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State/Territory Name: Texas

State Plan Amendment (SPA) #: 11-60 NIRT

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form
- 3) Superseding Page Listing
- 4) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-14-28
Baltimore, Maryland 21244-1850



Center for Medicaid and CHIP Services

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

FEB - 8 2012

RE: TN 11-60

Dear Mr. Millwee:

We have reviewed the proposed amendment to Attachments 4.19-A and 4.19-B of your Medicaid State plan submitted under transmittal number (TN) 11-60. The purpose of this amendment is to delete the pages in the Texas state plan governing the methodology for computing inpatient, outpatient, and physician supplemental Medicaid payments, also called the Upper Payment Limit (UPL) program.


We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. As part of the review process the State was asked to provide information regarding funding of the State share of expenditures under Attachments 4.19-A and 4.19-B. Based upon your assurances, Medicaid State plan amendment 11-60 is approved effective October 1, 2011. We are enclosing the HCFA-179 and the amended plan pages.

If you have any questions, please call Sandra Dasheiff, CPA at (214) 767-6490.


Sincerely,

Cindy Mann
Director
Center for Medicaid and CHIP Services

Enclosures

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES		1. TRANSMITTAL NUMBER: 11-060	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: October 1, 2011	
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 8 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: 42 C.F.R. §447.271, 42 C.F.R. §447.272, 42 C.F.R. §447.321 42 C.F.R. §447.325		7. FEDERAL BUDGET IMPACT: SEE ATTACHMENT a. FFY 2012 \$0 b. FFY 2013 \$0 c. FFY 2014 \$0	
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 purpose of this amendment is to delete the pages in the Texas State Plan governing the methodology for computing inpatient, outpatient, and physician supplemental Medicaid payments, also called the Upper Payment Limit (UPL) program.			
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: December 28, 2011			

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 12 - 28 - 2011	18. DATE APPROVED: FEB - 8 2012
PLAN APPROVED - ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: OCT - 1 2011	20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME: Penny Thompson	22. TITLE: Deputy Director, CMCS
23. REMARKS:	

Attachment to Blocks 8 & 9 of CMS Form 179

Transmittal Number 11-060

**Number of the
Plan Section or Attachment**

Attachment 4.19-A

Page 9b
N/A - delete page
N/A - delete page
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Attachment 4.19-B

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**Number of the Superseded
Plan Section or Attachment**

Attachment 4.19-A

Page 9b (TN 10-069)
Page 10 (TN 10-064)
Page 10a (TN 10-064)
Page 10a.1 (TN 09-034)
Page 10b (TN 10-064)
Page 10c (TN 03-030)
Page 10c.1 (TN 08-012)
Page 10d (TN 06-027)
Page 10e.1 (TN 09-034)

Attachment 4.19-B

Page 1a.4 (TN 09-031)
Page 1a.5 (TN 09-031)
Page 1a.6 (TN 11-003)
Page 1a.7 (TN 09-031)
Page 1a.8 (TN 09-031)
Page 1a.9 (TN 09-031)
Page 2a.1 (TN 10-064)
Page 2a.2 (TN 10-064)
Page 2a.3 (TN 09-034)

**METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – INPATIENT
HOSPITAL SERVICES (continued)**

(l) State-Owned Teaching Hospital Reimbursement Methodology.

- (1) For cost reporting periods beginning on or after September 1, 2008, HHSC or its designee reimburses state-owned teaching hospitals under methods and procedures described in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA).
- (2) For dates of admission on or after September 1, 2003, state-owned teaching hospitals with allowable direct graduate medical education (DGME) costs will receive a pro rata share of their annual DGME cost based on the availability of appropriated funds. DGME expenses are not considered costs associated with inpatient hospital services and are not settled to cost.
- (3) Interim payments are determined by multiplying a hospital's charges allowed under Medicaid by the interim rate effective on the date of admission derived from the hospital's most recent Medicaid cost report settlement, whether tentative or final.
- (4) Interim payments are subject to settlement at both tentative and final audit of a hospital's cost report.
- (5) Cost Settlement.
 - (A) The cost settlement process is limited by the TEFRA target cap set pursuant to the Social Security Act §1886(b) (42 U.S.C. §1395ww(b)).
 - (B) Notwithstanding the process in (1), HHSC or its designee uses each hospital's final audited cost report, which covers a fiscal year ending during a base year period, for calculating the TEFRA target cap for each hospital.
 - (C) HHSC or its designee selects a new base year period for calculating the TEFRA target cap at least every three years.
 - (D) HHSC or its designee increases a hospital's TEFRA target cap in years in which the target cap is not reset under this paragraph, by multiplying the target cap by the CMS Prospective Payment System Hospital Market Basket Index adjusted to the hospital's fiscal year.

(m) – (x) Intentionally left blank.

STATE <u>Texas</u>	A
DATE REC'D. <u>12-28-11</u>	
DATE APPROV'D. <u>FEB - 8 2012</u>	
DATE EFF. <u>10-01-11</u>	
HCFA 179 <u>11-60</u>	

SUPERSEDES: TN- 10-69

TN: 11-60

Approval Date: FEB - 8 2012

Effective Date: 10-01-11

Supersedes TN: 10-69

STATE <u>Texas</u>	A
DATE REC'D <u>12-7-10</u>	
DATE APP'D <u>2-2-11</u>	
DATE EFF <u>10-1-10</u>	
HCFA 170 <u>10-64</u>	

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State of Texas
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Page 10

(t) Inpatient Supplemental Payments to Hospitals

- (1) Calculation of the Medicaid Upper Payment Limit (UPL). The inpatient supplemental payments described in subsections (u) - (z) will be made in accordance with the applicable regulations regarding the Medicaid upper limit provisions codified at 42 CFR §447.272. The following method is used to reasonably estimate the Medicaid upper limit. The Medicare Standardized Amount is multiplied by the Medicaid Case Mix derived using Medicare Relative Weights to yield the Medicare DRG Reimbursement for Medicaid Claims. Medicare Pass-Through Payments is divided by Medicaid Discharges to yield Medicare Pass-Through Payments per Discharge. The Medicare DRG Reimbursement for Medicaid Claims is added to Medicare Pass-Through Payments per Discharge to yield the Medicare Equivalent Reimbursement per Discharge per Hospital. This Medicare Equivalent Reimbursement per Discharge per Hospital is multiplied by Medicaid Discharges to yield the Medicaid UPL per Hospital.
- (2) Definitions. When used in (u) - (z), the following terms have the following meanings, unless the context clearly indicates otherwise.
 - (A) Adjudicated Medicaid Claim - A hospital claim for payment for a covered Medicaid service that is paid or adjusted by HHSC or another payer.
 - (B) Disproportionate Share Hospitals (DSH) - Hospitals participating in the Texas Medical Assistance (Medicaid) program that meet the conditions of participation and that serve a disproportionate share of low-income patients are eligible for additional reimbursement from the DSH fund.
 - (C) DSH Limit - DSH Limit has the meaning assigned to the term "hospital specific limit," as determined under Appendix 1 to Attachment 4.19-A (relating to Reimbursement to Disproportionate Share Hospitals).
 - (D) Publicly-Owned or Publicly-Affiliated Hospital - A hospital owned by or affiliated with a city, county, hospital authority or hospital district.
- (3) The supplemental payments authorized for all hospitals identified in (u), (v) and (z) are subject to the following limits:
 - (A) For Disproportionate Share Hospitals, in each fiscal year the amount of any inpatient supplemental payments and outpatient supplemental payments will not exceed the hospital's Disproportionate Share Hospital Limit, as determined under Appendix 1 to Attachment 4.19-A (relating to Reimbursement to Disproportionate Share Hospitals); and

TN 10-64

Approval Date 2-2-11

Effective Date 10-1-10

Supersedes TN 09-34

Superseded By 09-34

Deleted by TN 11-60

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- (B) For all eligible hospitals, the amount of inpatient supplemental payments and fee-for-service Medicaid inpatient payments the hospital receives in a fiscal year will not exceed Medicaid inpatient billed charges for inpatient services provided by the hospital to fee-for-service Medicaid recipients in accordance with 42 CFR §447.271.
- (4) An eligible hospital under (u), (v) or (z) will receive quarterly supplemental payments. The quarterly payments will be:
- (A) For Non-Disproportionate Share Hospitals, the difference between a hospital's fee-for-service billed charges for adjudicated inpatient Medicaid claims and all Medicaid and other payments received during the calculation period for such claims.
- (B) For Disproportionate Share Hospitals, the lesser of:
- (i) The difference between a hospital's fee-for-service billed charges for adjudicated inpatient Medicaid claims and all Medicaid and other payments received during the calculation period for such claims; or
- (ii) One fourth of the difference between the hospital's DSH Limit and the hospital's DSH payments for the federal fiscal year.
- (5) At the time the fourth quarter payment is made for a given federal fiscal year, an eligible hospital under (u), (v) or (z) may be paid any unfunded supplemental payment which they were eligible to receive from the first three quarters of the federal fiscal year.

Superseded By 09-34

STATE <u>TEXAS</u>	A
DATE REC'D <u>12-7-10</u>	
DATE APP'D <u>2-2-11</u>	
DATE EFF. <u>10-1-10</u>	
HCFA 179 <u>10-64</u>	

TN 10-64

Approval Date 2-2-11

Effective Date 10-1-10

Supersedes TN 09-34

Deleted by TN 11-60

(u) Supplemental Payments to Certain Urban Hospitals

- (1) **Introduction.** Supplemental payments are available under this section for inpatient hospital services provided by eligible publicly-owned or -affiliated urban hospitals that serve high volumes of Medicaid and uninsured patients.
- (2) **Eligible hospitals.** Supplemental payments are available under this section for inpatient hospital services provided by publicly-owned hospitals in Bexar, Brazoria, Dallas, Ector, El Paso, Fort Bend, Harris, Lubbock, Nueces, Midland, Tarrant, Travis, and Wichita counties; and a hospital located in Potter County that is affiliated with the Amarillo Hospital District. The publicly-owned or -affiliated hospital or hospitals in each listed county that incur the greatest cost(s) for providing services to Medicaid and uninsured patients will be eligible to receive supplemental payments. No more than two hospitals in any county will be eligible.
- (3) **Dates of eligibility.** Supplemental payments will be made for inpatient services on or after July 6, 2001, for hospitals in Bexar, Dallas, Ector, El Paso, Harris, Lubbock, Nueces, Tarrant, and Travis counties. Supplemental payments will be made for inpatient services on or after February 7, 2004, for hospitals in Midland County. Supplemental payments will be made for inpatient services on or after May 29, 2004, for a hospital in Potter County affiliated with the Amarillo Hospital District. Supplemental payments will be made for inpatient services provided on or after September 1, 2009, for hospitals in Brazoria, Fort Bend, and Wichita counties, as well as any hospital in Dallas County or Harris County that was not eligible as of February 7, 2004, subject to the limits in paragraph (3) of this subsection (u).

STATE	<u>Texas</u>	A
DATE REC'D	<u>9-25-09</u>	
DATE APP'VD	<u>12-08-10</u>	
DATE EFF	<u>9-1-09</u>	
HCFA 179	<u>09-34</u>	

TN 09-034

Approval Date DEC - 8 2010

Effective Date 9-1-09

Supersedes TN New Page

Deleted by TN 11-60

(v) Supplemental Payments to Rural Public Hospitals

- (1) Introduction. Supplemental payments are available under (t) for inpatient hospital services provided to Medicaid patients by rural public hospitals.
- (2) Eligible hospitals. A publicly owned hospital located in a county of less than 100,000 population based on the most recent federal decennial census is eligible to receive supplemental payments under (t).

Superseded By 03-24

STATE	<u>TEXAS</u>	A
DATE RECD	<u>12-2-10</u>	
DATE APPVD	<u>2-2-10</u>	
DATE EFF	<u>10-1-10</u>	
HCFR 179	<u>10-104</u>	

TN 10-104

Approval Date 2-2-11

Effective Date 10-1-10

Supersedes TN 03-24

Deleted by TN 11-60

Page 10c

ATTACHMENT 4.19-A

(w) Notwithstanding other provisions of this attachment, supplemental payments will be made each state fiscal year in accordance with this subsection to state government-owned or operated hospitals for inpatient services provided to Medicaid patients.

(1) Supplemental payments are available under this subsection for inpatient hospital services provided by state government-owned or operated hospitals on or after December 13, 2003. To qualify for a supplemental payment, the hospital must be owned or operated by the state of Texas.

(2) The aggregate supplemental payment amount will be the annual difference between the aggregate upper payment limit and the inpatient fee-for-service Medicaid payments made to the state government-owned or operated hospitals under this attachment. The aggregate upper payment limit will be calculated, based on Medicare payment principles and in accordance with the federal upper limit regulations at 42 CFR 447.272, using the most recent cost report data available.

(3) The amount of the supplemental payment made to each state government-owned or operated hospital will be determined by:

(A) dividing each hospital's fee-for-service Medicaid payments by the sum of the Medicaid fee-for-service payments of all state government-owned or operated hospitals;

(B) multiplying the percentage calculated in (A) by the aggregate supplemental payment calculated in (2).

(4) Supplemental payments determined under this subsection will be calculated annually and paid at the end of each quarter.

(5) Supplemental payments made under this subsection when combined with other inpatient payments made under this attachment shall not exceed the maximum amounts allowable under applicable federal regulations at 42 CFR 447.271.

STATE <u>Texas</u>	A
DATE REC'D <u>12-23-03</u>	
DATE APPV'D <u>6-28-04</u>	
DATE EFF <u>12-13-03</u>	
HCFA 179 <u>TX 03-30</u>	

State: Texas
Transmittal Number: 03-030
Effective Date: 12/13/03
Supersedes: None - New Page

Approved: 28 June 2004

Deleted by TN 11-60

Page 10c.1

ATTACHMENT 4.19-A

(x) Children's Hospital Inpatient Supplemental Payments. Notwithstanding other provisions of this subchapter, supplemental payments are available under this section for inpatient hospital services provided by certain children's hospitals.

(1) For purposes of this section, "Children's Hospital" means a freestanding, non-profit children's hospital within Texas that is recognized by Medicare as a children's hospital and is exempted from the Medicare prospective payment system.

(2) Supplemental payments described in this section are made in accordance with the applicable regulations regarding the Medicaid upper payment limit provisions codified at 42 C.F.R. § 447.272.

(3) Supplemental payments are calculated on a quarterly basis and payments made on a periodic basis to eligible Children's Hospitals.

(4) The total amount of all annual supplemental payments is determined by dividing \$12,500,000 by (100% minus the current state fiscal year Federal Medical Assistance Percentage (FMAP)).

(5) The amount of the supplemental payment to a children's hospital is determined by the following process:

- (A) HHSC shall determine the hospital specific Disproportionate Share Hospital (DSH) limit for each children's hospital, as determined under Appendix I to Attachment 4.19A of the State Plan, using a 12-month consecutive period of the most recent data from the DSH program.
- (B) The hospital specific DSH limit shall be multiplied by a weighting factor to yield the weighted hospital specific limit for each hospital. The weighting factor for each hospital equals 40% divided by (100% - Medicaid %). The Medicaid % is the percent of a hospital's inpatient days of care provided to Medicaid eligible patients and shall be determined by using the most recent data from the DSH program. The maximum weight shall be 3.000.
- (C) Each hospital's pro rata share of the sum of the weighted hospital specific DSH limits for all children's hospitals shall be multiplied by the total amount of supplemental payments for a fiscal year to yield an initial computation of a hospital's annual supplemental payment.
- (D) Using the most recent data from the DSH program, DSH Room is determined for each hospital, which equals the difference between the hospital specific DSH limit and the total DSH payment to the hospital for the fiscal year. A supplemental payment to a hospital cannot exceed the hospital's DSH Room.
- (E) Since a supplemental payment to a hospital cannot exceed the hospital's DSH Room, the lesser of the initial computation of a hospital's supplemental payment and the hospital's DSH Room is determined. This amount is used to determine the total supplemental payment to each hospital in step (H) below.
- (F) The supplemental payment excess is the sum of the initial computation of a hospital's annual supplemental payment minus the hospital's DSH Room.
- (G) The supplemental payment excess shall be distributed, according to their proportionate share of total maximum DSH room, to hospitals that have not reached their hospital specific DSH limit.
- (H) The total supplemental payment to each children's hospital shall be the lesser of the initial supplemental payment calculation and their DSH Room plus their proportionate share of the supplemental payment excess.

STATE	<u>Texas</u>	A
DATE REC'D	<u>6-30-08</u>	
DATE APPROVD	<u>9-18-08</u>	
DATE EFF	<u>6-1-08</u>	
HCFA 179	<u>08-12</u>	

SUPERSEDES: TN- 06-21

Deleted by TN 11-60

(x) Effective September 1, 2006, reimbursement to hospitals in Bexar, Dallas, El Paso, Harris, Lubbock, Nueces, Tarrant and Travis service areas for inpatient services will be determined according to the methodology described and shall be reduced by the percent discounts in subsections (1) and (2) of this section. The percent discounts are necessary to achieve budgetary savings.

- (1) An eight percent discount may be applied to the reimbursement rates of all hospitals for inpatient services provided to Supplemental Security Income (SSI) and SSI-related clients in service areas as determined by the Health and Human Services Commission (HHSC).
- (2) In addition to the discount in subsection (1) of this section a percent discount as determined by HHSC may be applied to inpatient reimbursement rates in order to achieve necessary budgetary savings. This additional discount may be targeted to specific hospitals and vary by service area, depending on the amount necessary to achieve the targeted savings for each service area. This additional discount may also be applied to all inpatient services for traditional fee-for-service clients in service areas determined by HHSC.
- (3) In-state children's hospitals that are cost reimbursed are exempt from the percent discounts in subsections (1) and (2) of this section.
- (4) Definitions:
 - (A) Bexar Service Area means Atascosa, Bexar, Comal, Guadalupe, Kendall, Medina and Wilson counties.
 - (B) Dallas Service Area means Collin, Dallas, Ellis, Hunt, Kaufman, Navarro and Rockwall counties.
 - (C) El Paso Service Area means El Paso County.
 - (D) Harris Service Area means Brazoria, Fort Bend, Galveston, Harris, Montgomery and Waller counties.
 - (E) Lubbock Service Area means Crosby, Floyd, Garza, Hale, Hockley, Lamb, Lubbock, Lynn and Terry counties.
 - (F) Nueces Service Area means Aransas, Bee, Calhoun, Jim Wells, Kleberg, Nueces, Refugio, San Patricio and Victoria counties.
 - (G) Tarrant Service Area means Denton, Hood, Johnson, Parker, Tarrant and Wise counties.
 - (H) Travis Service Area means Bastrop, Burnet, Caldwell, Hays, Lee, Travis and Williamson counties.

STATE	TEXAS	A
DATE REC'D	10-2-06	
DATE AP'D	10-21-06	
DATE EFF	9-1-06	
HCFA 179	06-27	

SUBMITTED BY: [illegible]

Deleted by TN 11-60

State of Texas
Attachment 4.19-A
Page 10a.1

(z) Supplemental Payments to Private Hospitals.

- (1) Introduction.** Private Hospitals with an indigent care affiliation agreement with a hospital district or other local government entity and that serve high volumes of Medicaid and uninsured patients shall be considered eligible to receive supplemental payments under this section.
- (2) Eligible Hospitals.** Supplemental payments will be made for inpatient services on or after June 11, 2005, for eligible private hospitals in Hidalgo, Maverick, Montgomery, Travis, Bexar, and Webb Counties. Supplemental payments will be made for inpatient services on or after November 12, 2005, for all other eligible private hospitals.

TN 09-034

Approval Date DEC - 8 2010

Effective Date 9-1-09

Supersedes TN New Page

STATE	<u>Texas</u>	A
DATE REC'D	<u>9-25-09</u>	
DATE APPV'D	<u>1-20-11</u>	
DATE EFF	<u>9-1-09</u>	
HCFA 179	<u>09-31</u>	

Deleted by TN 11-60
 State of Texas
 Attachment 4.19-B
 Page 1a.4

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.

SUPERSEDES: TN- 04-29

TN No. 09-31 Approval Date 1-20-11 Effective Date 9-1-09

Supersedes TN No. 04-29

Deleted by TN 11-60

- (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:

SUPERSEDES: TN 04-29

STATE	<u>Texas</u>	A
DATE REC'D	<u>9-25-09</u>	
DATE APPL'D	<u>1-20-11</u>	
DATE EFF	<u>9-1-09</u>	
HCFA 179	<u>09-31</u>	

TN No. 09-31 Approval Date 1-20-11 Effective Date 9-1-09

Supersedes TN No. 04-29

Deleted by TN 11-60

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

Eligible state-owned or state-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
Texas A&M Health Science Center

- (B) Employed by a governmental hospital;
- (C) Employed by or under contract with a physician group practice organized by, under the control of, or under contract with a governmental hospital; or
- (D) Employed by or under contract with a physician group practice organized by, under the control of, or under contract with a non-profit, tax exempt hospital where both the hospital and the physician group practice provide medical education under contract to a state-owned medical school.

SUPERSEDES: TN- 10-63

STATE	<u>Texas</u>	A
DATE RECD	<u>3-31-2011</u>	
DATE APPL'D	<u>6-20-2011</u>	
DATE EFF	<u>1-8-2011</u>	
HCFA 179	<u>11-03</u>	

TN 11-03 Approval Date 6-20-2011 Effective Date 1-8-2011

Supersedes TN 10-63

Deleted by TN 11-60

- (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.

STATE	<u>TEXAS</u>
DATE REC'D	<u>9-25-09</u>
DATE APP'D	<u>1-20-11</u>
DATE EFF	<u>9-1-09</u>
HCFA 179	<u>09-81</u>

A

SUPERSEDES: NONE - NEW PAGE

TN No. 09-31 Approval Date 1-20-11 Effective Date 9-1-09

Supersedes TN No. SUPERSEDES: NONE - NEW PAGE

Deleted by ^{TN}11-60

- (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:

$$\frac{\text{(number of occurrences of CPT code with modifiers x Medicare anesthesia base units)}}{\text{the sum of the Medicaid paid units for that CPT code with modifiers}}$$
 - (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.

SUPERSEDES: NONE - NEW PAGE

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DATE REC'D	<u>9-25-09</u>	
DATE APP'VD	<u>1-20-11</u>	
DATE EFF	<u>9-1-09</u>	
HCFA 179	<u>09-31</u>	

TN No. 09-31 Approval Date 1-20-11 Effective Date 9-1-09

Supersedes TN No. **SUPERSEDES: NONE - NEW PAGE**

Deleted by TN 11-60

- (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.

STATE	<u>Texas</u>	A
DATE REC'D	<u>9-28-09</u>	
DATE APP'D	<u>1-20-11</u>	
DATE EFF	<u>9-1-09</u>	
HCFR 179	<u>09-31</u>	

SUPERSEDES: NONE - NEW PAGE

TN No. 09-31 Approval Date 1-20-11 Effective Date 9-1-09

Supersedes TN No. **SUPERSEDES: NONE - NEW PAGE**

STATE	<u>TEXAS</u>
DATE REC'D	<u>12-2-10</u>
DATE APP'D	<u>2-2-11</u>
DATE EFF	<u>10-1-10</u>
HCSA 179	<u>10-64</u>

A

Deleted by TN 11-60

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8. Outpatient Supplemental Payments to Hospitals

- (a) The supplemental payments described in this section 8 will be made in accordance with the applicable regulations regarding the Medicaid upper limit provisions codified at 42 CFR §447.321.
- (b) Definitions. When used in this section, the following terms have the following meanings, unless the context clearly indicates otherwise.
 - (1) Adjudicated Claims - A hospital claim for payment for a covered Medicaid service that is paid or adjusted by HHSC or another payer.
 - (2) Disproportionate Share Hospital (DSH) - Hospitals participating in the Texas Medical Assistance (Medicaid) program that meet the conditions of participation and that serve a disproportionate share of low-income patients are eligible for additional reimbursement from the DSH fund.
 - (3) DSH Limit - DSH Limit has the meaning assigned to the term "hospital specific limit," as determined under Appendix 1 to Attachment 4.19-A (relating to Reimbursement to Disproportionate Share Hospitals) for DSH Hospitals.
 - (4) Medicaid Allowable Outpatient Hospital Costs - Costs remaining when total billed outpatient hospital charges are reduced by a hospital outpatient reduction factor in accordance with 4(a) of Attachment 4.19-B (relating to Outpatient Hospital Reimbursement).
 - (5) Publicly-Owned or Publicly-Affiliated Hospital - A hospital owned by or affiliated with a city, county, hospital authority or hospital district.
- (c) Supplemental Payment Limits
 - (1) The supplemental payments authorized for all hospitals identified in 8(e), 8(f), and 8(h) are subject to the following limits:
 - (i) For Disproportionate Share Hospitals, in each fiscal year the amount of any inpatient supplemental payments and outpatient supplemental payments may not exceed the hospital's DSH Limit, as determined under Appendix 1 to Attachment 4.19-A (relating to Reimbursement to Disproportionate Share Hospitals);
 - (ii) The amount of outpatient supplemental payments and fee-for-service Medicaid outpatient payments the hospital receives in a fiscal year may not exceed Medicaid billed charges for outpatient services provided by the hospital to fee-for-service Medicaid recipients in accordance with 42 CFR §447.325.

TN 10-64

Approval Date 2-2-11

Effective Date 10-1-10

Supersedes TN 09-34

Superseded By 09-34

STATE	<u>Texas</u>	A
DATE REC'D	<u>09-25-09</u>	
DATE APP'D	<u>12-03-10</u>	
DATE EFF	<u>9-1-09</u>	
HCFA 170	<u>09-24</u>	

Deleted by TN 11-60

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(f) Outpatient Supplemental Payments to Private Hospitals

- (1) Introduction. Supplemental payments are available under this subsection (f) for outpatient hospital services provided by eligible private hospitals that serve Medicaid and uninsured patients.
- (2) Eligible Hospitals. Supplemental payments will be made for outpatient services on or after June 11, 2005 for eligible private hospitals in Hidalgo, Maverick, Montgomery, Travis, Bexar, and Webb Counties. Supplemental payments will be made for outpatient services on or after November 12, 2005 for all other eligible private hospitals.

(g) Outpatient Supplemental Payments to State-Owned Hospitals

- (1) Introduction. Supplemental payments will be made each fiscal year in accordance with this subsection (g) to state government-owned or operated hospitals for services provided to Medicaid patients.
- (2) Eligible Hospitals. Supplemental payments are available under this subsection (g) for outpatient hospital services provided by state government-owned or operated hospitals. To qualify for a supplemental payment, the hospital must be owned or operated by the state of Texas.
- (3) The amount of the supplemental payment made to each state government owned or operated hospital is the difference between the Medicaid fee-for-service outpatient payments received and 100% of the hospital's Medicaid allowable outpatient hospital cost. Medicaid payments and cost will be based on the most recent complete fiscal year period of fee-for-service adjudicated claims data.

(h) Outpatient Supplemental Payments to Rural Public Hospitals

- (1) Introduction. Supplemental payments are available under this subsection (h) for outpatient hospital services provided by eligible rural public hospitals that serve of Medicaid and uninsured patients.
- (2) Eligible Hospitals. Supplemental payments are available under this subsection (g) for outpatient hospital services provided by rural public hospitals located in a county of less than 100,000 population based on the most recent federal decennial census.

TN 09-034

Approval Date DEC - 8 2010

Effective Date 9-1-09

Supersedes TN New Page