TEXAS HEALTH AND HUMAN SERVICES COMMISSION
PROVIDER FINANCE DEPARTMENT

Notice of Proposed Adjustments to Fees, Rates or Charges for 2021 Quarterly Healthcare Common Procedure Coding System (HCPCS) Updates

Adjustments are proposed to be effective January 1, 2022

SUMMARY OF PROPOSED ADJUSTMENTS

To Be Effective January 1, 2022

Included in this document is information relating to the proposed adjustments to Medicaid payment rates for 2022 Quarterly Healthcare Common Procedure Coding System (HCPCS) Updates of (1) TOS 0 Blood Products, (2) TOS 1 Physician Administered Drugs, (3) TOS 9 Other Medical Items or Services. 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 January 1, 2022.

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 January 12, 2022, at 2:00 p.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 the Public Hearing Room 125 in the John H Winters Building located at 701 W 51st Street, Austin, Texas.

Please Register for the HHSC Public Rate Hearing for Annual Healthcare Common Procedure Coding System (HCPCS) Updates to be held on January 12, 2022, at 2:00 PM CST at:

https://attendee.gotowebinar.com/register/2693551020086627343
Webinar ID: 246-180-883

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

Should you have any questions regarding the information in this document, please contact:

Provider Finance for Acute Care Services
Texas Health and Human Services Commission
E-mail: PFDAcuteCare@hhs.texas.gov

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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 proposed payment rates were calculated in accordance with Title 1 of the Texas Administrative Code:

§355.8023, Reimbursement Methodology for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS);

§355.8085, which addresses the reimbursement methodology for Physicians and Other Practitioners;

§355.8441, which addresses reimbursement methodologies for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services (known in Texas as Texas Health Steps) and the THSteps Comprehensive Care Program (CCP); and

Proposed Rate Adjustments

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 $28.0672 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
- Rate determination methodologies related to outpatient hospital services are addressed in §355.8061.

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

HCPCS Att 1 – TOS 0 Blood Products
HCPCS Att 2 – TOS 1 Physician Administered Drugs
HCPCS Att 3 – TOS 9 Other Medical Items or Services

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. January 25, 2022**. 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 Guadalupe St, Austin, Texas 78751

Persons with disabilities who wish to attend the hearing and require auxiliary aids or services should contact the Provider Finance Department, (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 http://rad.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. During the current state of disaster due to COVID-19, physical forms of communication are checked with less frequency than during normal business operations. For quickest response, and to help curb the possible transmission of infection, please use e-mail or phone if possible for communication with HHSC related to this rate hearing.

Quarterly HCPCS Attachment B(1) -TOS 0 (Proposed to be effective January 1, 2022)

						CURRENT		1/1/2022		
TOS*	**Procedure Code**	**Long Description**	**Provider Type/ Provider Specialty**	**Age Range**	**Non-Facility (N)/ Facility (F)**	**Current Medicaid Fee**	**Current Adjusted Medicaid Fee**	**Proposed Medicaid Fee**	**Proposed Adjusted Medicaid Fee**	**Percent Change from Current Medicaid Fee**
0	P9025	Plasma, cryoprecipitate reduced, pathogen reduced, each unit		0-999	N/F	Not a Benefit	Not a Benefit	$48.30	$48.30	100.00%
0	P9025	Plasma, cryoprecipitate reduced, pathogen reduced, each unit	51	0-999	N/F	Not a Benefit	Not a Benefit	$48.30	$48.30	100.00%
0	P9025	Plasma, cryoprecipitate reduced, pathogen reduced, each unit	52	0-999	N/F	Not a Benefit	Not a Benefit	$48.30	$48.30	100.00%
0	P9026	Cryoprecipitated fibrinogen complex, pathogen reduced, each unit		0-999	N/F	Not a Benefit	Not a Benefit	$1.09	$1.09	100.00%

***Type of Service (TOS)**	
0	Blood
Provider Type/ Provider Specialty	
51	Ambulatory Surgical Center - Freestanding/Independent
52	Ambulatory Surgical Center - Hospital Based

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Quarterly HCPCS Attachment 2 - TOS 1 Drugs (Non-Oncology, Oncology, Vaccines & Toxoids) (Proposed to be effective January 1, 2022)

					CURRENT		1/1/2022		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	J0699	Injection, cefiderocol, 10 mg	18-999	N/F	$1.94	$1.94	$1.94	$1.94	100.00%
1	J7294	Segesterone acetate and ethinyl estradiol 0.15mg, 0.013mg per 24 hours; yearly vaginal system, each	0-999	N/F	$2,508.00	$2,508.00	$2,508.00	$2,508.00	100.00%
1	J7295	Ethinyl estradiol and etonogestrel 0.015mg, 0.12mg per 24 hours; monthly vaginal ring, each	0-999	N/F	$195.16	$195.16	$195.16	$195.16	100.00%
1	J9318	Injection, romidepsin, non-lyophilized, 0.1 mg	0-999	N/F	$32.62	$32.62	$32.62	$32.62	100.00%
1	J9319	Injection, romidepsin, lyophilized, 0.1 mg	0-999	N/F	$32.63	$32.63	$32.63	$32.63	100.00%
1	90671	***	18-999	N/F	Not a Benefit	Not a Benefit	$216.04	$216.04	100.00%
S	90671	***	18-20	N/F	Not a Benefit	Not a Benefit	$216.04	$216.04	100.00%
1	90677	***	18-999	N/F	Not a Benefit	Not a Benefit	$236.94	$236.94	100.00%
S	90677	***	18-20	N/F	Not a Benefit	Not a Benefit	$236.94	$236.94	100.00%

*Type of Service (TOS)	
1	Medical Services
S	THSTEPS Medical

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Quarterly HCPCS Attachment 3 - TOS 9 (Proposed to be effective March 1, 2022)

					CURRENT		3/1/2022		
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	Percent Change from Current Medicaid Fee
9	K1022	Addition to lower extremity prosthesis, endoskeletal, knee disarticulation, above knee, hip disarticulation, positional rotation unit, any type	0-999	N/F	Not a Benefit	Not a Benefit	$529.93	$529.93	100.00%

*Type of Service (TOS)	
9	Other Medical Items or Services

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