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### **State Plan Amendment (SPA) #: 16-0011**

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5. Approved SPA Page

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



**DIVISION OF MEDICAID & CHILDREN'S HEALTH - REGION VI**

June 6, 2016

Our Reference: SPA TX 16-0011

Mr. Gary Jessee  
State Medicaid/CHIP Director  
Health and Human Services Commission  
Post Office Box 13247  
Mail Code H100  
Austin, Texas 78711

**RECEIVED**

JUN 09 2016

OFFICE OF THE STATE  
MEDICAID DIRECTOR

Dear Mr. Jessee:

We have reviewed the State's proposed amendment to the Texas State Plan submitted under Transmittal Number 16-0011, dated March 31, 2016. This state plan amendment updates the physicians' and other practitioners', and tuberculosis clinic fee schedules.

Based on the information submitted, we have approved the amendment for incorporation into the official Texas State Plan with an effective date of January 1, 2016. A copy of the CMS-179 and approved plan page are enclosed with this letter.

If you have any questions please contact Suzette Seng of my staff. Ms. Seng may be reached at (214) 767-6478 or by Email at [Suzette.Seng@cms.hhs.gov](mailto:Suzette.Seng@cms.hhs.gov).

Sincerely,

  
for Bill Brooks  
Associate Regional Administrator

cc: Dana Williamson, Manager, Policy Development Support

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES</b>		1. TRANSMITTAL NUMBER:  <b>16-0011</b>	2. STATE:  <b>TEXAS</b>
		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:  <b>January 1, 2016</b>	
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:  <b>Social Security Act §1902(a)(30); 42 CFR 447.201(b).</b>		7. FEDERAL BUDGET IMPACT: <b>SEE ATTACHMENT</b> a. FFY 2016 (\$1,419,007) b. FFY 2017 (\$1,959,279) c. FFY 2018 (\$2,101,644)	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  <b>SEE ATTACHMENT TO BLOCKS 8 &amp; 9</b>		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT ( <i>If Applicable</i> ):  <b>SEE ATTACHMENT TO BLOCKS 8 &amp; 9</b>	
10. SUBJECT OF AMENDMENT:  <b>The proposed amendment updates the physicians' and other practitioners' and tuberculosis clinic fee schedules.</b>			
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: 		16. RETURN TO:  <b>Gary Jessee State Medicaid Director Post Office Box 13247, MC: H-100 Austin, Texas 78711</b>	
13. TYPED NAME: <b>Gary Jessee</b>			
14. TITLE: <b>State Medicaid Director</b>			
15. DATE SUBMITTED: <b>March 31, 2016</b>			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED: <b>March 31, 2016</b>		18. DATE APPROVED: <b>June 06, 2016</b>	
PLAN APPROVED – ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL:  <b>January 01, 2016</b>		20. SIGNATURE OF REGIONAL OFFICIAL:  for Bill Brooks	
21. TYPED NAME:  <b>Bill Brooks</b>		22. TITLE: <b>Associate Regional Administrator Division of Medicaid and Children's Health</b>	
23. REMARKS:			

## Attachment to Block 7 of CMS Form 179

### Transmittal Number 16-0011

	<b>Total Fiscal Impact</b>	<b>Federal</b>	<b>State</b>
<b>FFY 2016</b>	(\$2,483,821)	(\$1,419,007)	(\$1,064,814)
<b>FFY 2017</b>	(\$3,487,502)	(\$1,959,279)	(\$1,528,223)
<b>FFY 2018</b>	(\$3,740,912)	(\$2,101,644)	(\$1,639,268)

The above fiscal impact for physicians and other practitioners is based on the difference between the current rate and the newly implemented rate for which a rate was changed, multiplied by the trended units of service as described below.

FFY 2016: Federal fiscal year (FFY) 2014 units were trended to FFY 2015 by 1.0807 and then to 2016 by 1.0175, then pro-rated for the portion of the FFY during which the new rates will be in effect.

FFY 2017: The FFY 2016 trended unit amount was then trended to FFY 2017 by 1.0445.

FFY 2018: The FFY 2017 trended unit amount was then trended to FFY 2018 by 1.0445.

The applied federal medical assistance percentages are 57.13 percent for FFY 2016, 56.18 percent for FFY 2017, and 56.18 percent for FFY 2018.

#### **Explanation for Rate Change and Amendment Submission**

This state plan amendment implements changes to combinations of procedure code, type of service, modifier, and age group, and was the result of multiple actions:

- 16 procedure codes were updated for the biennial calendar fee review for Access to Care based on manual pricing and access-based fees. The reimbursement increased for six procedure codes, and remained the same for ten procedure codes.
- 5,619 procedure codes for the biennial calendar fee review for Musculoskeletal System Surgery were updated based on the Medicare relative value unit (RVU) times the age appropriate Medicaid conversion factor, the Medicare RVU for clinically comparable procedure code, 16 percent of the surgical rate for assistant surgery, and manual pricing. The reimbursement increased for 4,502 procedure codes, decreased for 989 procedure codes, and remained the same for 128 procedure codes.
- Nine procedure codes for the biennial calendar fee review for Q Codes were updated based on 85 percent of MediSpan average wholesale price (AWP) and the regional Medicare fee. The reimbursement rates increased for one

procedure code, decreased for seven procedure codes, and remained the same for one procedure code.

- Six procedure codes for the biennial calendar fee review for R Codes (Transportation of portable x-ray equipment to home or nursing home, per trip) were updated based on the median of other state's Medicaid rates. The reimbursement decreased for all six procedure codes.
- 18 procedure codes for the biennial calendar fee review for Radiopharmaceuticals were updated based on 85 percent of MediSpan AWP, the mean of other Medicaid State's rates, and manual pricing. The reimbursement increased for three procedure codes, decreased for two procedure codes, and remained the same for 13 procedure codes.
- 972 procedure codes for the biennial calendar fee review for Respiratory System Surgery were updated based on the Medicare RVU times the age appropriate Medicaid conversion factor, the regional Medicare fee, 16 percent of the surgical rate for assistant surgery, and manual pricing. The reimbursement increased for 22 procedure codes, decreased for 939 procedure codes, and remained the same for 11 procedure codes.
- Six procedure codes for the biennial calendar fee review for T Codes were updated based on based on the current Medicaid fee. The reimbursement remained the same for all six procedure codes.
- Six procedure codes for the medical policy review of Magnetoencephalography were reviewed. All six procedure codes were added as new Medicaid benefits with fees based on the regional Medicare fee.
- 29 procedure codes for the medical policy review of Diagnostic and Therapeutic Breast Procedures were reviewed. 13 procedure codes were added as Medicaid benefits, 12 procedure codes were updated, and four procedure codes were removed. Pricing was based on the Medicare RVU multiplied by the age appropriate Medicaid conversion factor and 16 percent of the surgical rate for assistant surgery.
- Five procedure codes for the medical policy review of Pathology and Laboratory Services - Microbiology were reviewed. All five procedure codes were discontinued due to currently existing comparable procedure codes that are existing Medicaid benefits.
- 98 procedure codes for the medical policy review of Vision Services Nonsurgical were reviewed. 62 procedure codes were added as new Medicaid benefits, 30 procedure codes were updated, and six procedure codes were removed. Pricing was based on the Medicare RVU multiplied by the age appropriate Medicaid conversion factor.
- Three procedure codes for the HCPCS Quarterly Update of Physician Administered Drugs (J9299 [replaces C9453], J2502 [replaces C9454], and J2860 [replaces C9455]) were added as Medicaid benefits based on 100 percent of the current Medicare Fee and 85 percent of the MediSpan AWP.
- Two procedure codes for the HCPCS Quarterly Update of Physician Administered Drugs (J1822 [replaces C9456] and Q9950 [(replaces C9457)]) were added as Medicaid benefits based on MediSpan AWP.

- 13 procedure codes for the HCPCS Annual Update of Physician Administered Drugs were added as new Medicaid benefits based on 85 percent of the MediSpan AWP, 89.5 percent of the MediSpan AWP, 89.5 percent of the current Medicare Fee for a clinically comparable procedure code, and 100 percent of the current Medicare Fee.
- 12 procedure codes for the HCPCS Annual Update of Medical Services and Home Health Services were added as new Medicaid benefits based on the Medicare RVU times the age appropriate Medicaid conversion factor.
- 116 procedure codes for the HCPCS Annual Update of Surgery and Assistant Surgery were added as new Medicaid benefits based on the Medicare RVU multiplied by the age appropriate Medicaid conversion factor and 16 percent of the surgical rate for assistant surgery.
- 84 procedure codes for the HCPCS Annual Update of Radiology, Professional and Technical Components were added as new Medicaid benefits based on the Medicare RVU multiplied by the age appropriate Medicaid conversion factor.
- 7 procedure codes for the HCPCS Annual Update of Laboratory, Professional and Technical Components were added as new Medicaid benefits based on the Medicare RVU multiplied by the age appropriate Medicaid conversion factor and the current clinical laboratory fee for a clinically comparable procedure code.
- 30 procedure codes for the HCPCS Annual Update of Radiation Therapy, Professional and Technical Components were added as new Medicaid benefits based on the Medicare RVU multiplied by the age appropriate Medicaid conversion factor.

Access to care will not be affected and communications with providers will be maintained to address any concerns, should they arise.

There were no across-the-board percentage decreases or increases.

**Attachment to Blocks 8 & 9 of CMS Form 179**

**Transmittal Number 16-0011**

**Number of the  
Plan Section or Attachment**

Attachment 4.19-B  
Page 1a.3

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

Attachment 4.19-B  
Page 1a.3 (TN 15-034)

State: Texas  
Date Received: 3-31-16  
Date Approved: 6-6-16  
Date Effective: 1-1-16  
Transmittal Number: 16-0011

**1. Physicians and Other Practitioners (continued)**

- (f) When a procedure code is nationally discontinued, a replacement procedure code is nationally assigned for the discontinued procedure code, and Medicaid implements the replacement procedure code, a state plan amendment will not be submitted since the fee for the service has not changed.
- (g) To ensure access to care and prompt provider reimbursement, when a new national procedure code is assigned to a physician-administered drug or biological product, a preliminary reimbursement rate will be established by the Texas Health and Human Services Commission (HHSC) based on the published Medicare reimbursement rate; or the average wholesale price (AWP) in the absence of a Medicare reimbursement rate for the procedure code or the comparable code. In accordance with 42 CFR §447.205(b)(1), a public notice and state plan amendment will not be submitted for this preliminary reimbursement rate. This will allow the new procedure code to be payable as the reimbursement process is completed with a public notice published and a state plan amendment submitted.
- (h) All fee schedules are available through the agency's website, as outlined on Attachment 4.19-B, page 1.
- (i) The agency's fee schedule was revised with new fees for services provided by physicians and other practitioners affiliated with tuberculosis clinics or employed by tuberculosis clinics effective January 1, 2016, and this fee schedule was posted on the agency's website on January 15, 2016.
- (j) The agency's fee schedule was revised with new fees for physicians effective January 1, 2016, and this fee schedule was posted on the agency's website on January 15, 2016.

State: Texas  
Date Received: 3-31-16  
Date Approved: 6-6-16  
Date Effective: 1-1-16  
Transmittal Number: 16-0011