**TEXAS HEALTH AND HUMAN SERVICES COMMISSION**
**PROVIDER FINANCE DEPARTMENT**

**Notice of Proposed Adjustments to the Texas State Plan Attachment 4.19-B pages include the following:**

**(1) Clinical Diagnostic Labs Fees Page 1c**
**(2) Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Page 3a**
**(3) Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services Page 25i**
**(4) Physician and Other Practitioners Page 1a.3**
**(5) Birthing Centers Page 8**

**Adjustments are proposed to be effective March 1, 2025**

## SUMMARY OF PROPOSED ADJUSTMENTS

Included in this document is information relating to the proposed adjustments to the Texas state plan pages. 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.

All proposed changes are provisional, and subject to leadership approval prior to submission to Centers for Medicare & Medicaid Services (CMS).

**Hearing**

The Texas Health and Human Services Commission (HHSC) will conduct a hearing to receive public comment on proposed adjustments to reimbursement rates related to the Texas state plan pages detailed in this document on November 12, 2024, at 9:00 AM. 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.

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 the North Austin Complex (NAC) Public Hearing Room 1.401, 1.402, 1.403 & 1.404 located at 4601 W Guadalupe St, Austin, Texas.

Please register for HHSC November 2024 Public Rate Hearing for Medicaid Reimbursement Rates on November 12, 2024, 9:00 AM CDT at:

https://attendee.gotowebinar.com/register/5854419373469218647

After registering, you will receive a confirmation email containing information about joining the webinar.

HHSC will consider all concerns expressed at the hearing prior to final adjustments 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 changes to payment rates for medical assistance. 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

## 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. Updates to the Texas state plan occur periodically, as required under the state rate review process.

## Proposed Adjustments

A summary of the proposed adjustments to the Texas state plan pages is listed below:

- The effective date and publishing date for each fee schedule.

Specific proposed adjustments to attachment 4.19-B plan pages are listed in the attachments outlined below:

(1) Clinical Diagnostic Labs Fees Page 1c
(2) Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Page 3a
(3) Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services Page 25i
(4) Physician and Other Practitioners Page 1a.3
(5) Birthing Centers Page 8

Proposed adjustments in this packet will subsequently be submitted to CMS for review and approval.

## Written Comments

Written comments regarding the proposed plan page amendments will be accepted in lieu of, or in addition to, oral testimony until approval by CMS. 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 hearing packet presents proposed plan page amendments and is distributed at HHSC public rate hearings and posted on the HHSC website at https://pfd.hhs.texas.gov/rate-packets. Proposed plan page amendments may or may not be adopted, depending on HHSC or CMS 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.

**3. Clinical Diagnostic Laboratory Services**

Medicaid providers of clinical diagnostic laboratory (CDL) services are reimbursed based on fee schedules as follows:

(a) The Texas Department of State Health Services (DSHS) Laboratory provides Early and Periodic Screening, Diagnostic and Treatment (EPSDT) medical and newborn screening services through a federal freedom-of-choice exemption as well as any other laboratory services provided that are not covered by this exemption. The DSHS laboratory is reimbursed for all laboratory services provided at a percentage of the Medicare fees.

(b) Sole community hospitals are reimbursed the lesser of their billed charges or the fee determined by HHSC, which is a percentage of the Medicare fee. The Medicaid fee for any new procedure codes added during the year will be based on a percentage of the Medicare fees in effect as of January 1 of that same year.

(c) The remaining providers of these services are reimbursed the lesser of their billed charges or the fee determined by HHSC, which is a percentage of the Medicare fee. The Medicaid fee for any new procedure codes added during the year will be based on a percentage of the Medicare fees in effect as of January 1 of that same year.

(d) The reimbursement methodologies in 3(a) – (c) ensure that Medicaid payments to these providers for these services meet the upper payment limit requirements in Section 1903(i)(7) of the Social Security Act by requiring that Medicaid payments for clinical laboratory services must not exceed the Medicare fee for the service on a per test basis. This provision does not apply to the DSHS laboratory reimbursement, Rural Hospitals, or Sole Community Hospitals, which will be established at a percentage of the Medicare fee.

(e) All fee schedules are available through the agency's website as outlined on Attachment 4.19-B, Page 1.

(f) With the exceptions noted on this page in (a) and (b), services related to the testing of COVID-19 (coronavirus), effective March 1, 2024, are reimbursed at 92% of the Medicare rate. Effective September 1, 2024, COVID-19 testing services will fully align with pricing methodologies as outlined in (a) through (e).

(g) The agency's fee schedule was revised with new fees for clinical diagnostic laboratory services effective March 1, 2025, and was posted on the agency's website on or prior to March 15, 2025.

**8. Home Health Services (continued)**

**(b) Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)**

(1) If the item of DMEPOS is covered by Medicare, the Medicaid fee will be equal to or a percentage of the Medicare fee schedule specific to Texas that is available at the time of the fee review unless there is documentation that the Medicare fee is insufficient for the items covered under the procedure code and required by the Medicaid population.

(2) For items of DMEPOS not paid at the Medicare fee, the provider will either be reimbursed a fee determined by HHSC or through manual pricing. The fee determined by HHSC will be based on cost information from providers, manufacturers, surveys of the Medicaid fees for other states, survey information from national fee analyzers, or other relevant fee-related information.

(3) Manual pricing is reasonable when one procedure code covers a broad range of items with a broad range of costs since a single fee may not be a reasonable fee for all items covered under the procedure code, resulting in access-to-care issues. Examples include 1) procedure codes with a description of “not otherwise covered,” “unclassified,” or “other miscellaneous,” and 2) procedure codes covering customized items. If manual pricing is used, the provider is reimbursed either the documented Manufacturer's Suggested Retail Price (MSRP) less 18 percent or the documented Average Wholesale Price (AWP) less 10.5 percent, whichever is applicable. If one of these is not available, the provider's documented invoice cost is used as the basis for manual pricing. AWP pricing is used primarily for nutritional products and DMEPOS items sold in pharmacies.

(4) The Medicaid fees for oxygen equipment, oxygen, and oxygen-related supplies will not exceed the Medicare fee for the same procedure code.

(5) All fee schedules are available through the agency’s website as outlined in Attachment 4.19-B, page 1.

(6) The agency’s fee schedule was revised with new fees for durable medical equipment, prosthetics, orthotics, and supplies effective March 1, 2025, and will be posted on the agency’s website by March 15, 2025.

**32. Reimbursement Methodologies for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services - continued**
**(10) Physician services**

(a) Services reimbursable only for Medicaid-eligible clients under age 21 include:

(1) Vaccines not covered by the Texas Vaccines for Children Program (TVCP) for clients under age 21, which are reimbursed as access-based fees in accordance with Item 1 of Attachment 4.19-B, relating to the reimbursement methodology for physicians and certain other practitioners. Payments based on a fee schedule are made for these services.

(2) Services delivered by school districts, in accordance with Item 32(17) of Attachment 4.19-B, relating to the reimbursement methodology for School Health and Related Services (SHARS).

(b) For dates of service on or after September 1, 2019, the reimbursement for services provided by a therapy assistant will be reimbursed at 80 percent of the rate paid to a licensed therapist for the same services.

(c) All fee schedules are available through the agency's website as outlined in Attachment 4.19-B, page 1.

(d) The agency's fee schedule was revised with new fees for EPSDT physician services effective March 1, 2025. The fee schedule will be posted on the agency website by March 15, 2025.

**1. Physicians and Other Practitioners (continued)**

(f) When a procedure code is nationally discontinued, a replacement procedure code is nationally assigned for the discontinued procedure code, Medicaid implements the replacement procedure code, and a state plan amendment will not be submitted since the fee for the service has not changed.

(g) All fee schedules are available through the agency's website, as outlined in Attachment 4.19-B, page 1.

(h) The agency's fee schedule was revised with new fees for services provided by physicians and other practitioners affiliated with tuberculosis clinics or employed by tuberculosis clinics, effective July 1, 2018. This fee schedule was posted on the agency's website on July 6, 2018.

(i) The agency's fee schedule was revised with new fees for therapy assistants. Effective September 1, 2019, the reimbursement for therapy assistants will equal 80 percent of the payment to a therapist.

(j) The agency's fee schedule was revised with new fees to include peer specialists, effective March 1, 2024. This fee schedule will be posted on the agency's website on or prior to March 15, 2024.

(k) For dates of service on or after February 1, 2021, the reimbursement for services provided by a licensed assistant behavioral analyst will be reimbursed at 80 percent of the rate paid to a licensed behavior analyst.

(l) The agency's fee schedule was revised with new fees for physicians and other practitioners effective March 1, 2025. The fee schedule will be posted on the agency website by March 15, 2025.

**17. Birthing Center Facility Services.**

Medicaid providers of birthing center services are reimbursed based on fee schedules as follows:

(a) Subject to the specifications, conditions, requirements and limitations established by HHSC; payment for covered birthing center services provided by a participating, licensed birthing center is limited to the lesser of the customary charge or the allowable rates per established fee schedule by HHSC.

(b) The fee schedule established by HHSC is based upon: (1) survey of costs to provide the services; (2) review of Medicaid fees paid by other states; (3) Medicaid fees for similar services; (4) Medicare fees; (5) pricing data from commercial carriers; and/or (6) some combination or percentage thereof.

(c) The birth attendant must be a physician or Certified Nurse-Midwife (CNM). The physician or CNM who was the birth attendant must be identified on the birthing center's claim. Prenatal, labor, delivery and postpartum services performed or provided by physicians or CNMs are not considered birthing center facility services.

(d) The birthing center must bill for the services that it provides. Unless approved by the State Agency or its designee, the birthing center may not bill for services provided by another type of provider. If the birthing center bills a single or itemized combined rate, charge, or amount for covered services for two or more providers, payment is the lesser of the single or itemized combined rate, charge or the amount that would have been paid had each performing provider billed separately.

(e) All fee schedules are available through the agency's website as outlined in Attachment 4.19-B, page 1.

(f) The agency's fee schedule was revised with new fees for providers of birthing center services effective for services on or after March 1, 2025. The fee schedule will be posted on March 15, 2025.