Health and Human Services Commission

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Rate Setting Process

- As directed by Government Code § 531.021(b), the Medicaid Rate Setting function has been centralized at HHSC to improve consistency and coordination.

- Chapter 62, Health and Safety Code designated HHSC as the agency with responsibility for administering the CHIP program. In that capacity, HHSC sets rates for CHIP.

- Government Code § 531.0057 and § 531.034 gives HHSC responsibility for reviewing the rules of other health and human services agencies for compliance with the coordinated strategic plan, existing statutory authority, rules of other health and human services (HHS) agencies, budgetary and other implications. The rule review process would include a review of rules establishing rate reimbursement methodologies for health and human services agencies.

- Government Code § 531.0055 gives HHSC broad oversight responsibility for the overall operations of health and human services agencies, including their rate setting activities.

How Rates are Set

- Historical Costs
- Modeling
- Appropriation Limit

Medicaid Rate Increases

Medicaid Rate Increases Authorized, 77th Legislative Session		
Type of Rate	**FY02-FY03 General Revenue Increase Appropriated**	**Effective Date**
Medicaid Managed Care	$35 million	9/1/01
Professional Fees*	$50 million	9/1/01
Dental Fees**	$20 million	10/1/01
Outpatient Hospital Services	$35 million	10/1/01
DHS Community Care Rates	$50 million	9/1/01
Nursing Facilities	$175 million	9/1/01
HCS Waiver	$2.5 million	9/1/01
ICFs-MR	Proceeds from the ICF-MR Quality Assurance Fee	9/1/01
Star+Plus	$4.5 million	1/1/02

*EPSDT rate increases were effective 9/1/01. Additional increases for high-volume providers were adopted effective 1/18/02.

** Rate increases for 33 selected procedures were effective 10/1/01. Additional increases for high-volume dental providers were adopted, effective 1/1/02.

- The legislature also directed HHSC to target Medicaid acute care rate increases to support specific providers and services, such as high-volume providers, providers along the border, and preventive care. In the area of community care and nursing facility care, increases were directed toward wages for personal attendants, nursing facility aides, and nurses.
- Additionally, the 77th legislature passed two bills, SB1053 and SB1299, related to Medicaid rates. SB1053 directs HHSC to establish a task force to issue a report by January 1, 2002 on increasing Medicaid reimbursement rates and financial incentives for physicians providing services to certain Medicaid and CHIP enrollees in the border region. SB 1299 charges a task force with comprehensively evaluating reimbursement rates statewide with a report due December 1, 2002. HHSC has established a single task force to issue both of these reports.

Nursing Facilities

- SB 1 appropriated $175 million GR ($438 million All Funds) to increase nursing facility rates. This funded an overall average rate of $95.16 for SFY 2002, an 11.3 percent increase over the SFY 01 average.
- $135 million GR was dedicated to address the general base rate (buildings, dietary, administration, medical supplies and equipment, laundry and basic staff compensation costs).
- $40 million GR was designated for quality and funded enhanced staffing rates. Providers choosing to participate in enhanced rates were able to receive up to approximately $4.00 per resident day above the previous enhancement level of $2.00, with the restriction that funds be used to enhance direct care staffing and/or to enhance direct care staff wages.
- Nursing facilities are reimbursed through uniform statewide rates based on daily level of service. The rates are essentially cost-based with adjustments for quality enhancements. Costs are categorized into five cost centers: direct care staff (nurse and nurse aide compensation); other residential care (medical supplies & equipment, laundry, etc.); dietary (food, supplies & dietary staff compensation); general and administrative; and fixed capital asset use fee (based on appraised property values of all facilities, limited to an annual increase of no more than the Personal Consumption Expenditures (PCE) inflation index).

Physician Rates

- SB 1 appropriated $50 million GR ($125 million All Funds) to increase rates for physician services.

- Of that amount, $31 million GR was dedicated to increasing the fee for EPSDT screens from $49 to $70. The increase was required by Rider 29 and was effective September 1, 2001.

- The remaining GR funds were intended to target high-volume providers as required by Riders 29 and 54. Effective January 18, 2002, three types of adjustments were implemented:

  - High-volume primary care providers (providing a minimum average of 300 services per month) received a 1.9 percent add-on payment for all services performed.
  - High-volume specialists (providing the top 50 percent of services) received a 6.1 percent add-on payment for all services performed.
  - For all high-volume providers, the most often billed office visit for an established patient increased from $27.28 to $29.52 or 8.2 percent.

Vendor Drugs

- The Vendor Drug Program establishes reimbursement for each prescription drug. The general formula includes the acquisition cost of the drug plus a dispensing fee, an inventory management factor, and a delivery incentive. The total under this formula is then compared to the reported Usual and Customary price and the lower of the two is paid.

- Approximately 85 percent of program cost is accounted for by reimbursement for the cost of drugs.

- Reimbursement for pharmacy operating costs is through a "Dispensing Expense" component. The current Dispensing Expense component is $5.27 per prescription, plus an add-on of $0.15 if prescriptions are delivered to the recipient. This component was determined based on historical costs and has been constant since 1997.

- New pharmacy services reimbursement rules were adopted with an effective date of October 21, 2001. Under these rules, the Commission may use whatever reliable market resources are available to set drug product pricing for the Medicaid Vendor Drug Program. This allows HHSC to respond more quickly to changes in the marketplace that influence reimbursement.

Outpatient Hospital Services

- SB 1 appropriated $35 million GR ($87.5 million All Funds) to increase rates for outpatient hospital services.
- Payments to high volume outpatient hospitals were increased by 5.2 percent, effective 10/01/01. Ambulatory Surgical Centers, Hospital-Based Ambulatory Surgical Centers and Birthing Centers, which qualified as high-volume, also received a 5.2 percent increase in payment rates, effective 10/14/01. The increased payment for these high-volume outpatient services affects an estimated 95 percent of total outpatient reimbursement paid.
- The outpatient hospital rates methodology provides for a retrospective cost-based payment using an interim payment rate, which is cost-settled after the year's close via a cost report. Outpatient hospital reimbursement for high-volume providers is at 84.48 percent of allowable cost and for the remaining providers at 80.30 percent of allowable cost.

Dental Services

- SB 1 appropriated $20 million GR ($50 million All Funds) to increase rates for dental services.

- Of that amount, $16 million GR was dedicated to increasing payments for 33 specific procedures that include exams, preventive measures and selected restorative procedures. Overall, rates for these procedures were increased by approximately 13.5 percent, effective October 1, 2001. For example, rates for periodic oral evaluations increased from $12.97 to $14.72 and rates for sealants were increased from $16.24 to $18.43.

- As required by Rider 30, the remaining $4 million GR provided increases to high-volume practitioners (those providing a minimum average of 300 services per month) particularly along the border and in rural areas. Effective January 1, 2002, high-volume practitioners will receive an additional increase of 3.7 percent for each dental service.

Medicaid HMO Rate Setting

- Capitation rates paid to HMOs are based on a model that consists of three parts: A rate based on historical fee-for-services utilization, adding on increases provided for by legislative appropriations or required by program policy changes, and the budget neutral risk adjustment.
- SB 1 appropriated $35 million GR ($87.5 All Funds) to increase rates for Medicaid STAR HMOs.
- Rate increases for STAR HMOs were effective September 1, 2001 and resulted in an overall increase of approximately 10 percent over FY01 rates.
- SB 1 also appropriated an additional $4.5 million GR for HMOs providing long-term care through the STAR-Plus program. Effective January 1, 2002 STAR-Plus rates were increased by 3.66 percent.

CHIP Rate Setting

- First-year CHIP rates were developed under a competitive bid process.
- A rate cap was established based on Medicaid fee-for-service experience adjusted for trend, benefit differences, administrative expenses, and the impact of managed care.
- No other reliable proxy was available at the time since covering the CHIP population with the services in the benefits package was new both to the state and to the health plans.
- Subsequent rates were updated for the current year based on actuarial analysis of plan experience.
- Effective October 1, 2001, CHIP rates increased by an average of 17.7 percent, plans had proposed increases averaging 50.7 percent.