TEXAS HEALTH AND HUMAN SERVICES COMMISSION
RATE ANALYSIS DEPARTMENT

Proposed Medicaid Payment Rates for Medicaid Calendar Fee Reviews for Medical Nutrition Therapy and Type of Services 1, 2, I, & T (Medical Services, Surgery, Professional Components, & Technical Components)

Payment rates are proposed to be effective January 1, 2013.

SUMMARY OF PROPOSED MEDICAID PAYMENT RATES

Effective January 1, 2013

Included in this document is information relating to the proposed Medicaid payment rates for Medicaid Calendar Fee Reviews for Medical Nutrition Therapy and Type of Services 1, 2, I, & T (Medical Services, Surgery, Professional Components, & Technical Components). The rates are proposed to be effective January 1, 2013.

Hearing

HHSC will conduct a public hearing to receive comments regarding the proposed Medicaid rates detailed in this document on November 14, 2012, at 1:30 p.m. in the Lone Star Conference Room in Building H of the Braker Center, at 11209 Metric Boulevard, Austin, TX 78758-4021, with entrance through Security at the front of the building facing Metric Boulevard. HHSC will consider concerns expressed at the hearing prior to final rate approval. This public hearing is held in compliance with the provisions of Human Resources Code §32.0282 and 1 TAC §355.105(g), which require a public hearing on proposed payment rates. Should you have any questions regarding the information in this document, please contact:

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Background

The Health and Human Services Commission (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 and clinical laboratory services are reviewed annually. These biennial reviews result in rates that are increased, decreased, or remain the same. The reviews are unrelated to any rate reduction imposed by the legislature but rather 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 Title 1 of the Texas Administrative Code (1 TAC):

- §355.8081, which addresses payments for laboratory and x-ray services,

radiation therapy, physical therapists' services, physician services, podiatry services, chiropractic services, optometric services, ambulance services, dentists' services, psychologists' services, licensed psychological associates' services, maternity clinic services, and tuberculosis clinic services;

- §355.8085, which addresses the reimbursement methodology for physicians and other medical professionals; and

- §355.8441, which addresses the reimbursement methodology for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services.

The reimbursement rates proposed reflect applicable reductions directed by the 2012-2013 General Appropriations Act, H.B. 1, 82nd Legislature, Regular Session. Detailed information related to specifics of the reductions can be found on the Medicaid fee schedules.

Proposed Rates

The methodologies used to determine the proposed fee-for-service Medicaid rates are summarized 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 $28.640 for most services provided to children 20 years of age and younger and $27.276 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.
- 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 Trailblazer
  - The current Medicaid fee for a similar service (comparable code)

- The most recent *HCPCS Fee Analyzer* or the (CPT) *Customized Fee Analyzer*, customized listings of the 25th, 50th, 75th, and 85th percentiles of reimbursement rates charged for each of the procedures in the Healthcare Common Procedure Coding System (HCPCS) and the Current Procedural Terminology (CPT) respectively, in the Dallas area
- 82 percent of the manufacturer suggested retail price (MSRP) supplied by provider associations or manufacturers, except for enteral and parenteral products which are priced at 89.5 percent of AWP
- Cost shown on a manufacturer's invoice submitted by the provider to HHSC

Proposed payment rates are listed in the attachments outlined below:

Attachment 1 – Medical Nutrition Therapy
Attachment 2 – TOS 1, 2, I, T