

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES		1. TRANSMITTAL NUMBER: 10-086	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: February 1, 2011	
5. TYPE OF PLAN MATERIAL (<i>Circle One</i>): <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 (<i>Separate Transmittal for each amendment</i>)			
6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR §440.20		7. FEDERAL BUDGET IMPACT: SEE ATTACHMENT a. FFY 2011 \$ (6,854,927) b. FFY 2012 \$ (9,258,046) c. FFY 2013 \$ (9,569,117)	
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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>): SEE ATTACHMENT TO BLOCKS 8 & 9	
10. SUBJECT OF AMENDMENT: The amendment implements a one percent payment reduction for hospital outpatient services.			
11. GOVERNOR'S REVIEW (<i>Check One</i>): <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: <i>[Signature]</i>		16. RETURN TO: Billy R. Millwee State Medicaid Director Post Office Box 85200 Austin, Texas 78711-5200	
13. TYPED NAME: Billy R. Millwee			
14. TITLE: State Medicaid Director			
15. DATE SUBMITTED: December 27, 2010			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: 28 December, 2010		18. DATE APPROVED: 16 March, 2011	
PLAN APPROVED – ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 1 February, 2011		20. SIGNATURE OF REGIONAL OFFICIAL: <i>[Signature]</i>	
21. TYPED NAME: Bill Brooks		22. TITLE: Associate Regional Administrator Division of Medicaid & Children's Health	
23. REMARKS:			

STATE <u>Texas</u>	A
DATE REC'D <u>12-28-10</u>	
DATE APPV'D <u>3-16-11</u>	
DATE EFF <u>2-1-11</u>	
HCFA 179 <u>10-86</u>	

4. Outpatient Hospital Services

Medicaid payments for outpatient hospital services are equal to a percentage of full, allowable costs and are determined in the following manner:

- (a) Interim Medicaid payments are paid for a hospital's allowable Medicaid Outpatient claim based on the following calculation:
 - (1) The allowable Medicaid Outpatient charges per claim are multiplied by the cost reduction percentage, described in (3) below;
 - (2) The results in (1) are multiplied by each hospital's ratio of cost to charges as derived from outpatient cost centers contained in the most recently filed Medicaid Hospital Cost Report (CMS Form 2552). This result is the Medicaid Outpatient Hospital Services claim interim payment.
 - (3) For services delivered on or after September 1, 2001, the cost reduction percentage is equal to 84.48 percent of allowable charges for a high-volume provider, and 80.3 percent of allowable charges for the remaining hospitals. A high-volume provider is defined as one that is paid at least \$200,000 during calendar year 2004.
- (b) Final Medicaid payment is determined by comparing allowed costs to interim payments. The State identifies the allowable costs from outpatient cost centers contained in the hospital fiscal year-end Medicaid Hospital Cost Report as filed on CMS Form 2552. These costs are reduced by the cost reduction factor, described in (3) above, and compared to the aggregate adjudicated interim Medicaid payments for claims with dates of service that match the corresponding hospital fiscal year-end cost report. This comparison will result in a payment or recoupment to/from the hospital provider, also described as an estimate of the total Medicaid outpatient hospital services costs for each provider. The most recent ratio of cost to charges from the cost report settlement process is applied to the future interim Medicaid payment (4)(A) above and is completed on each as filed, amended, or Medicare-audited cost report.
- (c) 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.
- (d) The reimbursement for services effective February 1, 2011 will be equal to the payment that would have been made on August 31, 2010, less two percent.
- (e) This methodology results in an estimate of total Medicaid outpatient hospital services cost for each provider that is consistent with the upper payment limit for such services described at 42 CFR 447.321.
- (f) The methodology described in this section is applicable to provider-based facilities as defined at 42 CFR 413.65.

5. **Hospital Ambulatory Surgical Centers (HASC)** are reimbursed in accordance with Attachment 4.19-B, page 7(f), relating to the reimbursement methodology for Ambulatory Surgical Centers (ASCs).

6. **Intentionally left blank.**

7. **Intentionally left blank.**

SUPERSEDES: TN- 10-43

TN 10-86

Approval Date 3-16-11

Effective Date 2-1-11

Supersedes TN 10-43