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

Division of Medicaid & Children's Health, Region VI

April 21, 2011

Our Reference: SPA TX 10-30

Mr. Billy Millwee
Associate Commissioner for Medicaid & CHIP
Health and Human Services Commission
Post Office Box 13247
Mail Code: H100
Austin, Texas 78711

Dear Mr. Millwee:

We have reviewed the State's proposed amendment to the Texas State Plan submitted under Transmittal Number 10-30, dated June 9, 2010. This state plan amendment updates the targeted case management for persons with chronic mental illness services fee schedule rate and implements a one percent reimbursement reduction.

Based on the information submitted, we have approved the amendment for incorporation into the official Texas State Plan with an effective date change of September 1, 2010. A copy of the CMS-179 and the approved plan pages are enclosed with this letter.

CMS is approving this state plan amendment; however, due to concerns regarding potential problems with access to care, CMS will continue to inquire about the results of the State's planned efforts to monitor access to care to help determine whether it has been negatively affected by this rate reduction or due to the State's rate reductions. If you have any questions, please contact Cheryl Rupley at (214) 767-6278.

Sincerely,

/s/

Bill Brooks
Associate Regional Administrator

Enclosures
cc: Emily Zalkovsky, Policy Development Support

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: **10-030**

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 1, 2010

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 USC 1396n(g)

7. FEDERAL BUDGET IMPACT: SEE ATTACHMENT
a. FFY **2010** **$(5,249)**
b. FFY **2011** **$(56,071)**
c. FFY **2012** **$(55,156)**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
SEE ATTACHMENT TO BLOCKS 8 AND 9

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
SEE ATTACHMENT TO BLOCKS 8 AND 9

10. SUBJECT OF AMENDMENT:
The proposed amendment is an update to the mental health targeted casement management fee schedule and implements the one percent payment reduction for reimbursements paid to mental health case management providers.

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:
Billy R. Millwee

14. TITLE:
State Medicaid Director

15. DATE SUBMITTED:
June 9, 2010

16. RETURN TO:
Billy R. Millwee
State Medicaid Director
Post Office Box 13247, MC: H-100
Austin, Texas 78711

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
9 June, 2010

18. DATE APPROVED:
21 April 2011

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
1 September, 2010

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME:
Bill Brooks

22. TITLE:
Associate Regional Administrator
Division of Medicaid & Children's Health

23. REMARKS:

FORM CMS – 179 (07-92)

STATE Texas DATE REC'D 6-9-10 DATE APPV'D 4-21-11 DATE EFF 9-1-10 HCFA 179 10-30	A

21. Case Management for persons with chronic mental illness

Reimbursement for case management services for individuals with chronic mental illness is subject to the specifications, conditions and limitations required by the Health and Human Services Commission (HHSC) or its designee. These include the specifications provided in OMB Circular A-87 and A-102.

The statewide reimbursement rates for the case management services program are interim throughout the rate period and subsequently adjusted to cost. HHSC or its designee determines statewide reimbursement rates biennially. The reimbursement rates are based upon allowable costs, as specified by the operating agency or its designee, for qualified staff, travel, facility, and administrative overhead expenditures. The unit of service is a fifteen minute face-to-face contact with a Medicaid-eligible individual.

The interim reimbursement rate in effect on September 30, 2007 will remain in effect from October 1, 2007 through August 31, 2010.

Claims for reimbursement for case management services include:
- Date of Service;
- Name of recipient;
- Identifying Medicaid number;
- Address;
- Name of provider agency;
- Unit(s) of service delivered; and
- Place of service.

Reimbursement rates are determined in the following manner:
1. Inclusion of certain reported expenses. Provider agencies must ensure that all requested costs are included in the cost report. Failure to do so may result in penalties.
2. Several different kinds of data are collected. These include the number of units of service. The cost data include direct costs, programmatic indirect costs, and general and administrative overhead costs.

- The reimbursement for services effective September 1, 2010 will be equal to the reimbursement on August 31, 2010, less one percent.

- The agency's fee schedule was revised with new fees effective for services on or after September 1, 2010. The fee schedule was posted by October 1, 2010.

- All fee schedules are available through the agency's website as outlined on Attachment 4.19-B, Page 1