FISCAL IMPACT REPORT

BILL NUMBER: Senate Bill 140
SHORT TITLE: Medicaid Personal Care SVC. Reimbursement

SPONSOR: Padilla
LAST UPDATE: **ORIGINAL DATE:** 1/28/2026 **ANALYST:** Chenier

APPROPRIATION*
(dollars in thousands)

FY26	FY27	Recurring or Nonrecurring	Fund Affected
	$51,400.0	Recurring	General Fund

*Amounts reflect most recent analysis of this legislation.

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT*
(dollars in thousands)

Agency/Program	FY26	FY27	FY28	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
		$51,360.0	$51,360.0	$102,720.0	Recurring	General Fund
		$128,721.0	$128,721.0	$257,442.0	Recurring	Federal funds
		$40.0	$40.0	$80.0	Recurring	Admin General Fund
		$40.0	$40.0	$80.0	Recurring	Admin Federal Funds
Total		**$180,161.2**	**$180,161.2**	**$360,322.5**	**Recurring**	

Parentheses ( ) indicate expenditure decreases.
*Amounts reflect most recent analysis of this legislation.

Senate Bill 140 duplicates House Bill 83

Sources of Information

LFC Files

Agency Providing Analysis
Health Care Authority

SUMMARY

Synopsis of Senate Bill 140

Senate Bill 140 (SB140) appropriates $51.4 million from the general fund to the Health Care Authority (HCA) to update the Medicaid personal care services fee schedule and increase

Medicaid reimbursement for personal care services.

The bill also requires HCA to establish minimum reimbursement rates for personal care services at $23.50 hourly, excluding gross receipts taxes (GRT), for consumer-delegated personal care services and $19.78 hourly, excluding GRT, for consumer-directed personal care services.

Personal care services provider agencies are required to use at least 70 percent of the Medicaid reimbursement to cover direct care workforce expenditures. Before calculating this amount, the costs of GRT shall be deducted from the total amount of Medicaid reimbursement that the provider agency receives. Providers are required to account for this requirement and provide the accounting to HCA upon request.

This bill does not contain an effective date and, as a result, would go into effect 90 days after the Legislature adjourns, which is May 20, 2026.

FISCAL IMPLICATIONS

The appropriation of $51.4 million contained in this bill is a recurring expense to the general fund. Any unexpended or unencumbered balance remaining at the end of FY27 shall revert to the general fund.

At the blended federal Medicaid matching rate, the appropriation in this bill would leverage $128.7 million in federal revenues, increasing spending on these providers to a total of $180.1 million.

HCA stated that the bill would potentially benefit 28,024 current service recipients in the Community Benefit Program in CY25, and 195 Billing Providers. The fiscal impact analysis relates to the adjustment of Medicaid fee schedules reflecting minimum wage reimbursement to rendering service providers. The fiscal impact analysis also recognizes HCA's need to hire an additional FTE to monitor/administer record-reporting and documentation of PCS reimbursement across Agency-Based providers.

HCA also stated that in CY25, Managed Care Organization reported spending $563.1 million for services directly related to the Act. These included: $333.8 million for Activities of Daily Living (ADL) across 125 provider agencies servicing 17,542 distinct clients; $214.6 million for PCS (HCPCS), and $15.7 million for Assisted Living Waiver Per Diems.

Given HCA's statement that they spent $563.1 million on these agencies in CY25, this rate adjustment would increase spending on PCS by 32 percent. According to HCA PCS rates have been increased by 51 percent over the past 7 years. Additionally, every 1 percent increase in PCS rates equates to $1.3 million in general fund revenue.

SIGNIFICANT ISSUES

Over the past several years, the Legislature has worked to expand access to care by establishing the Health Care Authority, directing one-time funding toward capacity-building initiatives, and raising Medicaid reimbursement rates by about $2.2 billion for hospitals, physical and behavioral health providers, services for individuals with developmental disabilities, and other critical

areas—aimed both at making rates more competitive and ensuring provider stability.

HCA provided the following:

> Personal Care Services currently are not captured by Fee Schedules in the Medicaid Program. Consequently, Managed Care Organizations (MCO) have discretion in reimbursing PCS. The Act would implement Fee schedules for Agency-Based PCS. However, the Act (as currently written) excludes the Self-Directed Community Benefit model as well as the 1915-C Waivers. Consequently, the Act would create disparity between reimbursements of similar services rendered throughout Medicaid programs.
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> The Act requires HCA to establish a minimum fee schedule for reimbursing Personal Care Services. The fee schedule must be established between HCA and CMS. This process is estimated to take between six (6) and twelve (12) months.
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> HCA has published a recommended payment rate via Letter of Direction #59. This Act would provide an increased minimum payment for Consumer Delegated members at $23.50 per hour over the recommended $17.20 per hour. However, the Act would provide a possible decrease for Consumer Directed members at $19.78 per hour, under the recommended rate of $20.40 per hour.
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> The oversight required to ensure that 70 percent of MCO payments go directly to DCWs would be a new function of the Medicaid agency. It would require PCS agencies to report their overhead costs, travel, training, and personal protective equipment costs and the hourly wage they pay. Then that would need to be compared to the MCO reports since MCOs are permitted to negotiate rates. This level of oversight and reporting would require one (1) new Full Time Employee (FTE).
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> In spring of 2024, the federal Centers for Medicare and Medicaid Services (CMS) issued the *Ensuring Access to Medicaid Services* final rule, also known as the Access Rule. The Access Rule requires a payment adequacy minimum performance standard that states must ensure 80% of Medicaid payments go to compensation for direct care workers by July 9, 2030. CMS has yet to publish guidance on the payment adequacy minimum performance standard and how states should implement, monitor and enforce it. CMS has not published clear information as to whether this rule will be enforced in the current administration.

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