# TEXAS HEALTH AND HUMAN SERVICES COMMISSION

# PROVIDER FINANCE DEPARTMENT

# Notice of Proposed Adjustments to Fees, Rates or Charges Healthcare Common Procedure Coding System (HCPCS)

## Adjustments are proposed to be effective

## September 1, 2024

## SUMMARY OF PROPOSED ADJUSTMENTS

## To Be Effective September 1, 2024

Included in this document is information relating to the proposed adjustments to Medicaid payment rates for Healthcare Common Procedure Coding System (HCPCS). The Texas Health and Human Services Commission (HHSC) intends to submit an amendment to the Texas State Plan for Medical Assistance under Title XIX of the Social Security Act to update the fee schedules to reflect these proposed adjustments. The rates are proposed to be effective March 1, 2024.

### Hearing

The Texas Health and Human Services Commission (HHSC) will conduct a hearing to receive public comment on proposed Medicaid payment rates detailed in this document on November 14, 2023, at 9:00 a.m. The hearing will be held in compliance with Texas Human Resources Code §32.0282, which requires public notice of and hearings on proposed Medicaid reimbursements. HHSC will broadcast the public hearing; the broadcast can be accessed at https://hhs.texas.gov/about-hhs/communications-events/live-archived-meetings. The broadcast will be archived and can be accessed on demand at the same website.

Due to the declared state of disaster stemming from COVID-19, this hearing will be conducted both in-person and as an online event. Members of the public may attend the rate hearing in person, which will be held in Public Hearing Rooms 1.401, 1.402, 1.403 and 1.404 in the North Austin Complex, 4601 W Guadalupe St, Austin, Texas.

Please register for HHSC Public Rate Hearing for Medicaid Reimbursement Rates on November 14, 2023 9:00 AM CDT at:

https://attendee.gotowebinar.com/register/4417991069141897 2

HHSC will consider all concerns expressed at the hearing prior to final rate approval. This public hearing will be held in compliance with the provisions of Human Resources Code §32.0282 which requires a public hearing on proposed payment rate adjustments. Should you have any questions regarding the information in this document, please contact:

Provider Finance Acute Care Services
Texas Health and Human Services Commission

E-mail: PFDAcuteCare@hhs.texas.gov

HHSC will broadcast the public hearing; the broadcast can be accessed at https://hhs.texas.gov/about-hhs/communications-events/live-archived-meetings. The broadcast will be archived and can be accessed on demand at the same website.

## Background

HHSC is responsible for the reimbursement determination functions for the Texas Medicaid Program. Proposed rates are calculated utilizing established methodologies that conform to the Social Security Act and related federal regulations, the federally approved Texas Medicaid State Plan, all applicable state statutes and rules, and other requirements. HHSC reviews the Medicaid reimbursement rates for all acute care services every two years. These biennial reviews result in rates that are increased, decreased, or remain the same. The reviews are conducted to ensure that rates continue to be based on established rate methodologies.

## Methodology

The specific administrative rules that govern the establishment of the fees in this proposal include these rules in the TAC:

- §355.8061, which addresses outpatient hospital reimbursement; and
- §355.8085, which addresses the reimbursement methodology for physicians and other practitioners; and
- §355.8441, which addresses the reimbursement methodology for early and periodic screening, diagnosis, and treatment services (EPSDT).

## Proposed Rate Adjustments

A summary of the methodologies used to determine the proposed fee-for-service Medicaid rates is listed below:

- Procedure codes and descriptions used in the Texas Medicaid Program are national standard code sets as required by federal laws; Healthcare Common Procedural Coding System (HCPCS) and Current Procedural Terminology (CPT).

- Resource-based fee (RBF) methodology uses relative value units (RVUs) established by Medicare times a conversion factor. Current conversion factors include $28.0672 for most services provided to children 20 years of age and younger and $26.7305 for services provided to adults 21 years of age and older. Fees for services provided to children and identified as having access-to-care issues may be assigned a higher conversion factor, currently $30.00.
- Access-based fees (ABFs) allow the state to reimburse for procedure codes not covered by Medicare or for which the Medicare fee is inadequate, or account for particularly difficult procedures, or encourage provider participation to ensure access to care.
- ABFs may also be established based on the Medicare fee for a service that is not priced using RVUs. Physician-administered drug pricing methodologies are outlined in §355.8085.
- For services and items that are not covered by Medicare or for which the Medicare rate is insufficient, different approaches are used to develop fees based on available information. These alternate methods include, as applicable:
  - The median or mean of the Medicaid fees from 14 states (the 10 most populous and the 4 bordering Texas) or the median or mean of the states that cover the service
  - Regional Medicare pricing from Novitas or a percentage of the Medicare fee
  - The current Medicaid fee for a similar service (comparable code)
  - 82 percent of the manufacturer suggested retail price (MSRP) supplied by provider associations or manufacturers
  - 89.5 percent of the average wholesale price for enteral and parenteral products
  - Cost shown on a manufacturer's invoice submitted by the provider to HHSC

Specific proposed payment rate adjustments are listed in the attachments outlined below:

HCPCS Att C(7a) – Q1 HCPCS TOS 1 Non-Drugs
HCPCS Att C(7b) – Q1 HCPCS TOS F

## **Written Comments**

Written comments regarding the proposed payment rate adjustments will be accepted in lieu of, or in addition to, oral testimony until 5 p.m. the day of

the hearing. Written comments may be sent by U.S. mail to the Texas Health and Human Services Commission, Attention: Provider Finance Department, Mail Code H-400, P.O. Box 149030, Austin, Texas 78714-9030; by fax to Provider Finance Department at (512) 730-7475; or by e-mail to PFDAcuteCare@hhs.texas.gov. In addition, written comments will be accepted by overnight mail or hand delivery to Texas Health and Human Services Commission, Attention: Provider Finance Department, Mail Code H-400, North Austin Complex, 4601 W Guadalupe St, Austin, Texas 78751.

Persons with disabilities who wish to attend the hearing and require auxiliary aids or services should contact Provider Finance Department at (512) 730-7401 at least 72 hours in advance for appropriate arrangements.

This public rate hearing briefing packet presents proposed payment rates and is distributed at HHSC public rate hearings and posted by the proposed effective date on the HHSC website at https://pfd.hhs.texas.gov/rate-packets. Proposed rates may or may not be adopted, depending on HHSC management decisions after review of public comments and additional information. Provider and public notification about adoption decisions are published on the Texas Medicaid and Healthcare Partnership (TMHP) website at http://www.tmhp.com in banner messages, bulletins, notices, and updates to the Texas Medicaid fee schedules. The fee schedules are available in static files or online lookup at http://public.tmhp.com/FeeSchedules.

**Preferred Communication.** For quickest response please use e-mail or phone, if possible, for communication with HHSC related to this rate hearing.

Persons with disabilities who wish to participate in the hearing and require auxiliary aids or services should contact Provider Finance at (512) 730-7401 at least 72 hours before the hearing so appropriate arrangements can be made.

**HCPCS C(7a) - TOS 1 Non-Drugs (Proposed to be effective September 1, 2024)**

| | | | | | CURRENT | | 9/1/2024 | | Percent Change from Current Medicaid Fee |
|---|---|---|---|---|---|---|---|---|---|
| TOS* | Procedure Code | Long Description | Age Range | Non-Facility (N)/ Facility (F) | Current Medicaid Fee | Current Adjusted Medicaid Fee | Proposed Medicaid Fee | Proposed Adjusted Medicaid Fee | |
| 1 | G0330 | Facility services for dental rehabilitation procedure(s) performed on a patient who requires monitored anesthesia (e.g., general, intravenous sedation (monitored anesthesia care) and use of an operating room | 0-999 | F | Not a Benefit | Not a Benefit | $1,377.94 | $1,377.94 | 100.00% |

| *Type of Service (TOS) | |
|---|---|
| 1 | Medical Services |

** Required Notice: The five-character code included in this notice is obtained from the Current Procedural Terminology (CPT®), copyright 2023 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures performed by physicians. The responsibility for the content of this notice is with HHSC and no endorsement by the AMA is intended or should be implied. The AMA disclaims responsibility for any consequences or liability attributable or related to any use, nonuse or interpretation of information contained in this notice. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained.

**HCPCS Attachment C(7b) - Q1 HCPCS TOS F (Proposed to be effective September 1, 2024)**

| | | | | | | | CURRENT | | 9/1/2024 | | Percent Change from Current Medicaid |
|---|---|---|---|---|---|---|---|---|---|---|---|
| TOS* | Procedure Code | Long Description | Modifier 1 | Age Range | Non-Facility (N)/ Facility | Provider Type/ Provider Specialty | Current Medicaid Fee | Current Adjusted Medicaid Fee | Proposed Medicaid Fee | Proposed Adjusted Medicaid Fee | |
| F | G0330 | Facility services for dental rehabilitation procedure(s) performed on a patient who requires monitored anesthesia (e.g., general, intravenous sedation (monitored anesthesia care) and use of an operating room | | 0-999 | F | 51,52 | Not a Benefit | Not a Benefit | $1,377.94 | $1,377.94 | 100.00% |
| F | 41899 | ** | U3 | 0-999 | F | 51,52 | $585.90 | $585.90 | Not a Benefit | Not a Benefit | -100.00% |

| *Type of Service (TOS) | |
|---|---|
| F | Ambulatory Surgical Center |
| **Modifier** | |
| U3 | Service associated with THSteps |
| **Provider Type** | |
| 51 | Ambulatory Surgical Center - Freestanding/Independent |
| 52 | Ambulatory Surgical Center - Hospital Based |

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