El Paso Health
HEALTH PLANS FOR EL PASOANS. BY EL PASOANS.

MEMORANDUM

TO: Valued Long Term Services and Support Providers (LTSS)

FROM: El Paso Health

DATE: 07/18/2024

RE: Fiscal Year 2025 Enhancement for Attendant Compensation-Request for Participation

Fiscal Year 2025 Enhancement for Attendant Compensation – Request for Participation

The Rate Enhancement Attendant Compensation program, overseen by the Health and Human Services Commission (HHSC), provides additional financial support for services rendered by non-medical attendants to Texas Medicaid STAR+PLUS recipients. If your organization employs such attendants, you may qualify to participate in this program. Entities already participating are required to reaffirm their involvement and update any changes annually by September 1st through this form.

For further details on the HHSC program, please visit:
https://pfd.hhs.texas.gov/long-term-services-supports/2025-rate-enhancement-attendant-compensation-information

Due Date:
Please submit this form annually by August 1st to secure benefits for the entire fiscal year. Submissions received after this date will result in rate enhancement payments commencing 30 calendar days following the receipt of the form.

Form Submission:
Mail: El Paso Health – Contracting Department, 1145 Westmoreland Dr., El Paso TX, 79925
Email: Contracting_Dept@elpasohealth.com
Fax: 915-298-7870

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Once we receive your form and confirm your participation in the program, we'll update your El Paso Health STAR+PLUS Agreement with the rate enhancement. If you have any questions, please call your Provider Relations Representative or call us at 915-532-3778.

□ I wish to participate in the FY 2025 (Sept 1 2024 to Aug 31 2025) Attendant Compensation Rate Enhancement Program with El Paso Health STAR+PLUS

Name:_____
Address:_____
City:_____State:_____ZIP Code: _____
Tax ID Number:_____NPI Number: _____
TX Department of Aging and Disability Contract Number: _____
Current Rate Enhancement Level: _____

Please briefly describe how the enhanced rate will benefit your attendants and outline your method for informing them about this rate increase.

_____
_____
_____

Signature:_____ Date:_____
Name: _____ Title: _____

You may locate the Fiscal Year 2025 Enhancement for Attendant Compensation-Request for Participation, EPH Notice FY25 Enhancement for Attendant Compensation.pdf, under Provider tab, Provider forms_Credentialing Packet forms at https://www.elpasohealth.com/providers/forms/#1574278002406-fccc5f2c-ea09.