

- A provider must be actively billing Medicaid services.

- A provider must agree to use at least 90 percent of payments made under this section for recruitment and retention efforts for direct care staff delivering HCBS services as defined in 355.207(b).
- A provider must agree payments made under this section can include one-time financial compensation directed toward direct care staff, including lump-sum bonuses, retention bonuses, and paid time off to receive a COVID-19 vaccination or to isolate after receiving a positive COVID-19 test. Funds under this section can be used to support reasonable employer administrative expenses, including payroll taxes and workers' compensation necessary to implement the financial compensation of HCBS direct care staff.

What initial reporting is required?

An initial report detailing the number of filled and vacant personal attendant and nursing staff as of March 1, 2022, is required from all providers who deliver eligible HCBS services with service dates between March 1, 2022, and August 31, 2022. The initial report can be submitted with the required attestation and is due by ~~Friday, July 1, 2022~~ Monday, August 15, 2022.

What final reporting is required?

All providers who deliver eligible HCBS services with service dates between March 1, 2022, and August 31, 2022, are required to complete a final report detailing the number of filled and vacant personal attendant and nursing staff. Providers will have at least 30 days to complete their final report.

How will staff retention be measured? Who is responsible for measuring staff retention rates?

HHSC requires that providers submit two reports regarding the use of funds and retention measures. Required reporting includes furnishing data to document vacancy rates in direct care staff positions, the direct care staff retention percentage, and other indicators related to direct care staff recruitment and retention as defined by HHSC. HHSC will calculate retention measures.

Where can a provider submit the required attestation and reporting?

The attestation and initial reporting can be submitted on the HHSC Provider Website by ~~Friday July 1, 2022~~ Monday, August 15, 2022.

Providers will have at least 30 days to submit the final report.

The required attestation and initial and final reporting can be submitted on the HHSC Provider Finance Website.

How will MCOs have access to the attestations? MCOs must be able to flag providers who have not attested in their claims payment systems.

All attestations and required reporting will be submitted directly to HHSC. MCOs will not need to track providers who have failed to complete attestation and required reporting. HHSC will notify MCOs through existing recoupment processes if a provider is eligible for recoupment due to non-attestation or failure to report.

Will the required reporting referenced in the rules be submitted by providers to HHSC?

Providers will be required to report to HHSC and attest they are using funds according to the intent of HHSC's spending plan. Providers must agree to use at least 90 percent of payments made under this section for recruitment and retention efforts for direct care staff delivering HCBS services. Providers must agree not to use the payments made under this section to increase hourly wages paid to direct care staff on an ongoing basis and limit the funds' use to types of compensation that will not result in future reductions to hourly wages when the payments are discontinued. Providers must submit two required reports pursuant to the proposed Texas Administrative Code Rule.

Are there any reporting requirements for MCOs?

If an MCO chooses to operationalize the provider bonus payments differently than HHSC's fee-for-service processes, additional information may be needed for tracking purposes. However, no additional reporting is required at this time.

Who do I contact if I have questions about required attestation and reporting?

Please direct all questions related to the HCBS ARPA Provider Retention payments to HHSC Provider Finance Department at PFD-LTSS@hhs.texas.gov.

How can I confirm that I submitted the attestation and required reporting correctly? (updated after 6.2022)

HHSC Provider Finance will reach out to each provider within 5 business days of submitting the required attestation and initial or final reports. If you have not received confirmation after 5 business days, please contact HHSC Provider Finance at PFD-LTSS@hhs.texas.gov.

What expectation does HHSC have for MCO monitoring and management of providers? MCOs request clear guidance in writing from HHSC on their expectations on the sections below because this instruction is needed for future audits of MCO claims. It is currently unclear what tools should be

used to ensure providers are meeting the requirements for these payments.

At this time, HHSC does not intend for MCOs to be required to monitor or manage providers. HHSC may request that MCOs share information regarding the additional payments and attestation and reporting requirements with their contracted providers.

Questions Related to the Distribution of Funds

How will funds be distributed?

For fee-for-service providers, HCBS ARPA funds will be distributed on a per claim basis for eligible services provided during March 1, 2022 through August 31, 2022. Providers contracted with a managed care organization (MCO) to provide HCBS services should contact their MCO with any questions about receiving payments.

HHSC's intention is that payments will be made on claims paid between March 1, 2022, through August 31, 2022. Claims may have to be reprocessed if HHSC does not receive final state and federal approvals prior to the beginning of the payment period.

What are the HCBS ARPA add-on rates?

The HCBS ARPA fee schedule is posted on the Provider Finance Website.

Questions Related Use of Funds

Can funds be used for administrative costs such as payroll taxes?

Funds under this section can be used to support reasonable employer administrative expenses, including payroll taxes and workers' compensation necessary to implement financial compensation for HCBS direct care staff.

Can HCBS ARPA funds be used for temporary direct care wage increases as hazard pay rather than one-time or lump-sum bonus payments? (updated 6.2022)

HHSC's spending plan limits the use of funds to one-time financial

compensation for direct care staff delivering HCBS services. Providers are prohibited from using 90% of ARPA funds to increase hourly wages, including overtime, paid to direct care staff on an ongoing basis.

Can HCBS ARPA funds be used to support other recruitment strategies beyond financial compensation for direct care staff, such as hiring on-the-ground recruiters? (updated 6.2022)

HHSC's spending plan require providers to use at least 90 percent of these funds for one-time financial compensation for their direct care workforce, including, but not limited to, lump-sum bonuses, retention bonuses, and paid time off for a COVID-19 vaccination. The 10 percent of these funds may be utilized for administrative purposes.

When must a provider expend all HCBS ARPA funds?

HHSC has not required providers to expend HCBS ARPA funds by a certain deadline. HHSC is urging all providers to expend funds as quickly as possible to meet the intent of the funding. HHSC requires final reporting about the fund's usage by November 30, 2022. However, HHSC has not required that all funds are spent by the time the final report is due.

Can a provider use the HCBS ARPA funds for retrospective costs that have been incurred during the COVID-19 Federally Declared Public Health Emergency (PHE) for recruitment and retention efforts?

Yes, providers have the flexibility to use HCBS ARPA funds made under this section for retrospective costs incurred to support personal attendant and nursing staff retention efforts.

How will one-time payments paid to direct care staff impact providers' requirements under the Fair Labor Standards Act (FLSA)? Would the HCBS ARPA funds used as recruitment bonuses be considered non-discretionary, and would they be considered base pay for the purposes of calculating FLSA overtime for direct care staff?

HHSC believes the requirements for financial compensation for direct care staff in the proposed TAC Rule are flexible enough to allow providers to construct their bonus plans in compliance with FLSA since HHSC is not mandating a particular bonus method.

How did the HCBS ARPA funding affect the capitation rates paid to the MCOs?

The capitation rate adjustments are based on the projected utilization of HCBS services and are consistent with HHSC's rate and fiscal projections informing capitation rates. Adjustments were also made to the administrative portion of the rate to acknowledge the additional administrative expenses an MCO may incur.

Providers may contract with more than one MCO. Would the provider be required to use retention bonuses in the same manner for a different MCO, or do they have the discretion to use dollars in more than one approach from different MCOs?

Providers have discretion in spending the funds. For example, they may offer recruitment bonuses, retention bonuses, paid time off for COVID-19 vaccines and boosters, etc. They must attest that they agree not to use the payments to increase hourly wages paid to direct care staff on an ongoing basis and to limit the use of funds to types of compensation that will not result in future reductions to hourly wages when the payments are discontinued.

Why were HCBS ARPA funds not distributed as lump-sum payments to providers?

HHSC does not have a mechanism to give providers lump-sum payments to reflect service provision during this payment period. Funds were added to MCO rates based on the changes to the fee-for-service fee schedule, not as a directed payment.

Operationalizing payment of the HCBS ARPA funds through claims in managed care creates a lot of administrative challenges. Electronic Visit Verification (EVV) is an example. How do we pay the portion of the claim for this program versus for the entire service once it clears EVV?

HHSC operationalized the payments through claims for HCBS services delivered through fee-for-service. In managed care, HCBS ARPA Provider Retention payments are not considered a directed payment program, and MCOs may choose to operationalize payments through another process. For fee-for-service contracts, HHSC intends to add the additional funds to the claim at payment, in alignment with how the Attendant Care Enhancement Program operates.

Was there consideration of a separate procedure code?

Yes. It was unfeasible given the short duration of the payments.

Is this only for in-network providers? Does the attestation cover non-network providers?

HCBS is not a directed payment program. MCOs may operationalize payments differently than HHSC's fee-for-service processes. HHSC is collecting attestations and reports, so MCOs will not need to collect that information.

HHSC's fee schedule does not always break down the units into 15-minute increments for services in managed care. Will the add-on payments be broken down to the right unit?

HHSC will publish managed care rates in 15-minute increments.

Questions related to Recoupment and Disallowance of Federal Funds

What happens if a provider does not submit the attestation or required reporting?

Providers who do not submit the required attestation, initial report, and final report will be subject to recoupment of all HCBS ARPA funds. Claims will be reprocessed at the non-HCBS ARPA rate that was in effect prior to March 1, 2022.

Will MCOs be required to recoup any payments?

HHSC will notify MCOs through existing recoupment processes if a provider is eligible for recoupment due to non-attestation or failure to report.

If MCOs have to recoup, how will that work? Given the financial audits MCOs receive, we are concerned about the process and keeping everything straight.

HHSC is finalizing fee-for-service procedures and may reprocess the claims without the add-on if a provider does not attest or does not provide the two required reports. The capitation rates include provision for the administrative expense through the variable administrative component to assist with the costs related to implementing these fee schedule changes. MCOs may use the same method as HHSC or use an existing method should the MCO recoup funds.