# TEXAS HEALTH AND HUMAN SERVICES COMMISSION
# RATE ANALYSIS DEPARTMENT

## Proposed Medicaid Payment Rates for Medicaid Biennial Calendar Fee Review for:

## (1) Family Planning
## (2) General and Integumentary System Surgery
## (3) Orthotics and Prosthetics
## (4) Physician Administered Drugs – Oncology
## (5) Physician Administered Drugs – Nononcology
## (6) Respiratory Therapists

**Payment rates are proposed to be effective**
**October 1, 2014**

## SUMMARY OF PROPOSED MEDICAID PAYMENT RATES

## Effective October 1, 2014

Included in this document is information relating to the proposed Medicaid payment rates for Medicaid Biennial Calendar Fee Review for (1) Family Planning, (2) General and Integumentary System Surgery, (3) Orthotics and Prosthetics, (4) Physician Administered Drugs – Oncology, (5) Physician Administered Drugs – Nononcology, and (6) Respiratory Therapists. The rates are proposed to be effective October 1, 2014.

### Hearing

The Health and Human Services Commission (HHSC) will conduct a public hearing to receive comments regarding the proposed Medicaid rates detailed in this document on August 21, 2014, at 1:30 p.m. in the Public Hearing Room in the Brown-Heatly Building at 4900 North Lamar Boulevard, Austin, Texas 78751, with entrance through Security at the front of the building facing Lamar 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 the Texas Administrative Code, Title 1 (1 TAC), §355.201, 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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HHSC also will broadcast the public hearing; the broadcast can be accessed at http://www.hhsc.state.tx.us/news/meetings.asp. The broadcast will be archived and can be accessed on demand at the same website.

### 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 specific administrative rules that govern the establishment of the fees in this proposal include these rules in 1 TAC:

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

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

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

- §355.8581, which addresses the reimbursement methodology for Family Planning Services.

## 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 $28.0672 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.
- 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

- 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
- 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

Proposed payment rates are listed in the attachments outlined below:

CFR Attachment 1 – Family Planning
CFR Attachment 2 – General and Integumentary System Surgery
CFR Attachment 3 – Orthotics & Prosthetics
CFR Attachment 4 – Physician Administered Drugs – Oncology
CFR Attachment 5 – Physician Administered Drugs – Nononcology
CFR Attachment 6 – Respiratory Therapists