Attachment C – Question 19 a, b, c, and d.
19. If the State is seeking prior approval for a uniform dollar or percentage increase (option c in Question 16), please address the following questions:
a. Will the state require plans to pay a uniform dollar amount or a uniform percentage increase?

The state is utilizing different payment requirements for the respective components of the program. The uniform dollar amount in Component 1 functions as a prospective payment to address fluctuations in funding that often occur in rural settings and a payment methodology to promote access to primary care services. The uniform rate increase in Component 2 will be applied specifically to the most frequently utilized primary and preventive care services. The payments will be triggered by successfully meeting program quality requirements that incentivize improvements in primary care.

b. What is the magnitude of the increase (e.g., $4 per claim or 3% increase per claim?)
Component 1

- $75.11 add-on per service billed as T1015 or Office Visit codes for freestanding rural health clinics (RHCs)
- $44.03 add-on per service billed as T1015 or Office Visit codes for hospital-based RHCs

Component 2

- 10.77% increase per T1015 or Office Visit claim for all RHCs. The percentage rate increase is applied to the individual MCO-adjudicated claim without the Component 1 payment. ~~These numbers are estimations but will be finalized in June.~~

c. Describe how will the uniform increase be paid out by plans (e.g., upon processing the initial claim, a retroactive adjustment done one month after the end of quarter for those claims incurred during that quarter).

A minimum of 30 Medicaid managed care encounters in the data year (March 1, 2019 to February 29, 2020) is required for program eligibility for all payment Components.

A. Component 1 will be a uniform dollar increase. Freestanding and hospital-based RHCs will receive a uniform dollar increase for All-Inclusive Clinic Visit (T1015) and Office Visit codes. In this preliminary calculation, payments are based on the adjusted SFY20 (March 1, 2019 – February 29, 2020) ~~the~~ count of claims for services provided and will be paid prospectively every month (equal to 1/12 of the annual amount) based on the historical utilization of the codes from the same SFY20 and trended forward with anticipated membership growth to SFY23 among the three Medicaid Managed Care populations (STAR, STAR+PLUS, and STAR Kids). ~~Final numbers will be provided in June.~~ All-Inclusive Clinic Visit (T1015) and Office Visit codes were determined using the adjusted SFY20 MCO claims payments for the STAR, STAR+PLUS, and STAR Kids programs. This methodology translates to approximately $75.11 add-on per unit for freestanding RHCs and approximately $44.03 add-on per unit for hospital-based RHCs. A reconciliation to actual utilization will occur at the end of the program period.

B. Component 2 will be a uniform percentage increase. Freestanding and hospital-based RHCs will receive a uniform percentage increase for All-Inclusive Clinic Visit (T1015) and Office Visit MCO payments for the STAR, STAR+PLUS, and STAR Kids programs. For Component 2, the uniform percent increase will be ~~approximately~~ 10.77% per T1015 or Office Visit claim for all RHCs. The percentage rate increase is applied to the individual MCO-adjudicated claim without the Component 1 payment.

Payments will be made as part of the MCO processing the initial claim and thus will be based on SFY 2023 claims.

d. Describe how the increase was developed, including why the increase is reasonable and appropriate for network providers that provide a particular service under the contract.

The T1015 and Office Visit codes represented 83% of the modified period MCO claims in the STAR, STAR+PLUS, and STAR Kids programs for freestanding and hospital-based RHCs. Narrowing the eligible codes to All-Inclusive Clinic Visit (T1015) and Office Visit will make the payments easier to operationalize. In addition, the two classes of RHCs targeted are (1) hospital-based RHCs, which include non-state government-owned and private RHCs, and (2) freestanding RHCs.

For Components 1 and 2, Texas believes that reimbursing RHCs utilizing the Medicare cost reports under the RHC demonstration model is reasonable and appropriate; thus, the program aims to reimburse the participants for the difference between the Medicare rates and MCO payments. The calculated Medicare rate from the most recently submitted Medicare cost report will be applied at the procedure code and modifier level to determine the difference in the Medicare rates and the MCO payments. Rural hospitals have closed at an unprecedented rate in the last five years, leaving rural health clinics an even more critical component in meeting healthcare needs in rural areas. This DPP will provide additional funding to assist these key providers and help maintain access to services for Medicaid beneficiaries residing in rural areas of the state.