DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
1301 Young Street, Room 833
Dallas, Texas 75202

Division of Medicaid & Children's Health, Region VI

January 20, 2011

Our Reference: SPA TX 09-31

Mr. Billy Millwee
Associate Commissioner for Medicaid & CHIP
Health and Human Services Commission
Post Office Box 13247
Mail Code: H100
Austin, Texas 78711

Dear Mr. Millwee:

We have reviewed the State's proposed amendment to the Texas State Plan submitted under Transmittal Number 09-31, dated September 25, 2009. This amendment updates the reimbursement methodology for Medicaid supplemental payments for physician services by expanding the number of providers eligible for these payments beginning September 1, 2009.

Additionally, please note that when the State submits a State Plan Amendment (SPA) that may impact Indians or Indian health providers, CMS will look for evidence of the State's Tribal consultation process for that SPA. Pursuant to the new section 1902(a)(73) of the Act added by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009, the State must submit evidence to CMS regarding the solicitation of advice prior to submission of the State Plan Amendment. Such consultation must include all federally-recognized tribes, Indian Health Service and Urban Indian Organizations within the State.

Based on the information submitted, we have approved the amendment for incorporation into the official Texas State Plan with an effective date change of September 1, 2009. A copy of the CMS-179 and the approved plan pages are enclosed with this letter.

If you have any questions, please contact Scott Harper at (214) 767-6564.

Sincerely,

Bill Brooks
Associate Regional Administrator

Enclosures
cc: Emily Zalkovsky, Policy Development Support

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES

1. TRANSMITTAL NUMBER: **09-031**

2. STATE: **TEXAS**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE AND MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: **September 1, 2009**

5. TYPE OF PLAN MATERIAL *(Circle One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR §447.204, Encouragement of provider participation;
42 CFR §447.321, Application of upper payment limits

7. FEDERAL BUDGET IMPACT: SEE ATTACHMENT
a. FFY **2009** **$ 109,099**
b. FFY **2010** **$ 1,309,190**
c. FFY **2011** **$ 1,146,689**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

SEE ATTACHMENT TO BLOCKS 8 & 9

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

SEE ATTACHMENT TO BLOCKS 8 & 9

10. SUBJECT OF AMENDMENT:

The proposed amendment updates the reimbursement methodology for Medicaid supplemental payments for physician services and expands the number of providers eligible for these payments.

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Sent to Governor's Office this date. Comments, if any, will be forwarded upon receipt.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

Chris Traylor

14. TITLE:

State Medicaid Director

15. DATE SUBMITTED:

September 25, 2009

16. RETURN TO:

Chris Traylor
State Medicaid Director
Post Office Box 85200
Austin, Texas 78711-5200

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 25 September, 2009

18. DATE APPROVED: 20 January, 2011

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
1 September, 2009

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Bill Brooks

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children's Health

23. REMARKS:

FORM CMS – 179 (07-92)

e. Supplemental Payments for Physician Services

(1) Introduction. Enrolled Medicaid providers that are identified in subsection (3) of this section may receive supplemental payments for physician services provided to Medicaid-eligible patients.

(2) Definitions. For purposes of this section, the following definitions apply:

(A) Adjudicated claim – A fee-for-service physician claim for a covered Medicaid service that is paid or adjusted by HHSC.

(B) Approved place of service – A hospital-sponsored location, such as an inpatient hospital, outpatient hospital, hospital-based clinic, or hospital-affiliated clinic.

(C) Calculation period – The federal fiscal quarter determined by HHSC for which supplemental payment amounts are calculated.

(D) Facility setting – An inpatient or outpatient hospital.

(E) Global payment – The payment amount for a defined subset of services encompassing the combined technical and professional components rendered during an episode of care.

(F) Governmental hospital – A hospital or hospital system affiliated with a hospital district created under Texas Health and Safety Code, Chapter 281.

(G) Medicaid Final Equivalent Units—Elements of measure used by HHSC to assign values to an individual physician service in the Medicaid program relative to the same individual physician service in the Medicare program. Medicaid Final Equivalent Units are determined using the methodologies described in subsection (6)(c) of this section, and are a factor in calculating supplemental payment amounts.

(H) Medicare anesthesia base units – Elements of measure used by Medicare to assign values to anesthesia services with time-based fees. The base units are a factor used in calculating the Medicaid Final Equivalent Units.

(I) Medicare anesthesia conversion factors – A factor used in calculating the Medicare Fee Equivalent Payment for anesthesia services with time-based fees. The Medicare anesthesia conversion factor for the "Rest of Texas" locality is used for calculating the anesthesia rate. HHSC will not compensate for regional variation in practice costs.

(J) Medicare Fee Conversion Factor (MFCF) – A CMS approved factor (145% of Medicare rates) used to convert the applicable Medicare fee to a fee that represents what commercial payors would reimburse physicians for eligible professional services.

(K) Nonfacility setting – A location other than an inpatient or outpatient hospital.

(L) Public funds – Funds derived from taxes, assessments, levies, investments, and other public revenues within the sole and unrestricted control of the governmental entity that owns or is affiliated with the enrolled Medicaid provider identified in subsection (3) of this section. Public funds do not include gifts, grants, trusts, or donations, the use of which is conditioned on supplying a benefit solely to the donor or grantor of the funds, such as the private operator of a hospital district's facility.

(3) Availability of supplemental payments. Supplemental payments are available under this section only for physician services performed by doctors of medicine and osteopathy licensed in Texas and affiliated with an enrolled Medicaid provider in one of the following ways:

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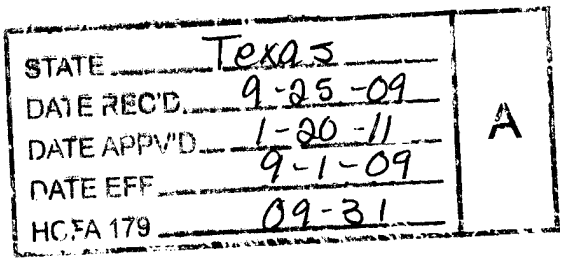
(A) Employed by an eligible physician group practice that is state-owned or -operated. Physicians under contract with such a physician group practice are not included in supplemental payment calculations.

Eligible state-owned or -operated physician group practices consist of those affiliated with:

University of Texas – Southwestern
University of Texas – San Antonio
University of Texas – Tyler
University of Texas – Houston
University of Texas Medical Branch – Galveston
University of Texas – MD Anderson Cancer Center
University of North Texas
Texas Tech University – Amarillo
Texas Tech University – El Paso
Texas Tech University – Lubbock
Texas Tech University – Odessa

(B) Employed by a governmental hospital; or

(C) Employed by or under contract with a physician group practice organized by, under the control of, or under contract with a governmental hospital.



(4) Required certification. Before a private physician practice group may receive supplemental payments under this section, the appropriate governmental entity and the private physician practice group must certify certain facts, representations, and assurances regarding program requirements.

(5) Calculation of supplemental payments. For each enrolled Medicaid provider identified in subsection (3) of this rule that is participating in this program, HHSC will calculate the supplemental payments for physicians' services under this section using the following methodology:

(A) HHSC will identify Medicaid claims adjudicated during the calculation period for services performed by eligible physicians at approved places of service.

(i) The identification of claims will be based on individual Current Procedural Terminology (CPT) codes contained in the Texas Medicaid Management Information System.

(ii) Supplemental payments for physician services are available only for benefits covered by Medicare.

(B) HHSC will determine the appropriate Medicare fee schedule based on the following criteria:

(i) If more than 50 percent of the claims identified in the calculation period were performed in a nonfacility setting, HHSC will use the nonfacility Medicare physician fee schedule for that physician group.

(ii) If 50 percent or more of the claims identified in the calculation period were performed in a facility setting, HHSC will use the facility Medicare physician fee schedule for that physician group.

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(iii) If a Medicare fee schedule is not available for a particular service, HHSC may use an alternative applicable Medicare fee schedule for those physician services.

(iv) HHSC will use the Medicare fee schedule in effect at the time the supplemental payments are calculated.

(C) Using all eligible procedures identified in subsection (6)(A), HHSC will determine the Medicaid Final Equivalent Units in one of the following ways, depending on whether the CPT code is related or unrelated to anesthesia.

(i) Related to Anesthesia

(I) For each anesthesia CPT code and unique set of modifiers that is paid using a time-based fee, the Medicaid Final Equivalent Units are derived using the following formula:

(number of occurrences of CPT code with modifiers x Medicare anesthesia base units) + the sum of the Medicaid paid units for that CPT code with modifiers;

(II) For those limited anesthesia codes that are not paid using a time-based fee, the Medicaid Final Equivalent Units equal the sum of the Medicaid paid units for that CPT code with modifiers.

(ii) Unrelated to Anesthesia. The Medicaid Final Equivalent Units equal the sum of the Medicaid paid units for that CPT code with modifiers.

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(D) HHSC will calculate the Medicare Fee Equivalent Payment by multiplying the Medicaid Final Equivalent Units by either the applicable Medicare fee or the applicable Medicare anesthesia conversion factor.

(E) HHSC will reduce the Medicare Fee Equivalent Payment determined under paragraph (D) by applying Medicaid pricing modifier reductions and assistant surgeon pricing adjustments in accordance with Texas Medicaid policy.

(F) HHSC will calculate the Payment Ceiling Amount by adding the Medicare Fee Equivalent Payments for all eligible CPT codes and multiplying the total by the Medicare Fee Conversion Factor of 145%.

(G) HHSC will calculate the supplemental payment amount by subtracting the Medicaid payments for all eligible CPT codes from the Payment Ceiling Amount.

(6) When a global payment that includes a technical component is made for physician services, supplemental payment is available only for the professional component and only when a doctor of medicine or doctor of osteopathy rendered those services.