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State/Territory Name: Texas

State Plan Amendment (SPA) #: 15-0003 NIRT

This file contains the following documents in the order listed:

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

CENTERS FOR MEDICARE & MEDICAID SERVICES

Financial Management Group

JUL 31 2015

Ms. Kay Ghahremani
State Medicaid/CHIP Director
Health and Human Services Commission
Post Office Box 13247
Mail Code: H100
Austin, Texas 78711

RE: TN 15-003

Dear Ms. Ghahremani:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 15-003. The proposal allows for an add-on payment for eligible individuals based on the Resource Utilization Groups (RUG-Ill) classification system for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID). Also, the proposed amendment replaces "ICF/MR" with "ICF/IID" and corrects page numbering.

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 funding of the State share of expenditures under Attachment 4.19-D.

Based upon the information provided by the State, Medicaid State plan amendment 15-003 is approved effective January 1, 2015. We are enclosing the CMS-179 and the amended plan pages.

If you have any questions, please call Tamara Sampson at (214) 767-6431.

Sincerely,

[redacted]

Timothy Hill
Director

Enclosures

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: **15-003**

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: **January 1, 2015**

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 and 447.272

7. FEDERAL BUDGET IMPACT: **SEE ATTACHMENT**
a. FFY 2015 **$312,528**
b. FFY 2016 **$524,694**
c. FFY 2017 **$523,380**

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 revises the reimbursement methodology for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) to calculate an add-on payment for eligible individuals based on the Resource Utilization Groups III (RUG-III) classification system. Individuals eligible are those who have lived in a large state-operated ICF/IID facility for at least six months immediately prior to referral to a non-state operated facility and meet specific high medical needs criteria. The proposed amendment also makes minor revisions to incorporate person first respectful language, replacing "ICF/MR" with "ICF/IID," and to correct the numbering style.

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.

[redacted]

13. TYPED NAME:
Kay Ghahremani

14. TITLE:
State Medicaid Director

15. DATE SUBMITTED:
February 4, 2015

16. RETURN TO:

Kay Ghahremani
State Medicaid Director
Post Office Box 13247, MC: H-100
Austin, Texas 78711

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
2-04-2015

18. DATE APPROVED:
JUL 31 2015

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JAN 01 2015

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME:
Kristin FAN

22. TITLE:
Deputy Director, FMG

23. REMARKS:

FORM CMS – 179 (07-92)

Attachment to Blocks 8 & 9 of CMS Form 179

Transmittal Number 15-003

Number of the Plan Section or Attachment	**Number of the Superseded Plan Section or Attachment**	
Attachment 4.19-D, ICF/IID	Attachment 4.19-D, ICF/MR	
Page 1	Page 1	(TN 05-003)
Page 2	Page 2	(TN 05-003)
Page 3	Page 3	(TN 05-003)
Page 4	Page 4	(TN 06-023)
Page 5	Page 4A	(TN 06-023)
Page 6	Page 5	(TN 09-036)
Page 7	Page 6	(TN 09-036)
Page 8	Page 7	(TN 09-036)
Page 9	Page 8	(TN 05-003)
Page 10	Page 9	(TN 09-002)
Page 11	N/A	New Page
Page 12	Page 10	(TN 11-026)
Page 13	Page 11	(TN 10-026)
Page 14	Page 11(a)	(TN 10-026)
Page 15	Page 12	(TN 12-023)
Page 16	Page 12a	(TN 12-023)
Page 17	Page 12b	(TN 12-023)

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Reimbursement Methodology for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)*

1. Authority. The Texas Health and Human Services Commission (HHSC), the Single State Medicaid Agency, has final approval authority of Medicaid payment rates. HHSC determines ICF/IID Medicaid payment rates after consideration of analysis of financial and statistical information, and the effect of the payment rates on the achievement of program objectives, including economic conditions and budgetary considerations.

2. General. Payment rates are uniform statewide for the same class of service and provider type. Payment rates are determined prospectively with retrospective adjustments as outline in this plan. The unit of service is a day of care provided to a Medicaid client. Payment rates will be determined for a period of two years for non-state operated facilities and for a period of one year to coincide with the state fiscal year for state-operated facilities.

3. Pro Forma Costing. When historical costs are unavailable, such as in the case of changes in program requirements, payment rates may be based on a pro forma approach. This approach involves using historical costs of delivering similar services, where appropriate data are available, and determining the types and costs of products and services necessary to deliver services meeting federal and state requirements.

4. Adjusting Payment Rates. HHSC may adjust payment rates to compensate for anticipated changes in laws, rules, regulations, policies, guidance, economic factors, or implementation of federal or state court orders or settlement agreements. Should HHSC adjust payment rates for these purposes, a state plan amendment will be submitted.

5. Cost Reports. In order to ensure adequate financial and statistical information upon which to base payment rates, each contracted provider is required to submit an annual cost report and, if necessary, (a) supplemental report(s). It is the responsibility of the provider to submit accurate and complete information in accordance with all pertinent cost report rules and cost report instructions.

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* "Intellectual disability" has the same meaning as "mental retardation" as used in other sections of the Texas Medicaid State Plan.

Reimbursement Methodology for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), continued

6. Allowable and Unallowable Costs. Allowable and unallowable costs are defined to identify expenses that are reasonable and necessary to provide client contracted care and are consistent with federal and state laws and regulations.

   (a) Allowable Costs. Allowable costs are expenses, both direct and indirect, that are reasonable and necessary in the normal conduct of operations to provide contracted client services meeting all pertinent state and federal requirements. Only allowable costs are included in the reimbursement determination process.

   (b) Unallowable Costs. Unallowable costs are expenses that are not reasonable or necessary. Providers must not report as an allowable cost on a cost report a cost that has been determined to be unallowable.

   (c) Detailed Definitions. Detailed definitions of allowable and unallowable cost are prescribed in Title 1 of the Texas Administrative Code, Chapter 355, Subchapter A, relating to Cost Determination Process.

   (d) Changes to Allowable and Unallowable Costs. Whenever a change is made to the definitions of allowable and unallowable costs as described in subsection (C) of this section that is anticipated to cause a change in the rate payable to a provider, a state plan amendment will be submitted.

7. Desk Reviews and Field Audits. Desk reviews and field audits are performed on provider cost reports in order to ensure that financial and statistical information reported in the cost report conforms to all applicable rules and instructions.

8. Informal Reviews and Appeals. A contracted provider may request an informal review and, subsequently, an appeal of a desk review or field audit disallowance.

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9. Projected Costs. HHSC determines reasonable methods for projecting each provider's costs to allow for significant changes in cost-related conditions anticipated to occur between the historical cost reporting period and the prospective rate period. Significant changes include, but are not limited to, wage-and-price inflation or deflation, changes in program utilization, modifications of federal or state regulations and statutes, and implementation of federal or state court orders and settlement agreements. HHSC may utilize a general cost inflation index obtained from a reputable independent professional source and, where HHSC deems appropriate and pertinent data are available, develop, and/or utilize several item-specific inflation indices.

   (a) General Cost Inflation Index. HHSC uses the Personal Consumption Expenditures (PCE) chain-type price index as the general cost inflation index. The PCE is a nationally recognized measure of inflation published by the Bureau of Economic Analysis of the U.S. Department of Commerce. To project or inflate costs from the reporting period to the prospective payment rate period, HHSC uses the lowest feasible PCE forecast consistent with the forecasts of nationally recognized sources available to HHSC at the time proposed payment rates are prepared for public dissemination and comment.

   (b) Item-specific and Program-specific Inflation Indices. HHSC may use specific indices in place of the general cost inflation index when appropriate item-specific or program-specific cost indices are available from cost reports or other surveys, other Texas state agencies or independent private sources, or nationally recognized public agencies or independent private firms, and HHSC has determined that these specific inflation indices are derived from information that adequately represents program(s) or cost(s) to which the specific index is to be applied. Nursing wages are inflated by wage inflation factors based on wage and hour survey information submitted on cost reports or special surveys, Social Security payroll taxes are inflated by FICA inflation factors based on data obtained from the Statistical Abstract of the United States, and federal and state unemployment taxes are inflated but FUTA/SUTA inflation factors based on data obtained from the Texas Workforce Commission.

   (c) State-operated facility costs used in the interim payment rate determination are adjusted in accordance with 10(a)(2)(A).

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Reimbursement Methodology for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), continued

10. Payment Rate Determination. Payment rates are determined for services provided to eligible consumers in ICF/IID facilities. HHSC determines payment rates for two types of facilities: state-operated and non-state operated.

(a) State-Operated Facilities. HHSC determines interim payment rates at least once annually. Interim rates are uniform statewide by class and do not vary by level of need. Interim rates are set prospectively with one or more settlements per fiscal year.

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

(A) Large facility — A facility with a Medicaid certified capacity of 17 or more as of the first day of the full month immediately preceding a 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) Small facility — A facility with a Medicaid certified capacity of 16 or fewer as of the first day of the full moth immediately preceding a rate's effective date or, if certified for the first time after a rate's effective date, as of the date of initial certification.

(2) Determination of State-Operated Facility Rates. Eligible state-operated facilities are reimbursed an interim rate with a settlement. HHSC will determine payment rates for state-operated facilities in the following manner:

(A) An interim payment rate is determined by unit of service for each class of state-operated facility based on the most recent cost reports accepted by HHSC adjusted to reflect changes in projected expenditures resulting from changes in economic conditions, occupancy levels, and projected operating budgets. Costs reported on the state-operated cost reports include all Medicaid allowable costs expended at the state-operated facilities including medical expenses and drug costs not paid through the consumer's Medicaid card or Medicare Part D.

(B) A settlement is determined for each state-operated facility on a facility-by-facility basis based on cost reports for the rate period as audited by HHSC if there is a difference between the allowable costs from the audited cost reports and the reimbursement due under the interim payment rate, including adjustments for applied income for the state fiscal year.

Reimbursement Methodology for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), continued

(C) Since provision is made to ensure that reasonable and necessary costs are covered, state-operated facilities do not qualify for additional supplemental reimbursement for individuals whose needs require a significantly greater than normal amount of care.

(D) Cost reports from facilities in this class will not be included in the cost arrays that are used to determine reimbursement rates for other classes of providers.

(E) During any fiscal year, if HHSC determines that actual costs merit a partial settlement related to that fiscal year to ensure the uninterrupted delivery of Medicaid services to individuals with intellectual disabilities, HHSC will initiate such a partial settlement. Following each fiscal year, HHSC will initiate an annual settlement to adjust Medicaid reimbursements to recover actual costs for that fiscal year.

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(b) Non-state-operated Facilities. This facility type includes both private and non-state governmental owned 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 14 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 13 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 10(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/IID providers. Included in the costs are:

(A) Direct services costs, included 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.

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(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.

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(4) Levels of need. Non-state operated daily reimbursement rates will be differentiated based on consumer level of need and the facility class. The level of need system is a classification system that differentiates rates based on the needs of the individuals served.

(A) The level of need classification is based upon the Inventory for Client and Agency Planning (ICAP) service levels. Individuals are classified in the intermittent category if they have an ICAP service level of 7, 8, or 9; individuals are classified at a limited level if they have an ICAP service level of 4, 5, or 6; individuals are classified at an extensive level if they have an ICAP service level of 2 or 3; individuals are classified as pervasive if they have an ICAP service level of 1; and individuals are identified as pervasive plus if they exhibit dangerous behaviors that require 1:1 supervision at least 16 hours per day.

(B) For individuals who have extraordinary medical needs or behavioral challenges, there is an opportunity to adjust the level of need to more appropriately reflect level of service needed. Individuals who receive three or more hours of nursing service a week are eligible to be moved to the next higher level of need (LON) category. An individual cannot move to the next higher LON category for both a medical and a behavior reason.

(5) Add-on reimbursement rate. There is an available add-on reimbursement rate, in addition to the daily reimbursement rate, for certain individuals.

(A) The add-on is based on the Resource Utilization Group (RUG-III) 34 group classification system, Version 5.20, index maximizing, as established by the State and the Centers for Medicare & Medicaid Services.

(B) There are three add-on groupings based on certain RUG-III 34 classification groups:

(i) Group 1 is comprised of Extensive Services 3 (SE3), Extensive Services 2 (SE2), and Rehabilitation D (RAD).

(ii) Group 2 is comprised of Rehabilitation C (RAC), Rehabilitation B (RAB), Extensive Services 1 (SE1), Special Care C (SSC), Special Care B (SSB), and Special Care A (SSA).

(iii) Group 3 is comprised of Rehabilitation A (RAA), and Clinically Complex groups CA1, CA2, CB1, CB2, CC1, and CC2.

Reimbursement Methodology for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), continued

(C) An individual must meet the following criteria to be eligible to receive the add-on rate:

(i) be assigned a RUG-III 34 classification in Group 1, Group 2, or Group 3;

(ii) be a resident of a large state-operated facility for at least six months immediately prior to referral; and

(iii) have a level of need which includes a medical level of need increase as described in (4)(B) above, but not be assessed a level of need of pervasive plus.

(D) The add-on for each Group is determined based on date and costs from the most recent nursing facility cost reports accepted by HHSC.

(i) For each Group, compute the median direct care staff per diem base rate component for all facilities as specified in the Nursing Facility State Plan Attachment 4.19-D(IV)(B)(3); and

(ii) Subtract the average nursing portion of the current recommended modeled rates as specified in 10(b)(3) of this attachment.

(E) Until such time as HHSC has received, verified and evaluated adequate cost data from participating ICF/IID providers, the add-on rate for each Group will be adjusted each time that HHSC adjusts the Nursing Facility RUG-III rate upon which it is based.

(F) The add-on rates can be found at http://www.hhsc.state.tx.us/Rad/long-term-svcs/icf/index.shtml

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11. Medical Service and Durable Medical Equipment Covered as ICF/IID Services. Individuals who reside in non-state operated ICF/IID facilities receive medical and dental service through the Medicaid identification card. With the exception of the durable medical equipment described in subparagraphs (A)-(D) below and augmentative communication devises (ACDs), any medical expenses other than services covered elsewhere in the State Plan are the responsibility of the ICF/IID provider. For durable medical equipment other than ACD, ICF/IID providers will be paid for the actual cost of a consumer's durable medical equipment costs up to $5,000 per consumer per year through a voucher system if:

    (a) the cost of the equipment exceeds $1,000;

    (b) the ICF/IID provider receives prior approval to purchase the equipment;

    (c) the ICF/IID provider submits a voucher for the cost of the equipment; and

    (d) if the consumer is eligible for Medicare benefits, the ICF/IID provider as submitted a Medicare claim prior to requesting payment.

    Costs reimbursed through the voucher system are not used in setting the reimbursement rates for ICF/IID services.

12. Payment for Dental Services Available to Consumers in ICF/IID. Payments for dental services as described in item 15b of Appendix 1 to Attachment 3.1-A and Item 15b of Appendix 3.1-B for persons 21 years of age and older who reside in an ICF/IID will be based on Texas Health Steps policies, procedures, limitations, and rates, and will be obtained through the consumer's Medicaid card.

13. Medicare Part D. For individuals eligible for Medicare Part D, the cost of any drug that is in a category that is covered by Medicare Part D is unallowable for cost reporting purposes.

14. Augmentative Communication Devices.

    (a) HHSC or its designee reimburses ICF/IID providers for costs necessarily incurred to provide augmentative communication devises (ACDs) to residents of ICF/IID facilities that demonstrate a verifiable medical need. This payment is not part of the facility reimbursement rate and is a separate payment amount reimbursed to the ICF/IID through a voucher.

    (b) The ICF/IID is required to request two bids for an ACD of a type that meets the recipient's need and the reimbursement of the devise will be the lesser of the two

Reimbursement Methodology for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), continued

bids. In the event that only one bid can be obtained due to a lack of ACD providers, a request for an exception will be considered by HHSC or its designee. Prior authorization is still required if an exception is granted by HHSC or its designee.

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15. Effective September 1, 2011, payment rates for non-state operated facilities will be equal to the rates in effect on August 31, 2010, less 5 percent. These rates were posted on the agency's website at http://www.hhsc.state.tx.us/rad on September 1, 2011.

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Reimbursement Methodology for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), continued

16. Attendant Compensation Rate Enhancement

(a) Attendant compensation cost center. This cost center will include attendant employee salaries and/or wages (including payroll taxes, worker's compensation, or employee benefits), contract labor costs, and personal vehicle mileage reimbursement for attendants.

(b) Rate year. The rate year begins on the first day of September and ends on the last day of August of the following year.

(c) Open enrollment. Each contracted provider must notify HHSC in a manner specified by HHSC of its desire to participate or its desire not to participate in the Attendant Compensation Rate Enhancement and its desired level of participation in an enrollment period prior to the rate year.

(d) Determination of attendant compensation rate component for nonparticipating contracted providers. An attendant compensation cost center rate component will be calculated separately for day habilitation and residential services based on the percentage of the direct service cost component from (X)(B)(2)(a) accruing from day habilitation attendant compensation costs and residential attendant compensation costs, respectively.

(e) Determination of attendant compensation rate enhancements. Attendant compensation rate enhancement payment increments of $0.05 are associated with each attendant compensation rate enhancement level. The maximum number of rate enhancement payment levels is 25 for a maximum rate enhancement payment per unit of service of $1.25.

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(f) Spending requirements for participating contracted providers. Participating contracts are subject to a spending requirement with recoupment calculated separately for their day habilitation and residential services as follows: Accrued attendant compensation revenue per unit of service is multiplied by 0.90 to determine the spending requirement per unit of service. The accrued attendant compensation spending per unit of service will be subtracted from the spending requirement per unit of service to determine the amount to be recouped. If the accrued attendant compensation spending per unit of service is greater than or equal to the spending requirement per unit of service, there is no recoupment. The amount paid for attendant compensation per unit of service after adjustments for recoupment must not be less than the amount determined for nonparticipating contracted providers.

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Reimbursement Methodology for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), continued

17. Supplemental payments to qualifying non-state government-owned intermediate care facilities for individuals with intellectual disabilities (ICF/IID).

(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/IID 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 government entity to HHSC.

(4) Medicaid supplemental payment limit — The maximum supplemental payment available to a participating non-state government-owned ICF/IID 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/IID — An ICF/IID 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, health care district, city, or county.

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(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/IID. 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/IID 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/IID 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/IID. The Medicare-equivalent payment for each non-state government-owned ICF/IID is calculated as follows based on date 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 costs by 1.12.

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

(2) The Medicaid supplemental payment limit for each participating non-state government-owned ICF/IID 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 for all non-state government-owned ICFs/IID, 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/IID on a quarterly basis subsequent to the Medicaid supplemental payment limit calculation period.

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

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