

**Department of State Health Services
Council Agenda Memo for State Health Services Council
February 24, 2011**

Agenda Item Title: Amendment to a rule concerning rehabilitative services reimbursement methodology

Agenda Number: 4.c

Recommended Council Action:

For Discussion Only

For Discussion and Action by the Council

Background:

The Health and Human Services Commission (HHSC) Rate Analysis Department develops and adopts payment rates for all Medicaid services, and adopts rules for the rate methodology. Mental health rehabilitative services are funded through the Medicaid budget.

Payments are made to qualified providers delivering rehabilitative services provided to Medicaid-eligible individuals who are eligible for services according to the program rules established by the Department of State Health Services (DSHS). Mental health rehabilitative services are services that:

- are individualized age-appropriate training and instructional guidance that address an individual's functional deficits due to severe and persistent mental illness or serious emotional disturbance;
- are designed to improve or maintain the individual's ability to remain in the community as a fully integrated and functioning member of that community; and
- consist of the following services: crisis intervention services, medication training and support services, psychosocial rehabilitative services, skills training and development services, and day programs for acute needs.

Key Health Measures:

The proposed amendment will provide consistency in the cost reporting rules with other HHSC programs that submit cost reports and will define the new reimbursement methodology for this service. This proposed amendment is not expected to impact the delivery of rehabilitative services to consumers.

Summary:

The purpose of the proposed amendment is to define a new reimbursement methodology for rehabilitative services. Providers in the mental health rehabilitation program are currently paid a statewide interim rate that is settled to each provider's costs within certain parameters. The Centers for Medicare and Medicaid Services (CMS) informed HHSC that the current cost settlement process for this program was not acceptable and that the cost settlement would need to be changed. This rule proposal eliminates the cost settlement methodology and replaces it with a prospective, uniform, statewide reimbursement rate that CMS has indicated is acceptable.

There is no fiscal impact to the State as a result of this rule proposal; however, individual providers will have their payment rates increased or decreased as a result of this change.

Summary of Input from Stakeholder Groups:

The current providers of this service are local mental health authorities, which are governmental entities recognized by the State. HHSC has attended meetings of the Texas Council of Community Centers to address the rule changes and emailed the organization a copy of the proposed amendment. As of the date of this memorandum, staff have not received any feedback from stakeholders regarding the proposed amendment.

Proposed Motion:

Motion to recommend HHSC approval for publication of rules contained in agenda item #4.c

Approved by Assistant Commissioner/Director: Dan Huggins, Director, HHSC Rate Analysis, Acute Care Services **Date:** 2/1/11

Presenter: Yvonne Moorad, Rate Analyst **Program:** HHSC Rate Analysis, Acute Care Services **Phone No.:** 512-491-1831

Approved by CCEA: Carolyn Bivens **Date:** 1/31/2011

Title 1. Administration
Part 15. Texas Health and Human Services Commission
Chapter 355. Reimbursement Rates
Subchapter F. Reimbursement Methodology for Programs Serving Persons with Mental Illness
and Mental Retardation
Amendment §355.781

Proposed Preamble

The Texas Health and Human Services Commission (HHSC) proposes to amend the Medicaid reimbursement rule at Title 1, Part 15, Chapter 355, Subchapter F, §355.781, Rehabilitative Services Reimbursement Methodology.

BACKGROUND AND JUSTIFICATION

Providers in the mental health rehabilitation program are currently paid a statewide interim rate that is settled to each provider's costs within certain parameters. The Texas Health and Human Services Commission (HHSC) proposes to amend §355.781 to eliminate the current cost settlement process and implement a prospective uniform statewide reimbursement rate methodology.

The Centers for Medicare and Medicaid Services (CMS) informed HHSC that the current cost settlement process for this program was not acceptable and that either the cost settlement would need to be changed or eliminated. This rule proposal eliminates the cost settlement methodology and replaces it with a prospective, uniform, statewide reimbursement rate that CMS has indicated is acceptable.

This rule will update and clarify current requirements for the Rehabilitative Services program and delete outdated information.

SECTION-BY-SECTION SUMMARY

Proposed amended §355.781(a) adds language that describes the type of service provided, establishes the Department of State Health Services (DSHS) as the agency responsible for determining program eligibility, and adds a reference that identifies where the rate determination authority can be found under in this chapter. Paragraphs (a)(1) and (2) are deleted to eliminate specific references to the Health and Human Services Commission (HHSC) as the agency reimbursing a qualified rehabilitative service provider and to eliminate information regarding cost-effective operations and State appropriations that are not pertinent to the rate methodology.

Proposed amended §355.781(b) removes the subsection title and replaces it with a new title, adds language that specifies that rates are prospective and uniform statewide for defined services, and reformats the section. Additionally, the amendment deletes the definition of "interim rate" and "service type" and moves the definition of "unit of service" to subsection (c). The amendment

also removes information set out in agency program rules that are not pertinent to the reimbursement methodology.

Proposed amended §355.781(c) describes the unit of service previously described in paragraph (b)(3) and reformats the section. The amendment eliminates language regarding the reporting of costs that are contained in the cost-determination process rules that are referenced in the new subsection (e).

Proposed amended §355.781 (d) eliminates language regarding the current reimbursement methodology and cost settlement provisions. Subsection (d)(1) describes the reimbursement methodology for determining initial rates effective September 1, 2011, and subsection (d)(2) describes the reimbursement methodology for determining rates effective after September 1, 2011.

Proposed new §355.781(e) describes the cost-reporting process and references the cost determination process rules, which govern cost reporting and adjustments to reported costs.

FISCAL NOTE

Greta Rymal, Deputy Executive Commissioner for HHSC, has determined that during the first five-year period the amended rule is in effect and the rules are repealed there is no fiscal impact to the State. However, individual providers will have their payment rates increased or decreased as a result of this change. The current providers of this service are Mental Health Authorities, which are governmental entities recognized by the State.

SMALL AND MICRO-BUSINESS IMPACT ANALYSIS

Carolyn Pratt, Director of Rate Analysis, has determined that there will be no adverse economic effect on small or micro-businesses as a result of enforcing or administering the proposed section. There is no anticipated economic cost to persons who are required to comply with the proposed section. There is no anticipated effect on local employment in geographic areas affected by this section.

PUBLIC BENEFIT

Carolyn Pratt, Director of Rate Analysis, has determined that for each of the first five years the amendment is in effect, the expected public benefit of the amendment of this rule is the elimination of duplicate and obsolete rules. The public benefit of the rule amendment is that HHSC will provide consistency in the cost reporting rules with other HHSC programs that submit cost reports and will define the new reimbursement methodology for this service.

REGULATORY ANALYSIS

HHSC has determined that this proposal is not a “major environmental rule” as defined by §2001.0225 of the Texas Government Code. A “major environmental rule” is defined to mean a rule the specific intent of which is to protect the environment or reduce risk to human health

from environmental exposure and that may adversely affect, in a material way, the economy, a sector of the economy, productivity, competition, jobs, the environment or the public health and safety of a state or a sector of the state. This proposal is not specifically intended to protect the environment or reduce risks to human health from environmental exposure.

TAKINGS IMPACT ASSESSMENT

HHSC has determined that this proposal does not restrict or limit an owner's right to his or her property that would otherwise exist in the absence of government action and, therefore, does not constitute a taking under §2007.043 of the Government Code.

PUBLIC COMMENT

Written comments on the proposal may be submitted to Yvonne Moorad, Senior Rate Analyst of Acute Care Services, Rate Analysis Department, Texas Health and Human Services Commission, P.O. Box 85200, MC-H400, Austin, Texas 78708-5200; by fax to (512) 491-1998; or by e-mail to Yvonne.Moorad@hhsc.state.tx.us within 30 days of publication of this proposal in the *Texas Register*.

STATUTORY AUTHORITY

The amendment is proposed under Texas Government Code §531.033, which authorizes the Executive Commissioner of HHSC to adopt rules necessary to carry out the commission's duties; Texas Human Resources Code §32.021 and Texas Government Code §531.021(a), which provide HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas; and Texas Government Code §531.021(b), which establishes HHSC as the agency responsible for adopting reasonable rules governing the determination of fees, charges, and rates for medical assistance payments under the Human Resources Code, Chapter 32. The proposed rule amendment affects the Human Resources Code, Chapter 32, and the Texas Government Code, Chapter 531. No other statutes, articles, or codes are affected by this proposal.

Legend: (Proposed Amendment(s))

Single Underline = Proposed new language

[Bold Print, and Brackets] = Current language proposed for deletion

Regular Print = Current language

(No change.) = No changes are being considered for the designated subdivision

§355.781. Rehabilitative Services Reimbursement Methodology.

(a) Authority. [General information.] Payments are made to qualified providers delivering rehabilitative services provided to Medicaid-eligible individuals who are eligible for services according to the program rules established by the Department of State Health Services (DSHS). The reimbursement determination authority is specified in §355.101 of this title (relating to Introduction).

[(1) The Texas Health and Human Services Commission (HHSC) will reimburse qualified rehabilitative services providers for rehabilitative services provided to Medicaid-eligible persons with mental illness.]

[(2) The HHSC establishes the reimbursement rate. The HHSC sets reimbursement rates that reflect cost-effective operations and are within State appropriation constraints.]

(b) Reimbursement rates. [Definitions.] Prospective and uniform statewide rates for rehabilitative services are determined for rehabilitative services as specified in Mental Health Services program rules in Title 25, Part 1, Chapter 419, Subchapter L, for the following:

[(1) Interim rate--Rate paid to a rehabilitative services provider based on cost reports prior to settle-up conducted in accordance with subsection (d)(4) of this section.]

[(2) Service type-- Types of Medicaid reimbursable rehabilitative services as specified in program rules for the following:]

(1) [(A)] Day programs for acute needs--adult;

(2) [(B)] Crisis intervention services--individual-child/adolescent and adult;

(3) [(C)] Medication training and support--individual-child/adolescent and adult;

(4) [(D)] Medication training and support--group-adult;

(5) [(E)] Medication training and support--group-child/adolescent;

(6) [(F)] Psychosocial rehabilitative services--individual-adult;

- (7) [(G)] Psychosocial rehabilitative services--group-adult;
- (8) [(H)] Skills training and development--individual-child/adolescent and adult;
- (9) [(I)] Skills training and development--group-adult; and
- (10) [(J)] Skills training and development-group-child/adolescent.

(c) Units of service. Qualified providers are reimbursed based on the following face-to-face units of service:

[(3) Unit of service--The amount of time an individual, eligible for Medicaid rehabilitative services or non-Medicaid rehabilitative services (or parent or guardian of the person of an eligible minor), is engaged in face-to-face contact with a person described in program rules established by The Department of State Health Services (DSHS). The units of service are as follows:]

- (1) [(A)] Day programs for acute needs--45-60 continuous minutes;
- (2) [(B)] Crisis intervention services--15 continuous minutes;
- (3) [(C)] Medication training and support--15 continuous minutes;
- (4) [(D)] Psychosocial rehabilitative services--15 continuous minutes; and
- (5) [(E)] Skills training and development--15 continuous minutes.

[(c) Reporting of Costs.]

[(1) Cost reporting. Rehabilitative services providers must submit information quarterly, unless otherwise specified, on a cost report formatted according to HHSC's specifications. Rehabilitative services providers must complete the cost report according to §§355.101, 355.102, 355.103, 355.104, and 355.105 of this title (relating to Introduction, General Principles of Allowable and Unallowable Costs, Specifications for Allowable and Unallowable Costs, Revenues, and General Reporting and Documentation Requirements, Methods, and Procedures).]

[(2) Reporting period and due date. Rehabilitative services providers must prepare the cost report to reflect rehabilitative services provided during the designated cost report-reporting period. The cost reports must be submitted to the HHSC no later than 45 days following the end of the designated reporting period unless otherwise specified by the HHSC.]

[(3) Extension of the due date. The HHSC may grant extensions of due dates for good cause. A good cause is one that the rehabilitative services provider could not reasonable be expected to control. Rehabilitative services providers must submit request

for extensions in writing. Requests for extensions must be received by HHSC prior to the cost report due date. HHSC will respond to requests within 15 days of receipt.]

[(4) Failure to file an acceptable cost report. If a rehabilitative services provider fails to file a cost report according to all applicable rules and instructions, HHSC will notify DSHS to place the rehabilitative services provider on vendor hold until the rehabilitative services provider submits an acceptable cost report.]

[(5) Allocation method. If allocations of cost are necessary, rehabilitative services providers must use and be able to document reasonable methods of allocation. HHSC adjusts allocated costs if HHSC considers the allocation method to be unreasonable. The rehabilitative services provider must retain work papers supporting allocations for a period of three years or until all audit exceptions are resolved (whichever is longer).]

[(6) Cost report certification. Rehabilitative services providers must certify the accuracy of cost reports submitted to HHSC in the format specified by HHSC. Rehabilitative services providers may be liable for civil and/or criminal penalties if they misrepresent or falsify information.]

[(7) Cost data supplements. HHSC may require additional financial and statistical information other than the information contained on the cost report.]

[(8) Allowable and unallowable costs. Cost reports may only include costs that meet the requirements as specified in §355.102 and §355.103 of this title (relating to General Principles of Allowable and Unallowable Costs and Specifications for Allowable and Unallowable Costs).]

[(9) Review of cost reports. HHSC reviews each cost report to ensure that financial and statistical information submitted conforms to all applicable rules and instructions. The review of the cost report includes a desk review. HHSC reviews all cost reports according to the criteria specified in §355.106 of this title (relating to Basic Objectives and Criteria for Audit and Desk Review of Cost Reports). If a rehabilitative services provider fails to complete the cost report according to instructions or rules, HHSC returns the cost report to the rehabilitative services provider for proper completion. HHSC may require information other than that contained in the cost report to substantiate reported information. Providers will be notified of the results of a desk review or a field audit in accordance with §355.107 of this title (relating to Notification of Exclusions and Adjustments).]

[(10) On-site audits. HHSC may perform on-site audits on all rehabilitative services providers that participate in the Medicaid program for rehabilitative services. HHSC determines the frequency and nature of such audits but ensures that they are not less than that required by federal regulations related to the administration of the program.]

[(11) Notification of exclusions and adjustments. HHSC notifies rehabilitative services providers of exclusions and adjustments to reported expenses made during desk reviews and on-site audits of cost reports.]

[(12) Reviews and administrative hearings. Rehabilitative services providers may request an informal review and, if necessary, an administrative hearing to dispute the action taken by HHSC1 under §355.110 of this title (relating to Informal Reviews and Formal Appeals).]

[(13) Access to records. Each rehabilitative services provider must allow access to all records necessary to verify cost report information submitted to HHSC. Such records include those pertaining to related-party transactions and other business activities engaged in by the rehabilitative services provider. If a rehabilitative services provider does not allow inspection of pertinent records within 14 days following written notice HHSC will notify DSHS to place the rehabilitative services provider on vendor hold until access to the records is allowed. If the rehabilitative services provider continues to deny access to records, DSHS may terminate the rehabilitative services provider agreement with the rehabilitative services provider.]

[(14) Record keeping requirements. Rehabilitative services providers must maintain service delivery records and eligibility determination for a period of five years or until any audit exceptions are resolved (whichever is later). Rehabilitative services providers must ensure that records are accurate and sufficiently detailed to support the financial and statistical information contained in cost reports.]

[(15) Failure to maintain adequate records. If a rehabilitative services provider fails to maintain adequate records to support the financial and statistical information reported in cost reports, HHSC allows 30 days for the rehabilitative services provider to bring record keeping into compliance. If a rehabilitative services provider fails to correct deficiencies within 30 days from the date of notification of the deficiency, HHSC will notify DSHS to terminate the rehabilitative services provider agreement with the rehabilitative services provider.]

[(d) Reimbursement determination. HHSC determines reimbursement according to §355.101 of this title (relating to Introduction). Rehabilitative services providers are reimbursed a uniform, statewide interim rate with a cost-related year-end settle-up. The HHSC determines reimbursement in the following manner:]

[(1) Inclusions of certain reported expenses. Rehabilitative services providers must ensure that all allowable costs are included in the cost report.]

[(2) Data collection. The HHSC collects several different kinds of data. These include the number of units of service that individuals receive and cost data, including direct costs, programmatic indirect costs, and general and administrative overhead costs. These costs include salaries, benefits, and other costs. Other costs include non-salary related costs such as building and equipment maintenance, repair, depreciation,

amortization, and insurance expenses; employee travel and training expenses; utilities; and material and supply expenses.]

[(3) Interim rate methodology. The interim rate is determined biennially for each service type based on cost reports.]

[(A) The HHSC projects and adjusts reported costs from the historical reporting period to determine the interim rate for the prospective reimbursement period. Cost projections adjust the allowed historical costs based on significant changes in cost-related conditions anticipated to occur between the historical cost period and the prospective reimbursement period. Changes in cost-related conditions include, but are not limited to, inflation or deflation in wage or price, changes in program utilization and occupancy, modification of federal or state regulations and statutes, and implementation of federal or state court orders and settlement agreements. Costs are adjusted for the prospective reimbursement period by a general cost inflation index as specified in §355.108 of this title (relating to Determination of Inflation Indices).]

[(B) For each settle-up service, each rehabilitative services provider's projected cost per unit of service is calculated. The mean rehabilitative services provider cost per unit of service is calculated, and the statistical outliers (those rehabilitative services providers whose unit costs exceed plus or minus (+/-) two standard deviations of the mean rehabilitative services provider cost) are removed. After removal of the statistical outliers, the mean cost per unit of service is calculated. This mean cost per unit of service becomes the recommended reimbursement per unit of service.]

[(4) Settle-up process. At the end of each reimbursement period, the HHSC will compare the amount reimbursed at the interim rate for each settle-up service and the rehabilitative services provider's costs for each service, as submitted on its cost report in accordance with subsection (c) of this section.]

[(A) Rehabilitative service provider's, whose costs are less than 95% of the amount reimbursed at the interim rate, will be required to pay to DSHS agency 100% of the difference between its allowable costs and 95% of the amount reimbursed at the interim rate for each settle-up service. DSHS will notify the rehabilitative services provider of the amount due by certified mail and the rehabilitative services provider will remit the repayment amount within 60 days of notification. DSHS will apply a vendor hold on Medicaid payments to a rehabilitative services provider for not making the payment to DSHS within 60 days of receiving notice.]

[(B) If a rehabilitative services provider's costs exceed the amount reimbursed at the interim rate, DSHS will reimburse the rehabilitative services provider the difference between its allowable costs and the reimbursement at the interim rate up to 125% of the interim rate for each settle-up service. DSHS will notify the rehabilitative services provider of the amount owed to the provider via certified mail. DSHS will make payment within 30 days of the date the notice was received, as indicated by the certified mail receipt.]

[(5) Adjustments to the reimbursement determination methodology. HHSC may adjust reimbursement if new legislation, regulations, or economic factors affect costs as described in §355.109 of this title (relating to Adjusting Reimbursement When New Legislation, Regulations, or Economic Factors Affect Costs).]

(d) Rate methodology.

(1) Initial rates. Initial statewide rates effective September 1, 2011, will be determined by summing the total agency expenditures to provide rehabilitative services for each type of service for the most recent cost-settled fiscal year, and dividing by the total number of units of each type of service provided during that fiscal year. The total agency expenditure to provide rehabilitative services includes both the interim rates paid and any adjustments made to the interim rates, such as additional payments or recoupments.

(2) Cost report-based rates. After HHSC determines that cost data collected as described in subsection (e) of this section are reliable and sufficient to support development of a cost report-based rate, HHSC will develop statewide reimbursement rates using that data to replace the initial rates as follows:

(A) Project each provider's total allowable cost for each type of service from the historical cost reporting period to the prospective reimbursement period using inflation factors set out in §355.108 of this title (relating to Determination of Inflation Indices) to arrive at the projected cost for each type of service;

(B) For each provider, divide the projected cost for each type of service, determined in subparagraph (A) of this paragraph, by the provider's total units of service for each type of service delivered during the historical cost-reporting period, to arrive at the provider's projected cost for each unit of service for each type of service; and

(C) For each type of service:

(i) Arrange all providers' projected cost for each unit of service in an array from low to high, with the corresponding total number of units of service for each provider;

(ii) Sum the total number of units of service for each provider in the array progressively from low to high to create a running total;

(iii) Divide the total number of units of service by two (2);

(iv) Identify the value, from the running total sums calculated in clause (ii) of this subparagraph, that is closest to the result in clause (iii) of this subparagraph; and

(v) Identify the cost for each unit of service that corresponds to the value identified in clause (iv) of this subparagraph to arrive at the recommended rate for that service.

(e) Reporting of costs.

(1) All rehabilitative services providers must submit a cost report unless the number of days between the date the first client received services and the fiscal year end is 30 days or fewer. The provider may be excused from submitting a cost report if circumstances beyond the control of the provider make cost-report completion impossible, such as the loss of records due to natural disasters or removal of records from the provider's custody by any governmental entity. Requests to be excused from submitting a cost report must be received by the Health and Human Services Commission Rate Analysis Department before the due date of the cost report.

(2) Cost reporting. Rehabilitative services providers must submit cost report data according to HHSC's specifications. In addition to the requirements of this section, the cost reporting guidelines will be governed by the information in §355.101 of this title (relating to Introduction), §355.102 of this title (relating to General Principles of Allowable and Unallowable Costs), §355.103 of this title (relating to Specifications for Allowable and Unallowable Costs), §355.104 of this title (relating to Revenues), §355.105 of this title (relating to General Reporting and Documentation Requirements, Methods, and Procedures), §355.106 of this title (relating to Basic Objectives and Criteria for Audit and Desk Review of Cost Reports), §355.107 of this title (relating to Notification of Exclusions and Adjustments), §355.108 of this title (relating to Determination of Inflation Indices), §355.109 of this title (relating to Adjusting Reimbursement When New Legislation, Regulations, or Economic Factors Affect Costs), §355.110 of this title (relating to Informal Reviews and Formal Appeals), and §355.11 of this title (relating to Administrative Contract Violation).

(3) Providers are responsible for reporting only allowable costs on the cost report, except where cost report instructions indicate that other costs are to be reported in specific lines or sections. Only allowable cost information is used to determine recommended rates. To ensure that the database reflects costs and other information which are necessary for the provision of services and is consistent with federal and state regulations, HHSC excludes from rate determination any unallowable expenses included in the cost report and makes the appropriate adjustments to expenses and other information reported by providers.

(4) Individual provider cost reports may not be included in the database used for reimbursement determination if:

(A) there is reasonable doubt as to the accuracy or allowability of a significant part of the information reported; or

(B) an auditor determines that reported costs are not verifiable.