DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES

1. TRANSMITTAL NUMBER: **09-036**

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 5, 2009

5. TYPE OF PLAN MATERIAL *(Circle One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR §440.150

7. FEDERAL BUDGET IMPACT: SEE ATTACHMENT
a. FFY **2009** **$ 29,217**
b. FFY **2010** **$407,174**
c. FFY **2011** **$363,331**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
SEE ATTACHMENT

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
SEE ATTACHMENT

10. SUBJECT OF AMENDMENT:

The proposed amendment will eliminate direct service spending requirements for the Intermediate Care Facilities for Persons with Mental Retardation (ICF/MR) program effective for costs accrued on or after September 5, 2009. The amendment also modifies the descriptions of the cost components included in the ICF/MR rates and updates the reimbursement methodology to eliminate references to an outdated model.

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: Sent to Governor's Office this date. Comments, if any, will be forwarded upon receipt.

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME:
Chris Traylor

14. TITLE:
State Medicaid Director

15. DATE SUBMITTED:
September 25, 2009

16. RETURN TO:
Chris Traylor
State Medicaid Director
Post Office Box 85200
Austin, Texas 78711-5200

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED:
11-5-09

PLAN APPROVED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
SEP - 5 2009

[redacted]

21. TYPE NAME:
William Lasowski

22. TITLE:
Deputy Director, CMSO

23. REMARKS:

FORM HCFA-179(07-92)

Instructions on Back

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State: TEXAS

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X. Payment Rate Determination continued.

(c) Dietary costs, including compensation costs for dietary personnel as well as costs for food and dietary supplements.

(d) Transportation, facilities and operations costs, including compensation costs for maintenance personnel and drivers, maintenance supplies, contract maintenance and repairs, building and building equipment, departmental equipment and transportation equipment rental/lease and depreciation, land and leasehold improvement, depreciation/amortization, mortgage interest, property taxes, property and vehicle insurance, and utilities and telecommunications.

(e) Administration expenses, compensation costs for administration personnel such as facility administrator, clerical support and central office staff, management contract fees, professional service fees, contracted administrative staff, general liability insurance, interest expense on working capital, allowable advertising, travel and seminars, dues and subscriptions, office supplies, central office costs and other office expenses.

(3) Determination of modeled rates. The modeled rates are determined using the most recent audited cost reports available at the time the proposed rates are calculated and projected to the rate period. HHSC adjusts reported expenses using a cost finding methodology to determine daily allowed costs. Providers are responsible for eliminating all unallowable expenses from the cost report. HHSC will exclude unallowable costs from the cost report and will exclude entire cost reports from rate determination if it believes that the cost reports do not reflect economic and efficient use of resources.

(B) Non-state-operated Facilities. HHSC determines payment rates. Payment rates are uniform statewide by class and by level of need. Payment rates are determined prospectively.

(1) Rate classes. The non-state-operated facilities are divided into three classes that are determined by the size of the facility.

(a) Large facility – a facility with Medicaid certified capacity of fourteen or more beds as of the first day of the full month preceding the rate's effective date or, if certified for the first time after a rate's effective date, as of the date of the initial certification;

(b) Medium facility – a facility with Medicaid certified capacity of nine through thirteen beds as of the first day of the full month preceding the rate's effective date or, if certified for the first time after a rate's effective date, as of the date of the initial certification; and

(c) Small facility – a facility with Medicaid certified capacity of eight or fewer beds as of the first day of the full month preceding the rate's effective date or, if certified for the first time after a rate's effective date, as of the date of the initial certification.

(2) Cost components. The modeled rates described in section X(B)(3) are based on cost components shown below. The determination of these cost components is based on historical costs and financial, statistical, and operational information collected from ICF/MR providers. Included in the costs are:

(a) Direct services costs, including compensation costs for direct care personnel and direct care supervisors.

(b) Other resident care costs, including compensation costs for laundry and housekeeping personnel, social workers, medical records personnel, resident care training personnel, therapists, psychologists and other direct care consultants, as well as costs for medical equipment and supplies, and laundry/housekeeping equipment and supplies.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-13-15
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations, CMSO

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

NOV - 5 2009

RE: TN 09-36

Dear Mr. Traylor:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 09-36. The proposed amendment will eliminate mandatory spending requirements for direct services in the Intermediate Care Facilities for Persons with Mental Retardation (ICF/MR) program effective for costs incurred on or after September 5, 2009.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13) and 1902(a)(30), and 1903(a) 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 Attachment 4.19-D. Based upon your responses we are pleased to inform you that Medicaid State plan amendment 09-36 is approved effective September 5, 2009. We are enclosing the HCFA-179 and the new plan pages.

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

Sincerely,

[redacted]

Cindy Mann
Director
Center for Medicaid and State Operations (CMSO)

Enclosures

Attachment to Blocks 8 and 9 to CMS Form 179

Transmittal No. 09-036, Amendment No. 882

Number of the Plan Section or Attachment	**Number of the Superseded Plan Section or Attachment**
Attachment 4.19-D, ICF/MR	Attachment 4.19-D, ICF/MR
Page 5	Page 5 (TN 05-003)
Page 6	Page 6 (TN 05-003)
Page 7	Page 7 (TN 05-003)