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		Version 2.1	

DOCUMENT HISTORY LOG

STATUS ¹	DOCUMENT REVISION ²	EFFECTIVE DATE	DESCRIPTION ³
Baseline	2.0	September 1, 2013	Initial version of Uniform Managed Care Manual Chapter 13.1, "Supplemental Payments for Qualified Providers" Chapter 13.2 applies to contracts issued as a result of HHSC RFP numbers 529-06-0293, 529-10-0020, and 529-12-0002.
Revision	2.1	March 20, 2014	Section VI. "MCO's Financial Statistical Reports (FSRs)" is deleted in its entirety.

¹ Status is represented as "Baseline" for initial issuances, "Revision" for changes to the Baseline version, and "Cancellation" for withdrawn versions.

² Revisions are numbered according to the version of the issuance and sequential numbering of the revision—e.g., "1.2" refers to the first version of the document and the second revision.

³ Brief description of the changes to the document made in the revision.



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I. APPLICABILITY OF CHAPTER 13.1

This chapter applies to Managed Care Organizations (MCOs) participating in the STAR, STAR+PLUS, and STAR Health Programs. References to “Medicaid” or the “Medicaid Managed Care Program(s)” apply to the STAR, STAR+PLUS, and STAR Health Programs. The term “MCO” includes health maintenance organizations (HMOs), exclusive provider organizations (EPOs), insurers and any other entities licensed or approved by the Texas Department of Insurance. The requirements in this chapter apply to all programs, except where noted.

II. PURPOSE\BACKGROUND

In accordance with PPACA, as amended by Section 1202 of the Health Care and Education Reconciliation Act, and corresponding federal regulations at 42 C.F.R. §§ 438.6 and 438.804, Medicaid MCOs must make supplemental payments to qualified Medicaid providers.

This chapter details the types of providers who are eligible for supplemental payments, provided they comply with HHSC’s self-attestation requirements. It also includes the requirements for verifying MCO payments to qualified providers, and the procedures for supplemental payment adjustments, including documentation of recoupments of overpaid amounts.

III. QUALIFIED PROVIDERS

As required by federal law and regulation, the following types of providers are eligible for supplemental payments for primary care services:

1. physician with a specialty designation of family medicine, general internal medicine, or pediatric medicine; and
2. specialists and subspecialists within those designations as recognized by the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA), the American Board of Physician Specialties (ABPS), or the American Board of Allergy and Immunology (ABAI).

The term “general internal medicine” encompasses internal medicine and all subspecialties recognized by the ABMS, AOA, and ABPS.

In order to be qualified for the supplemental payment:



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1. physicians must first self-attest to a covered specialty or subspecialty designation; and
2. as part of that attestation, they must specify that they are board certified in an eligible specialty or subspecialty or that 60 percent of their Medicaid billings for the prior year were for the Evaluation and Management (E&M) codes specified in the regulation.

Services eligible for supplemental payments are the following codes, or their successor codes:

1. E&M ICD-9 codes 99201 through 99499; and
2. Services related to the Administration of Vaccines (CPT-4 codes 90460, 90461, 90471, 90472, 90473 and 90474).

As described in the Contract, HHSC or its Administrative Services Contractor will conduct the provider self-attestation process and determine which providers and services are eligible for supplemental payments. Providers who complete the self-attestation process on or before HHSC's initial enrollment deadline will be eligible for supplemental payments for dates of service from January 1, 2013, through December 31, 2014. Providers who complete the self-attestation process after the initial enrollment deadline will be eligible for supplemental payments beginning on the month the self-attestation is accepted by HHSC.

If the MCO makes payments to a billing provider group (such as a group practice, facility, or institution) under a Network Provider Agreement, the agreement must ensure that the full amount of supplemental payments described in this chapter are passed down from the billing provider group to the eligible provider.

IV. INFORMATION FROM HHSC

HHSC or its Administrative Services Contractor will provide a "Supplemental Payment Report" to the MCO detailing the amount of the supplemental payment that the MCO must issue to the qualified provider. The "Supplemental Payment Report" will identify the supplemental payment amount and the following.

- Plan code
- MCO ID
- Claim line number/Internal Control Number (ICN)
- Member ID
- National Provider Identifier (NPI) for billing and performing provider



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- Date of service
- Amount of supplemental payment to be issued by the MCO (the “Base Supplemental Payment”)

For adjustments, the following is required.

- Plan code
- MCO ID
- Member ID
- NPI for billing and performing provider
- Date of service
- Original Claim/ICN
- Adjusted Claim/ICN
- Adjusted amount based on the amount of over- or underpayment based on claim payment adjustment (the “Supplemental Payment Adjustment”)

V. MCO’S CONFIRMATION REPORT

The MCO must submit a “Confirmation Report” to HHSC no later than 60 calendar days after receipt of HHSC’s Supplemental Payment Report with confirmation that it paid the full amount of the supplemental payments to qualified providers. The Confirmation Report will include the following.

- Plan Code
- MCO ID
- Original Claim/ICN
- Adjusted Claim/ICN
- Member ID
- NPI for billing and performing provider
- Date of Service
- Base Supplemental Payment
- Supplemental Payment Adjustment
- The amount of the Base Supplemental Payment minus the Supplemental Payment Adjustment, if any (the “Actual Supplemental Payment”)
- Date Actual Supplemental Payment was generated
- Invoice/electronic transfer identification number