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State/Territory Name: Texas

State Plan Amendment (SPA) #: 16-0006

This file contains the following documents in the order listed:

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

CENTERS FOR MEDICARE & MEDICAID SERVICES
CONSORTIUM FOR MEDICAID & CHILDREN'S HEALTH OPERATIONS

DIVISION OF MEDICAID & CHILDREN'S HEALTH - REGION VI

August 02, 2016

Our Reference: SPA TX 16-0006

Mr. Gary Jessee
State Medicaid/CHIP Director
Health and Human Services Commission
Post Office Box 13247
Mail Code H100
Austin, Texas 78711

Dear Mr. Jessee:
We have reviewed the State's proposed amendment to the Texas State Plan submitted under Transmittal Number 16-0006, dated June 21, 2016. This state plan amendment aligns state plan language with the shift from a fee-for-service payment system to a managed care payment system by adjusting the underlying methodology and data sources for determining Program for All Inclusive Care for the Elderly (PACE) reimbursement. The proposed amendment also implements new requirements for reimbursement methodology set out in House Bill 3823, 84th Texas Legislature, Regular Session, which is codified at Texas Human Resources Code sections 32.0532 through 32.0534.

Based on the information submitted, we have approved the amendment for incorporation into the official Texas State Plan with an effective date of October 1, 2016. A copy of the CMS-179 and approved plan page are enclosed with this letter.

If you have any questions please contact Suzette Seng of my staff. Ms. Seng may be reached at (214) 767-6478 or by Email at Suzette.Seng@cms.hhs.gov.

Sincerely,

[redacted]

Bill Brooks
Associate Regional Administrator

cc: Dana Williamson, Manager, 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: **16-0006**	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: **October 1, 2016**	

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:	7. FEDERAL BUDGET IMPACT:	
42 CFR §460.182	a. **FFY 2016**	**SEE ATTACHMENT $0**
	b. **FFY 2017**	**$0**
	c. **FFY 2018**	**$0**
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 purpose of this amendment is to align State Plan language with the shift from a fee-for-service payment system to a managed care payment system by adjusting the underlying methodology and data sources for determining Program for All Inclusive Care for the Elderly (PACE) reimbursement. The proposed amendment also implements new requirements for reimbursement methodology set out in House Bill 3823, 84th Texas Legislature, Regular Session, which is codified at Texas Human Resources Code sections 32.0532 through 32.0534.

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. [redacted] CY OFFICIAL:	16. RETURN TO:
13. TYPED NAME: **Gary Jessee**	**Gary Jessee** **State Medicaid Director** **Post Office Box 13247, MC: H-100** **Austin, Texas 78711**
14. TITLE: **State Medicaid Director**	
15. DATE SUBMITTED: **June 21, 2016**	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: June 21, 2016	18. DATE APPROVED: August 2, 2016
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: October 1, 2016	20. SIGNATURE OF REGIONAL OFFICIAL: for [redacted]
21. TYPED NAME: Bill Brooks	22. TITLE: Associate Regional Administrator Division of Medicaid and Children's Health

23. REMARKS:

FORM CMS – 179 (07-92)

Attachment to Blocks 8 & 9 of CMS Form 179

Transmittal Number 16-0006

Number of the Plan Section or Attachment	**Number of the Superseded Plan Section or Attachment**
Supplement 3 to Attachment 3.19-A	Supplement 3 to Attachment 3.19-A
Page 6a	Page 6a (TN 06-07)
Page 6b	Page 6b (TN 09-29)
Page 6c	N/A (New Page)

State: Texas
Date Received: June 21, 2016
Date Approved: August 02, 2016
Date Effective: October 01, 2016
Transmittal Number: 16-0006

IV. Reimbursement Methodology for Program for All-Inclusive Care for the Elderly (PACE) (continued)

(a) General specifications. The Texas Health and Human Services Commission (HHSC) determines the upper payment limits and reimbursement rates for each PACE contractor.

(b) Frequency of reimbursement determination. The upper payment limits and reimbursement rates are determined coincident with the state's biennium.

(c) Upper payment limit determination. There are three upper payment limits calculated for each PACE contract: one for clients eligible only for Medicaid services (Medicaid-only clients), one for clients eligible for both Medicare and Medicaid services (dual-eligible clients), and one for clients eligible for only Medicare services as Qualified Medicare Beneficiaries (QMBs). An average monthly historical cost per client receiving nursing facility services and Home and Community Based Services (HCBS) under the fee-for-service payment system or the managed care program is calculated for the counties served by each PACE contract for the upper payment limits for Medicaid-only clients and for dual-eligible clients.

(1) The upper payment limits for Medicaid-only and for dual-eligible clients for the biennium are calculated for the base period using historical claims data and member-month data from the most recent state fiscal year of complete claims available prior to the state's biennium.

(2) The historical costs are derived from claims data for clients receiving nursing facility services or HCBS services in the counties served by each PACE contract meeting the following criteria:

(i) age 55 and older; and

(ii) have Medicare coverage or who do not have Medicare coverage.

(3) The historical costs include:

(i) acute care services, including inpatient, outpatient, professional, and other acute care services;(ii) prescriptions;

(iii) medical transportation;

(iv) nursing facility services;

(v) hospice services;

(vi) long-term care specialized services, such as physical therapy, occupational therapy, and speech therapy;

(vii) HCBS services;

(viii) Primary Home Care (including Family Care) services; and

(ix) Day Activity and Health Services.

(4) To determine an average monthly historical cost for the counties served by each PACE contract, the total historical claims data for the counties served by each PACE contract are divided by the number of member months for the counties served by each PACE contract.

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IV. Reimbursement Methodology for Program for All-Inclusive Care for the Elderly (PACE) (continued)

(5) An adjustment for administrative costs is added to the average monthly historical cost per client. The per member per month amount is added for:

(i) processing claims based on the state's cost to process claims under the managed care payment system; and

(ii) case management based on the state's cost to provide case management under the managed care payment system for HCBS clients.

(6) The sum of the average monthly historical cost per client for each PACE contract and the amounts from (5) above are projected from the claims data base period identified in (c)(1) to the rate period to account for anticipated changes in costs for each PACE contract. The methodology used for trending historical costs for calculating PACE UPLs and rates is comparable to that used for trending costs in the managed care program.

The PACE Upper Payment Limit (UPL) method can be adjusted as determined actuarially appropriate for statistical outliers, small populations, programmatic changes, catastrophic events, or other economic changes. Other sources of data may be considered and used as deemed necessary for the purpose of providing sufficient data for calculation of an appropriate UPL.

(d) The upper payment limit for QMBs is determined on a statewide basis using the average cost incurred by Medicaid for Medicare co-insurance and deductibles.

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IV. Reimbursement Methodology for Program for All-Inclusive Care for the Elderly (PACE) (continued)

(e) Payment rate determination. There are three reimbursement rates calculated for each PACE contract: one for clients eligible only for Medicaid services (Medicaid Only rate), one for clients eligible for both Medicare and Medicaid services (Dual Eligible rate), and one for clients eligible for only Medicare services as Qualified Medicare Beneficiaries (QMBs). The payment rates for each of the three categories of clients for each PACE contract are determined by multiplying the upper payment limits calculated for each PACE contract by a factor less than 1.0. The factor may be reduced as necessary to establish a rate consistent with available funds.

(1) In setting the reimbursement rates under the PACE program, HHSC will ensure that:

(A) reimbursement rates for providers under the program are adequate to sustain the program; and

(B) the program is cost-neutral or costs less when compared to the cost to serve a population in the STAR + PLUS Medicaid managed care program that is comparable in:

(i) age;

(ii) eligibility factors, including:

(I) income level;

(II) health status; and

(III) impairment level;

(iii) geographic location;

(iv) living environment; and

(v) other factors HHSC determines to be necessary.

(2) For purposes of Subsection (e)(1)(B), HHSC will consider data on the cost of services provided to comparable recipients enrolled in the STAR + PLUS Medicaid managed care program to calculate the upper payment limit component of the PACE program reimbursement rates. The cost of those services includes the Medicaid capitation payment per recipient and Medicaid payments made on a fee-for-service basis for services not covered by the capitation payment.

(3) The PACE payment rate determined above is less than the amount that would otherwise have been paid under the Texas State Plan if the participants were not enrolled under the PACE program.

(f) Reporting of cost. HHSC may require the PACE contractor to submit financial and statistical information on a cost report or in a survey format designated by HHSC. Cost report completion is governed by the requirements of the Cost Determination Process. HHSC may also require the PACE contactor to submit audited financial statements.

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