DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid, CHIP, and Survey & Certification

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

OCT 12 2010

RE: TN 10-56

Dear Mr. Millwee:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 10-56. This amendment revises the reimbursement methodology for nursing facilities to delete the requirement that payment rates for pediatric care nursing facilities equal the rates in effect on August 31, 2009, plus 2.79 percent.

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 your assurances we are pleased to inform you that Medicaid State plan amendment 10-56 is approved effective September 1, 2010. We are enclosing the HCFA-179 and the amended plan page.

If you have any questions, please call Sandra Dasheiff, CPA at (214) 767-6490.

Sincerely,

[redacted]

Cindy Mann
Director
Center for Medicaid, CHIP, and Survey & Certification

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

1. TRANSMITTAL NUMBER: **10-056**

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, 2010**

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 §440.40 and §440.155
Section 1905(a)(4)(A) and (B) of the Social Security Act

7. FEDERAL BUDGET IMPACT: SEE ATTACHMENT
a. FFY 2010 **$ 41,606**
b. FFY 2011 **$ 444,476**
c. FFY 2012 **$ 426,142**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
SEE ATTACHMENT TO BLOCKS 8 AND 9

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
SEE ATTACHMENT TO BLOCKS 8 AND 9

10. SUBJECT OF AMENDMENT:

The proposed amendment revises the reimbursement methodology for nursing facilities to delete the requirement that payment rates for pediatric care nursing facilities equal the pediatric care nursing facility payment rates in effect on August 31, 2009, plus 2.79 percent.

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. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME:
Billy R. Millwee

14. TITLE:
State Medicaid Director

15. DATE SUBMITTED:
September 17, 2010

16. RETURN TO:
Billy R. Millwee
State Medicaid Director
Post Office Box 85200
Austin, Texas 78711-5200

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 21 September, 2010

18. DATE APPROVED: 10-12-10

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: SEP - 1 2010

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: William Lasowski

22. TITLE: Deputy Director, CMCS

23. REMARKS:

FORM CMS – 179 (07-92)

Attachment to Blocks 8 and 9 to CMS Form 179

Transmittal No. 10-056, Amendment No. 949

Number of the Plan Section or Attachment	**Number of the Superseded Plan Section or Attachment**
Attachment 4.19-D, NF Page 4d	Attachment 4.19-D, NF Page 4d (TN 09-016)

Reimbursement Methodology for Nursing Facilities (continued)

(3) Payment rate determination. Payment rates will be determined in the following manner:

(a) Payment rates for this class of service will be determined annually, coincident with the state's fiscal year on a facility-specific basis for the pediatric care facility. The total allowable costs from the most recent cost report deemed acceptable are adjusted for inflation from the cost report period to the rate period. The adjusted cost is divided by the greater of total patient days of service reported on the cost report or the days of service at 85 percent of contracted capacity of the pediatric care facility. The resulting cost per day is multiplied by a factor of 1.03 to determine the final facility-specific rate. If no acceptable cost report is available, the provider will be required to submit a cost report covering the time period specified by HHSC. A nursing facility that contains a pediatric care facility distinct unit must complete two cost reports: one cost report for the pediatric care facility distinct unit and one cost report for the remainder of the facility.

(b) The facility-specific payment rate will be paid for all Medicaid residents of a qualifying pediatric care facility regardless of the RUG-III level of the resident.

(c) Pediatric care facilities will not be eligible to receive the ventilator-dependent or the children-with-tracheostomies supplemental reimbursements.

(d) Pediatric care facilities are not eligible to participate in the Enhanced Direct Care Staff Rate.