

## Table of Contents

State/Territory Name: Texas

State Plan Amendment (SPA) #: 12-23 NIRT

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form
- 3) Superseding Page Listing
- 4) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Mail Stop S3-14-28  
Baltimore, Maryland 21244-1850



**Center for Medicaid and CHIP Services**

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

**AUG 30 2012**

RE: TN 12-23

Dear Mr. Traylor:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 12-23. This amendment provides for supplemental payments to non-state government-owned intermediate care facilities for persons with mental retardation.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 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 the funding of the State share of expenditures under Attachment 4.19-D. Based upon your assurances, Medicaid State plan amendment 12-23 is approved effective October 1, 2012. 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,

A large black rectangular box redacting the signature of Cindy Mann.

Cindy Mann  
Director  
Center for Medicaid and CHIP Services

Enclosures

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE AND MEDICAID</b>		1. TRANSMITTAL NUMBER:  <b>12-023</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>October 1, 2012</b>	
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: <b>42 CFR §440.150 and 447.272</b>		7. FEDERAL BUDGET IMPACT: SEE ATTACHMENT  a. FFY 2013      \$ 1,931,533 b. FFY 2014      \$ 1,931,533 c. FFY 2015      \$ 1,931,533	
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 (If Applicable):  <b>SEE ATTACHMENT TO BLOCKS 8 &amp; 9</b>	
10. SUBJECT OF AMENDMENT:  <b>The proposed amendment revises the reimbursement methodology for intermediate care facilities for persons with mental retardation (ICFs/MR) to add a methodology related to supplemental payments for non-state government-owned ICFs/MR.</b>			
11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <b>Sent to Governor's Office this date. Comments, if any, will be forwarded upon receipt.</b> <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO:  <b>Billy R. Millwee State Medicaid Director Post Office Box 13247, MC: H-100 Austin, Texas 78711</b>	
13. TYPED NAME: <b>Billy R. Millwee</b>			
14. TITLE: <b>State Medicaid Director</b>			
15. DATE SUBMITTED: <b>June 8, 2012</b>			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED:		18. DATE APPROVED: <b>AUG 30 2012</b>	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL:  <b>OCT - 1 2012</b>		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: <b>Penny Thompson</b>		22. TITLE: <b>Deputy Director, CMCS</b>	
23. REMARKS:			

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

**Transmittal Number 12-023**

**Number of the  
Plan Section or Attachment**

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

Attachment 4.19-D, ICF/MR  
Page 12  
Page 12a  
Page 12b

Attachment 4.19-D, ICF/MR  
N/A – New Page  
N/A – New Page  
N/A – New Page

**XVII. Supplemental payments to qualifying non-state government-owned intermediate care facilities for persons with mental retardation (ICFs/MR).**

- (a) The supplemental payments described in this section will be made in accordance with the applicable regulations regarding Medicaid upper payment limit provisions codified at Title 42 Code of Federal Regulations (CFR) §447.272.
- (b) Definitions. When used in this section, the following definitions apply.
- (1) Aggregate upper payment limit – A reasonable estimate of the amount that would be paid for the services furnished by non-state government-owned ICFs/MR under Medicare payment principles.
  - (2) HHSC – The Texas Health and Human Services Commission or its designee.
  - (3) Intergovernmental transfer (IGT) – A transfer of public funds from a governmental entity to HHSC.
  - (4) Medicaid supplemental payment limit – The maximum supplemental payment available to a participating non-state government-owned ICF/MR for a specific Medicaid supplemental payment limit calculation period.
  - (5) Medicaid supplemental payment limit calculation period – The federal fiscal quarter determined by HHSC for which supplemental payment amounts are calculated.
  - (6) Non-state government-owned ICF/MR – An ICF/MR where a non-state governmental entity is party to the facility's Medicaid contract.
  - (7) Non-state government-entity – A community center established under Chapter 534, Subchapter A of the Texas Health and Safety Code or a hospital authority, hospital district, healthcare district, city, or county.

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STATE	Texas
DATE REC'D	6-08-12
DATE APP'D	AUG 30 2012
DATE EFF	10-01-12
HCFA 179	12-23

**SUPERSEDES:** ~~TN~~ New Page

TN: 12-23

Approval Date: AUG 30 2012

Effective Date: 10-01-12

Supersedes TN: New Page

XVII. Supplemental payments to qualifying non-state government-owned intermediate care facilities for persons with mental retardation (ICFs/MR) (continued)

- (8) Public funds – Funds derived from taxes, assessments, levies, investments, and other public revenues within the sole and unrestricted control of the governmental entity that is party to the Medicaid contract of the ICF/MR. Public funds do not include gifts, grants, trusts, or donations, the use of which is conditioned on supplying a benefit solely to the donor or grantor of the funds.

(c) Medicaid supplemental payment limits.

- (1) The aggregate supplemental payment amount for non-state government-owned ICFs/MR is calculated for each Medicaid supplemental payment limit calculation period by taking the difference between the aggregate upper payment limit from subparagraph (A) of this paragraph and the aggregate Medicaid payment from subparagraph (B) of this paragraph:

- (A) The aggregate upper payment limit for non-state government-owned ICFs/MR will be calculated based on Medicare payment principles and in accordance with the Medicaid upper payment limit provisions codified at Title 42 CFR §447.272. The aggregate upper payment limit is equal to the sum of the Medicare-equivalent payments for all non-state government-owned ICFs/MR. The Medicare-equivalent payment for each non-state government-owned ICF/MR is calculated as follows based on data from the most recent reliable Medicaid cost report.

- (i) Determine the Medicare adjusted cost by subtracting ancillary and capital costs from total Medicaid allowable costs and multiplying the remaining costs by 1.12.

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DATE APP'D <u>AUG 30 2012</u>	
DATE EFF <u>10-01-12</u>	
HCFA 179 <u>12-23</u>	

SUPERSEDES: ~~TN~~ New Page

TN: 12-23

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Effective Date: 10-01-12

Supersedes TN: New Page

XVII. Supplemental payments to qualifying non-state government-owned intermediate care facilities for persons with mental retardation (ICFs/MR) (continued)

- (ii) Determine the Medicare adjusted cost per day of service by dividing the value from clause (i) of this subparagraph by the total days of service.
- (iii) Determine the Medicare-equivalent payment by multiplying the result from clause (ii) of this subparagraph by the total Medicaid days of service.

(B) The aggregate Medicaid payment for non-state government-owned ICFs/MR prior to the supplemental payment will be the sum of Medicaid level of need (LON) payments for all non-state government-owned ICFs/MR as captured on the most recent reliable Medicaid cost report.

(2) The Medicaid supplemental payment limit for each participating non-state government-owned ICF/MR for each Medicaid supplemental payment limit calculation period will be determined by dividing that facility's Medicaid days of service during the Medicaid supplemental payment limit calculation period by the total Medicaid days of service during the Medicaid supplemental payment limit calculation period for all non-state government-owned ICFs/MR, multiplying the resulting percentage by the aggregate supplemental payment amount from paragraph (1) of this subsection, and dividing the resulting product by four.

(d) Payment frequency. HHSC will distribute Medicaid supplemental payments to participating non-state government-owned ICFs/MR on a quarterly basis subsequent to the Medicaid supplemental payment limit calculation period.

(e) Required application. Before a non-state government-owned ICF/MR may receive supplemental payments under this section, the non-state governmental entity that is party to the ICF/MR's Medicaid provider agreement must submit a properly completed "Medicaid Supplemental Payment Program Certification of ICF/MR Participation." The non-state governmental entity will use this form to certify that it is a party to the ICF/MR's Medicaid provider agreement.

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