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State/Territory Name: Texas

State Plan Amendment (SPA) #: 18-0007

This file contains the following documents in the order listed:

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

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



Financial Management Group

MAY 23 2018

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

RE: TN 18-0007

Dear Ms. Muth:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 18-0007. The proposed amendment modifies the reimbursement methodology for non-state Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs) by requiring only even-year cost reports beginning with providers' 2018 fiscal year cost reports. Additionally, the amendment will require providers to submit an Attendant Compensation Report for odd years beginning with the providers' 2017 fiscal year. Also, the proposed amendment will repeal the Medicaid Spending Requirement.

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.

We are pleased to inform you that Medicaid State plan amendment 18-0007 is approved effective March 1, 2018. We are enclosing the CMS-179 and the new plan pages.


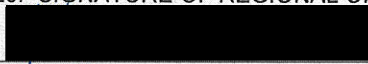
If you have any questions, please call Tamara Sampson at (214) 767-6431.

Sincerely,

A black rectangular box redacting the signature of Kristin Fan.

Kristin Fan
Director

Enclosures

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES		1. TRANSMITTAL NUMBER: 18-0007	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: March 1, 2018	
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 CFR §§ 440.167, 440.225 Section 1905(a)(24) of the Social Security Act		7. FEDERAL BUDGET IMPACT: SEE ATTACHMENT a. FFY 2018 \$54,815 b. FFY 2019 \$75,155 c. FFY 2020 \$77,222	
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 will modify the reimbursement methodology in the State Plan for non-state operated Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs) by requiring only even-year cost reports beginning with providers' 2018 fiscal year cost reports. Additionally, the amendment will also require providers to submit an Attendant Compensation Report for odd years beginning with the providers' 2017 fiscal year. Lastly, the amendment will repeal the Medicaid Spending Requirement beginning September 1, 2017.			
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: Stephanie Muth State Medicaid Director Post Office Box 13247, MC: H-100 Austin, Texas 78711	
13. TYPED NAME: Stephanie Muth			
14. TITLE: State Medicaid Director			
15. DATE SUBMITTED: March 26, 2018			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: March 26, 2018		18. DATE APPROVED: MAY 23 2018	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: March 1, 2018		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: KRISTIN FAN		22. TITLE: Director, FMC	
23. REMARKS:			

Attachment to Blocks 8 & 9 of CMS Form 179

Transmittal Number 18-0007

**Number of the
Plan Section or Attachment**

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

Attachment 4.19-D

Page 1

Page 9

Page 12

N/A - Delete Page

Attachment 4.19-D

Page 1 (TN 15-003)

Page 9 (TN 15-003)

Page 12 (TN 15-024)

Page 18 (TN 15-024)

State: Texas

Date Received: March 26, 2018

Date Approved: MAY 23 2018

Date Effective: March 1, 2018

Transmittal Number: 18-0007

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 a cost report every other year 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.

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

TN: 18-0007 Approval Date: MAY 23 2018
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State: Texas
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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 <https://ad.hhs.texas.gov/>

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

15. Effective September 1, 2015, payment rates for non-state operated facilities, including both private and non-state government owned facilities, will be equal to the rates in effect on August 31, 2015, plus 2.02 percent. This payment rate increase uses the allowable/unallowable costs that are currently defined in the approved plan pages at Attachment 4.19-D, ICF/IID. These rates were posted on the agency's website at <https://rad.hhs.texas.gov/> on September 1, 2015.

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Transmittal Number: 18-0007

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

“RESERVED”

TN: 18-0007 Approval Date: May 23, 2018
Supersedes TN: 15-024 Effective Date: March 1, 2018

State: Texas Date Received: March 26, 2018 Date Approved: May 23, 2018 Date Effective: March 1, 2018 Transmittal Number: 18-0007
