TEXAS HEALTH AND HUMAN SERVICES COMMISSION
RATE ANALYSIS DEPARTMENT

Proposed Medicaid Payment Rates for Medicaid Calendar Fee Reviews for Anesthesia, Birthing Centers, Cardiovascular System Surgery, Digestive System Surgery, Eye and Ocular Adnexa Surgery, G Codes (screening, mammography, vessel mapping, and ultrasound), Nervous System Surgery, Proton Therapy, and Urinary System Surgery

Payment rates are proposed to be effective July 1, 2012

SUMMARY OF PROPOSED MEDICAID PAYMENT RATES

Effective July 1, 2012

Included in this document is information relating to the proposed Medicaid payment rates for Medicaid Calendar Fee Reviews for Anesthesia, Birthing Centers, Cardiovascular System Surgery, Digestive System Surgery, Eye and Ocular Adnexa Surgery, G Codes (screening, mammography, vessel mapping, and ultrasound), Nervous System Surgery, Proton Therapy, and Urinary System Therapy. The rates are proposed to be effective July 1, 2012.

Hearing

HHSC will conduct a public hearing to receive comments regarding the proposed Medicaid rates detailed in this document on May 15, 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):

- §355.8001, which addresses the reimbursement methodology for vision care services**;**

- §355.8021, which addresses the reimbursement methodology for home health services and durable medical equipment, prosthetics, orthotics and supplies**;**

- §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, including medical services, surgery, assistant surgery, and physician administered drugs/biologicals; medical services, surgery, assistant surgery, radiology, laboratory, and radiation therapy;

- §355.8181, which addresses the reimbursement methodology for birthing center services;

- §355.8441, which addresses the reimbursement methodology for durable medical equipment and expendable supplies in Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program (known in Texas as Texas Health Steps); and

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.
- Manual pricing is used for any procedure code when a wide range of products or services are covered by a procedure code with a wide range of costs. Manual pricing is always used for miscellaneous procedure codes, which are established to allow payment for necessary services or products that are not adequately described by any other procedure code.
- For Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS), participating providers are reimbursed the lesser of the billed amount or the Medicaid reimbursement rate. The Medicaid reimbursement rate is usually a percentage of the Medicare reimbursement rate for the procedure code on the Medicare fee schedule specific to Texas that is available at the time of the review unless that rate is insufficient for the items covered under the procedure code that are required by the Texas Medicaid population.
- 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.
  - Physician-administered drugs are reimbursed at 85 percent of the average wholesale price (AWP) for drugs and biologicals over 12 months old. Drugs and biologicals that are less than 12 months old, vaccines and infused drugs are reimbursed at 89.5 percent of AWP.
  - 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.
  - Most recent American Dental Association *Survey of Dental Fees* for the West South Central region (which includes Texas).
  - 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 – Anesthesia
Attachment 2 – Birthing Centers
Attachment 3 – Cardiovascular System Surgery
Attachment 4 – Digestive System Surgery
Attachment 5 – Eye and Ocular Adnexa Surgery
Attachment 6 – G Codes (screening, mammography, vessel mapping, and ultrasound)
Attachment 7 – Nervous System Surgery
Attachment 8 – Proton Therapy
Attachment 9 – Urinary System Therapy