

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 26, 2011

Our Reference: SPA TX 11-07

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 11-07, dated February 3, 2011. This state plan amendment implements a one percent reimbursement reduction and updates the fee schedule for targeted case management services for individuals with chronic mental illness.

Based on the information submitted, we have approved the amendment for incorporation into the official Texas State Plan with an effective date change of February 1, 2011. A copy of the CMS-179 and the approved plan pages are enclosed with this letter.

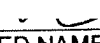
If you have any questions, please contact Cheryl Rupley at (214) 767-6278.

Sincerely,

Bill Brooks
Associate Regional Administrator

Enclosures

cc: Emily Zalkovsky, Policy Development Support

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES		1. TRANSMITTAL NUMBER: 11-007	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 (Circle One): <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 (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: 42 USC 1396n(g)		7. FEDERAL BUDGET IMPACT: SEE ATTACHMENT a. FFY 2011 \$ (76,250) b. FFY 2012 \$(106,076) c. FFY 2013 \$(109,640)	
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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): SEE ATTACHMENT TO BLOCKS 8 & 9	
10. SUBJECT OF AMENDMENT: The proposed amendment is an update to the fee schedule for case management for persons with chronic mental illness and implements a one percent payment reduction for reimbursements paid to mental health case management providers.			
11. GOVERNOR'S REVIEW (Check One): <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: Billy R. Millwee State Medicaid Director Post Office Box 13247, MC: H-100 Austin, Texas 78711	
13. TYPED NAME: Billy R. Millwee			
14. TITLE: State Medicaid Director			
15. DATE SUBMITTED: February 3, 2011			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: 3 February, 2011		18. DATE APPROVED: 26 April, 2011	
PLAN APPROVED – ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 1 February, 2011		20. SIGNATURE OF REGIONAL OFFICIAL:	
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>2-3-11</u>	
DATE APPROV'D	<u>4-26-11</u>	
DATE EFF	<u>2-1-11</u>	
HC.FA 179	<u>11-07</u>	

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. The Health and Human Services Commission (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 through January 31, 2011 will be equal to the reimbursement on August 31, 2010, less one percent.
 - The reimbursement for services effective February 1, 2011 will be equal to the reimbursement on August 31, 2010, less two percent.
 - The agency's fee schedule was revised with new fees effective for services on or after February 1, 2011. The fee schedule will be posted by April 8, 2011.
 - All fee schedules are available through the agency's website as indicated on Attachment 4.19-B, Page 1.

TN 11-07 Approval Date 4-26-11 Effective Date 2-1-11

Supersedes TN 10-30

SUPERSEDES: TN- 10-30