

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

August 30, 2010

Our Reference: SPA TX 10-044

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 10-044, dated June 7, 2010. This amendment reduces the rates for Medicaid services by ambulatory surgical centers (ASCs) and hospital based ASCs by 1%.

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, 2010. A copy of the CMS-179 and the approved plan pages are enclosed with this letter.

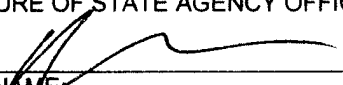

If you have any questions, please contact Ford J. Blunt at (214) 767-6381.

Sincerely,

Bill Brooks
Associate Regional Administrator

Enclosures

cc: Emily Zalkovsky, Policy Development Support

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES		1. TRANSMITTAL NUMBER: 10-044	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, 2010	
5. TYPE OF PLAN MATERIAL (Circle One): <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR §440.20, §440.90		7. FEDERAL BUDGET IMPACT: SEE ATTACHMENT a. FFY 2010 \$ (96,956) b. FFY 2011 \$ (1,035,787) c. FFY 2012 \$ (1,018,883)	
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 amendment implements a one percent payment reduction for Medicaid services provided by ambulatory surgical centers and hospital based ambulatory surgical centers.			
11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: Sent to Governor's Office this date. Comments, if any, will be forwarded upon receipt. <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: Billy R. Millwee State Medicaid Director Post Office Box 13247, MC: H-100 Austin, Texas 78711	
13. TYPED NAME: Billy R. Millwee			
14. TITLE: State Medicaid Director			
15. DATE SUBMITTED: June 7, 2010			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: 7 June, 2010		18. DATE APPROVED: 30 August, 2010	
PLAN APPROVED – ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 1 September, 2010		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: BILL BROOKS		22. TITLE: Associate Regional Administrator Div of Medicaid & Children's Health	
23. REMARKS:			

16. Ambulatory Surgical Centers (ASCs) (continued)

(f) Example 2:

1. Billed charges = \$75.00
2. Medicaid published fee = \$80.00
3. Lesser of billed charges or Medicaid published fee = \$75.00, which becomes the allowed amount.
4. Since the billed charges are not greater than the Medicaid fee plus the 5.2% high-volume provider payment add-on (i.e., $\$80.00 + \$4.16 = \$84.16$), no high-volume provider payment add-on is applied, resulting in the actual payment to the provider of \$75.00.

(g) Example 3:

1. Billed charges = \$82.00
2. Medicaid published fee = \$80.00
3. Lesser of billed charges or Medicaid published fee = \$80.00, which becomes the allowed amount.
4. Since the billed charges are not greater than the Medicaid fee plus the 5.2% high-volume provider payment add-on (i.e., $\$80.00 + \$4.16 = \$84.16$), only part of the high-volume provider payment add-on is applied, i.e., up to the billed charges, resulting in the actual payment to the provider of \$82.00.

(h) Medicaid payments for ASC services do not exceed Medicare payments for these same ASC services.

(i) The reimbursement for services effective September 1, 2010, will be equal to the payment that would have been made on August 31, 2010, less one percent.

(j) All fee schedules are available through the agency's website as outlined on Attachment 4.19-B, page 1.

SUPERSEDES: TN- 07-28

STATE	<u>Texas</u>	A
DATE REC'D	<u>6-7-10</u>	
DATE APP'VD	<u>8-30-10</u>	
DATE EFF	<u>9-1-10</u>	
HCFA 179	<u>10-14</u>	

TN No. 10-44 Approval Date 8-30-10 Effective Date 9-1-10

Supersedes TN No. 07-28