Texas Administrative Code
Title 1. Administration
Part XV. Texas Health and Human Services Commission
Chapter 355. Medicaid Reimbursement Rates
Subchapter J. Purchased Health Services
Division 4. Medicaid Home Health Program
§355.8021. Reimbursement Methodology for Home Health Services

ADOPTION PREAMBLE

The Health and Human Services Commission (HHSC) adopts an amendment to §355.8021 with changes to the proposed text published in the May 17, 2002, issue of the *Texas Register* (27 TexReg 4250).

The justification for the amendment is to replace the current reasonable cost principles reimbursement methodology with a fee schedule developed by HHSC and updated every four years for the various therapy, nursing and aide services provided under the Texas Medicaid Home Health program. The initial fee schedule is based upon an analysis of current payments with input from home health providers and is intended to be budget neutral.

During the comment period, comments were received from the Texas Association for Home Care, a hospital representative, and an individual. The following is a summary of comments received and the commission's response to each comment.

Comment: The rule should be reformatted into (A) and (B) only to make it read a bit clearer.

Response: The commission disagrees with this comment as it believes that the current format is clear.

Comment: The commission should publish the initial fee schedule as part of the preamble.

Response: The commission agrees. The initial fee schedule is as follows:

Skilled Nursing Visit - $100.94
Physical Therapy Visit - $116.36
Occupational Therapy Visit - $118.62
Speech Language Pathology Visit - $119.61
Aide Visit - $47.03

Comment: "I am offering these comments in order to clarify the intent of the commission staff when this rule was developed. I am a former employee of the Health & Human Services Commission and was largely responsible for conducting the analysis that underlies the proposed recommendation. I was also the leader of the workgroup comprised of industry and association representatives that oversaw the transition from a previously cost-based reimbursement system to that of a prospective fee schedule.

"The main changes that I am recommending are the references in the proposed rule that states that the initial, and subsequent, fee schedules are based upon an analysis of the cost of the various services. The analysis to create the initial fee schedule was based upon an averaging of Medicaid payments to selected high-volume providers. The confusion has occurred because these payments were determined based upon Medicare's definition of reasonable cost, as it existed prior to October 1, 2000. However, a primary objective in making the transition to a fee

schedule was that it would be budget neutral. Hence, the analysis must necessarily be based upon the payment system that was in place at the time of the transition.

"As to subsequent analysis, while the costs of providing the various services should certainly be included, Medicare cost reports will no longer be available, which was the tool that the state relied upon as the basis for its historical payment system. To base subsequent payments only on a review of cost will likely place an undue burden on the state in the way audit functions and allowable cost determinations, the elimination of which was a major reason for the transition (sic). The state should also have the latitude to look at the current market for these services as the basis for payment.

"My specific recommendations to clarify the rule are: 1) #2(B) delete 'and each fee schedule developed under this paragraph'. This paragraph relates only to the development of the weighted Average Rate for the initial fee schedule. #2(B)(i) change to 'The WAR is based on a representative sampling of Medicaid payments to … a "high-volume" Medicaid providers is a provider that is identified in at least the top 25% of Medicaid payments for these services.' Change "for the most recent twelve months of available data" to "for the most recent six months of available data." The analysis was performed on 6 months of data available at the time of the workshops and there was consensus that this was an adequate period. #2(C) change "rebasing" to 'HHSC will conduct an analysis.'"

Response: The commission agrees with the commenter's suggestions and has made the suggested changes.

Comment: The commission should change the definition of "high volume provider" in (a)(2)(A)(i) to "For purposes of this paragraph, a "high-volume" Medicaid provider is a provider that is identified in at least the top 45% of Medicaid payments for these services for the most recent six months of available data."

Response: The commission agrees, as the data used in developing the initial fee schedule was based upon providers identified in the top 45%. During the comment period, the Texas Association for Home Care requested a review of the payments to the sampled providers, and this review demonstrated that the high-volume Medicaid providers were in the top 45% of Medicaid payments for those services and time period.

In addition, the commission has revised the text in subsection (a)(2)(C) to clarify the data that will be used in future analyses.

The amendment is adopted to be effective September 1, 2002, under the Texas Government Code, §531.033, which provides the Commissioner of HHSC with broad rulemaking authority; Human Resources Code, §32.021 and the Texas Government Code, §531.021(a), which provide the Health and Human Services Commission (HHSC) with the authority to administer the federal medical assistance (Medicaid) program in Texas; and the Texas Government Code, §531.021(b), which provides HHSC with the authority to propose and adopt rules governing the determination of Medicaid reimbursements. The amendment implements the Government Code, §§531.033 and 531.021(b).

§355.8021. Reimbursement Methodology for Home Health Services.

(a) Reimbursement methodology for services provided by a home health agency.

(1) Except for expendable medical supplies and DME, authorized home health services provided for eligible Medicaid recipients are reimbursed the lesser of:

(A) the amount billed to Medicaid by the agency; or

(B) the fee established for the specific authorized home health service and published as part of a fee schedule developed by the commission in accordance with paragraph (2) of this subsection.

(2) HHSC will establish a fee schedule for Medicaid-reimbursable therapy, nursing, and aide services provided by a home health agency in accordance with this paragraph.

(A) HHSC bases the initial fee schedule upon an analysis of providers' Medicaid payments for providing Medicaid-reimbursable therapy, nursing, and aide services.

(B) HHSC calculates a Weighted Average Rate (WAR) for the initial fee schedule developed under this paragraph.

(i)The WAR is based on a representative sampling of Medicaid payments to "high-volume" Medicaid providers for therapy, nursing, and aide services that are eligible for reimbursement by Medicaid. For purposes of this paragraph, a "high-volume" Medicaid provider is a provider that is identified in the top 45% of Medicaid payments for these services for the most recent six months of available data.

(ii) HHSC averages the sampled Medicaid payments received by all high-volume providers for a specified home health service. HHSC weights the average Medicaid payment by the total number of services reimbursed by Medicaid in this sample. HHSC applies the weighted average rate to the fee schedule.

(C) Following development of the initial fee schedule, HHSC will conduct an analysis no later than December 31, 2004. HHSC will conduct an analysis that will include, but not be limited to, payments for as well as the costs associated with providing these Medicaid-reimbursable therapy, nursing, and aide services at least every four (4) years thereafter. HHSC will seek input from contracted home health services providers and other interested parties in performing this analysis.

(b) – (c) (No change)

This agency hereby certifies that the adoption has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.