LFC Requester:	Eric Chenier

AGENCY BILL ANALYSIS - 2026 REGULAR SESSION

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SECTION I: GENERAL INFORMATION

{Indicate if analysis is on an original bill, amendment, substitute or a correction of a previous bill}

Date Prepared: 1/19/26 **Bill Number:** HB83 **Original** X **Amendment** **Substitute**
Short Title: MINIMUM MEDICAID REIMBURSEMENTS FOR PERSONAL CARE SERVICES
Sponsor: Rep. Rebecca Dow
Name and Code Number: HCA 630
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SECTION II: FISCAL IMPACT

APPROPRIATION (dollars in thousands)

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

(Parenthesis ( ) indicate expenditure decreases)

REVENUE (dollars in thousands)

Estimated Revenue			Recurring or Nonrecurring	Fund Affected
FY26	**FY27**	**FY28**	Recurring	

(Parenthesis ( ) indicate revenue decreases)

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY26	FY27	FY28	3 Year Total Cost	Recurring or Nonrecurring	Fund Affected
	$0.0	$51,360.0	$51,360.0	$102,720.0	Recurring	Program General Fund
	$0.0	$128,721.2	$128,721.2	$257,442.5	Recurring	Program Federal Fund
	$0.0	**$180,081.2**	**$180,081.2**	**$360,162.5**	**Recurring**	**Program Total**
	$0.0	$40.0	$40.0	$80.0	Recurring	Admin General Fund
	$0.0	$40.0	$40.0	$80.0	Recurring	Admin Federal Fund
	$0.0	**$80.0**	**$80.0**	**$160.0**	**Recurring**	**Admin Total**
	$0.0	**$180,161.2**	**$180,161.2**	**$360,322.5**	**Recurring**	**Grand Total**

(Parenthesis ( ) Indicate Expenditure Decreases)

SECTION III: NARRATIVE

BILL SUMMARY

Synopsis: HB83 makes an appropriation of $51.4 million from the General Fund to the Health Care Authority (HCA) for expenditures in FY27 to create the Medicaid personal care services fee schedule and increase Medicaid reimbursement for personal care services pursuant to Section 1 of this act. HB 83 would also require that direct care workers be reimbursed for at least 70% of the payment to the agency. Any unexpended balance remaining at the end of fiscal year 2027 shall revert to the general fund. The fiscal impacts of this Bill relate to HB55 FY25.

FISCAL IMPLICATIONS

The Act would potentially benefit 28,024 current service recipients in the Community Benefit Program in CY 2025, 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.

SIGNIFICANT ISSUES

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.

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.

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.

In CY 2025, 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, CPT 99509), across 125 provider agencies servicing 17,542 distinct clients; $214.6 million for PCS (HCPCS T1019), and $15.7 million for Assisted Living Waiver Per Diems (HCPCS T2031). HCA understands the Act will benefit Medicaid PCS/ADL providers and members from higher reimbursement rates, effectively bolstering the size and quality of the underlying workforce and access to care for a significant number of members.

The oversight required to ensure that 70% 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).

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.

PERFORMANCE IMPLICATIONS

The Act requires HCA implement minimum reimbursement rates for PCS: (1) $23.50/hour and (2) $19.78/hour. Both reimbursement rates exclude GRT. Consequently, GRT is deducted before calculating the minimum Medicaid reimbursements that PCS agencies receive. Also, PCS provider agencies are required to use at least 70% of Medicaid reimbursements to cover direct care workforce expenditures. PCS provider agencies must maintain documentation that 70% (or higher)

of Medicaid reimbursement is spent on direct care workforce expenditures and make these records available to HCA within a reasonable amount of time.

ADMINISTRATIVE IMPLICATIONS
The administrative impact on HCA would be securing federal approval for the general fund for PCS provider wages and direct care workers compensation, identifying affected providers and waiver service categories, and overseeing/monitoring the implementation.

This would require a Medicaid Supplement to providers, a Medicaid Letter of Direction to the MCOs, and MCO Policy Manual update.

ITD would need to provide assistance for any potential system modifications to support the above.

CONFLICT, DUPLICATION, COMPANIONSHIP, RELATIONSHIP
This bill relates to HB55 FY25.

TECHNICAL ISSUES
There are no known technical issues at this time.

OTHER SUBSTANTIVE ISSUES
None at this time.

ALTERNATIVES
N/A

WHAT WILL BE THE CONSEQUENCES OF NOT ENACTING THIS BILL
If this Act is not enacted, there will not be any change to the current reimbursement to PCS providers and the direct care staff. At this time, there is not a minimum fee schedule for Agency-Based Community Benefit services. Rates would continue to be paid at the discretion of the MCOs with guidance from Letter of Direction #59.

AMENDMENTS