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State Plan Amendment (SPA) #: 15-024

This file contains the following documents in order listed:

1. CMS 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



Financial Management Group

APR 11 2016

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

RE: TN 15-024

Dear Mr. Jessee:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 15-024. This proposed state plan amendment revises the reimbursement methodology to add an overall spending requirement and adjust payment rates for non-state and private operated Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).

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.

Based upon the information provided by the State, Medicaid State plan amendment 15-024 is approved effective September 1, 2015. We are enclosing the CMS-179 and the new plan pages.

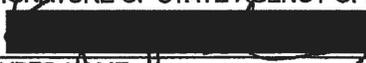
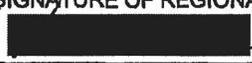
If you have any questions, please call Tamara Sampson at (214) 767-6431.

Sincerely,

A black rectangular redaction box covering 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: 15-024	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: September 1, 2015	
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 2015 \$ 275,724 b. FFY 2016 \$3,310,526 c. FFY 2017 \$3,274,899	
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 to add an overall spending requirement and adjust payment rates for non-state operated Intermediate Care Facilities for Individuals with Intellectual Disabilities.			
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: Kay Ghahremani State Medicaid Director Post Office Box 13247, MC: H-100 Austin, Texas 78711	
13. TYPED NAME: Kay Ghahremani			
14. TITLE: State Medicaid Director			
15. DATE SUBMITTED: September 30, 2015			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: September 30, 2015		18. DATE APPROVED: APR 11 2016	
PLAN APPROVED – ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: September 1, 2015		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Kristin FAN		22. TITLE: Director, FMC	
23. REMARKS:			

Attachment to Block 7 of CMS Form 179

Transmittal Number 15-024

	Total Fiscal Impact	Federal	State
FFY 2015	\$ 474,977	\$ 275,724	\$ 199,253
FFY 2016	\$5,794,725	\$3,310,526	\$2,484,199
FFY 2017	\$5,778,893	\$3,274,899	\$2,503,994

The above fiscal impact for non-state operated Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs) is based on the difference between the current rate, the newly implemented rate, and projected ICF/IID utilization data.

The applied federal medical assistance percentages are 58.05 percent for FFY 2015, 57.13 percent for FFY 2016, and 56.67 percent for FFY 2017.

Explanation for Rate Change and Amendment Submission

This state plan amendment modifies the reimbursement methodology in the State Plan to add an overall spending requirement and adjust payment rates for non-state operated ICF/IIDs as a result of the 2016-2017 General Appropriations Act (Article II, H.B. 1, 84th Legislature, Regular Session, 2015, Department of Aging and Disability Services, Rider 40), which appropriated general revenue funds for provider rate increases for the ICF/IID program and required HHSC to establish a system of an overall spending requirement that ensures each provider expend at least 90 percent of all funds received through the ICF/IID Medicaid payment rates on ICF/IID Medicaid services.

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Attachment to Blocks 8 & 9 of CMS Form 179

Transmittal Number 15-024

**Number of the
Plan Section or Attachment**

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

Attachment 4.19-D
Page 12

Attachment 4.19-D
Page 12 (TN 15-003)

Attachment 4.19-D
Page 18

Attachment 4.19-D
Page 18 (New Page)

State: Texas
Date Received: September 30, 2015
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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 <http://www.hhsc.state.tx.us/rad> on September 1, 2015.

(a) Rate Increase Opt-out Provision

- (1) Facilities may opt out of this 2.02 percent rate increase via an online form provided by HHSC at <http://www.hhsc.state.tx.us/rad/long-term-svcs/hcs/opt-out-info.shtml>; facilities that opt out of the rate increase are not subject to the Medicaid Spending Requirement described on Attachment 4.19-D, ICF/IID, Page 18, section (18).
- (2) Opt-out forms must be completed and submitted prior to the effective date of the rate increase. For facilities that opt out, payment rates effective September 1, 2015, will be equal to payment rates in effect on August 31, 2015.
- (3) In situations where there is a change of ownership mid-year, the new owner will be given an opportunity to change the prior owner's opt-in/opt-out decision effective the first day of the new contract.

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TN: 15-024 Approval Date: APR 11 2016 Effective Date: 9-1-2015

Supersedes TN: 15-003

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

18. Medicaid Spending Requirement and Recoupment Process

- (a) Effective for costs and revenues accrued on or after September 1, 2015, all non-state operated ICF/IID facilities (including both private and non-state government owned facilities) that did not opt out of the rate increase as described under section (15) are required to spend at least 90 percent of revenues received through the ICF/IID daily Medicaid payment rates on Medicaid allowable costs under the ICF/IID program.
- (b) Accountability period. Each accountability period begins the first day of September and ends on the last day of August of the following year.
- (c) Providers that fail to meet the 90 percent spending requirement for an accountability period are subject to a recoupment of the difference between 90 percent of the revenues they received through the ICF/IID daily Medicaid payment rate for services provided during the accountability period and their accrued Medicaid allowable ICF/IID costs for the accountability period. At no time will a provider's payments for an accountability period after recoupment be less than the payments the provider would have received if it had opted out of the rate increase.
- (d) Compliance with the spending requirement will be determined on an annual basis through an analysis of the provider's Medicaid revenues and expenditures for the accountability period as gathered through the provider's audited Medicaid cost report.

All submitted cost reports are audited for completeness, accuracy and compliance with cost reporting rules. The review process takes approximately six months to complete. Once a cost report is reviewed, the provider is given an opportunity to request an informal review and, if desired, a formal appeal of any changes made to its cost report by HHSC. Once a cost report is finalized, HHSC will analyze the cost report data to determine if the provider owes a recoupment, and any recoupment will be submitted to the Department of Aging and Disability Services to be entered into the claims management system. Once entered into the claims management system, recoupments are automatically collected through reductions to the provider's outgoing payments, and the federal share of the recoupment is returned to the federal government.

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Supersedes TN: New Page