TPTA opposes the substantial rate reductions for therapy services proposed by the Texas Health & Human Services Commission (HHSC).

Multiple rate reductions have already been made over the past 15 months to decrease state Medicaid expenditures for therapy services. These reductions include a 1% rate reduction in September 2010, a second 1% rate reduction in February 2011, and a 5% rate reduction for non-home-based providers effective September 2011. The Appropriations Act made it clear that no further cuts were to be made to therapy services during the 2012-2013 biennium.

The proposed therapy payment reductions are drastic; equating to nearly 52% overall. Physical and occupational therapy rate reductions across all settings average nearly 54%. Based on 2010 utilization numbers provided by HHSC, the proposed rate reductions will result in an overall decrease in payment to all therapy services (among all service delivery models) of $249,669,831.51. Of that total, $82.9 million will be directed at physical and occupational therapy interventions.

The current proposed rate would put most practitioners at reimbursement rates below actual expenses. A 2010 national benchmark study of therapy private practices reported that the average cost per visit was $79.74. At the current rates, therapists barely break even – the proposed rates would result in a loss. The amount of non-billable time associated with family/co-giver education for complex patients, high 'no-show' rates (30% compared to 12% for other patient classifications) and other administrative duties are much higher for Medicaid recipients as compared to non-Medicaid patients. This should be considered when setting reasonable therapy service fees.

76% of all Medicaid recipients are children under the age of 19; 87% of all Medicaid recipients are children who may also be disabled and/or blind. As demonstrated in the Kaiser study below, expenditures do not directly correlate with the enrollment. A team of reviewers analyzed a 2000 study by the Centers for Medicare and Medicaid Services (CMS) and stated that “benefits that these individuals tend to consume...such as physical therapy...tend to be expensive because they are frequently required over lengthy periods of time...”.

Medicaid recipients often have co-morbidities that impact delivery of care and rate of recovery. These include, but are not limited to: cardiac diseases; diabetes and associated problems; circulatory deficiencies; obesity; nutritional deficits; and vestibular problems which all impact the patient’s ability to attain rehabilitation goals as quickly as non-Medicaid patients. These co-morbidities create greater challenges for the provider and patient alike. These co-morbidities also present a complex patient.

Patient health improvement for complex patients requires additional time to be spent educating patients and/or their family members. Due to many socioeconomic and other factors, many patients and/or their families are unable to implement the prescribed plan of home care required in order to see marked improvement between patient visits. This requires providers to spend additional time demonstrating and reinforcing the need for patient and/or family involvement in obtaining optimal function.

Medicaid is difficult for providers to navigate. An evaluation of Texas Medicaid provider administration amongst physicians found that Medicaid policy was confusing. In addition, the evaluation found that physicians often had to resubmit denied claims “at least twice over 47 percent of the time.” These assessments are consistent with the experiences of therapy providers. Texas physical therapists report that Medicaid payment and coverage policies are difficult to find and that the website is extremely difficult to navigate.

The substantial reductions proposed by HHSC are likely to greatly decrease patient access to therapy services and patients will be forced to utilize more expensive forms for care such as emergency rooms and hospitals. The TPTA believes that the proposed reductions have not been available to providers long enough to sufficiently determine whether they put Medicaid recipients at risk for significant reduction in access to care. Additionally, providers are just now adapting to the reductions in payment that occurred in the past 14 months.

HHSC needs to take a balanced approach to resolving unnecessary expenditures while ensuring that providers can operate on the rates set for Medicaid. TPTA recommends the following:

- Propose a fee schedule that is based on Medicare Allowable 'Plus' for specific procedures utilizing a conversion factor that permits providers to have fair and adequate payments for service and to continue operations.
- Establish a system for provider enrollment regardless of practice setting to require credentialing of all practitioners.
- Implement policies to promote the use of Medical Necessity as the benchmark forjustifying services, using CMS resources as a guide.

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ii “Medicaid Rates 10.21.11 Therapies+Comparison+for+Discussion+Group+(proposed+fees+and+UOS) Spreadsheet.” Texas Human Services Commission. Email data sent to K. Hutto from HHSC staff, 10/21/11.