

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



**Center for Medicaid, CHIP, and Survey & Certification**

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

SEP -6 2011

RE: TN 11-26

Dear Mr. Millwee:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 11-26. This amendment revises the reimbursement methodology for non-state operated intermediate care facilities for persons with mental retardation (ICF/MR) to indicate that payment rates effective September 1, 2011 will be equal to rates in effect August 31, 2010, less five 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 access to care issues and the funding of the State share of expenditures under Attachment 4.19-D. Based upon your assurances, Medicaid State plan amendment 11-26 is approved effective September 1, 2011. 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,

A solid black rectangular box redacting the signature of the sender.

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

Enclosures

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b> <b>FOR: CENTERS FOR MEDICARE AND MEDICAID</b>		1. TRANSMITTAL NUMBER:  <b>11-026</b>	2. STATE:  <b>TEXAS</b>
		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:  <b>September 1, 2011</b>	
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:  <b>42 CFR §440.150</b>		7. FEDERAL BUDGET IMPACT: SEE ATTACHMENT  a. FFY 2011      \$ (327,184) b. FFY 2012      \$ (3,773,907) c. FFY 2013      \$ (3,601,780)	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  <b>SEE ATTACHMENT TO BLOCKS 8 &amp; 9</b>		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):  <b>SEE ATTACHMENT TO BLOCKS 8 &amp; 9</b>	
10. SUBJECT OF AMENDMENT:  <b>The proposed amendment will revise the reimbursement methodology for non-state operated intermediate care facilities for persons with mental retardation to indicate that payment rates effective September 1, 2011 will be equal to rates in effect August 31, 2010, less five percent.</b>			
11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED      Sent to Governor's Office this date. Comments, if any, will be forwarded upon receipt. <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL:  		16. RETURN TO:  <b>Billy R. Millwee          State Medicaid Director          Post Office Box 13247, MC H-100          Austin, Texas 78711</b>	
13. TYPED NAME:  <b>Billy R. Millwee</b>			
14. TITLE:  <b>State Medicaid Director</b>			
15. DATE SUBMITTED:  <b>July 15, 2011</b>			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED: <b>15 July, 2011</b>		18. DATE APPROVED: <b>SEP - 6 2011</b>	
<b>PLAN APPROVED - ONE COPY ATTACHED</b>			
19. EFFECTIVE DATE OF APPROVED MATERIAL:  <b>1 September, 2011</b>		20. SIG 	
21. TYPED NAME:  <b>Penny Thompson</b>		22. TITLE:  <b>Deputy Director, CMCS</b>	
23. REMARKS:			

**Attachment to Blocks 8 & 9 to CMS Form 179**

**Transmittal Number 11-026**

**Number of the  
Plan Section or Attachment**

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

Attachment 4.19-D, ICF/MR  
Page 10

Attachment 4.19-D, ICF/MR  
Page 10 (TN 10-073)

**Reimbursement Methodology for Intermediate Care Facilities for Persons with  
Mental Retardation (ICF/MR) (continued)**

- XV. Effective September 1, 2010 through January 31, 2011, payment rates for non-state operated facilities will be equal to the rates in effect on August 31, 2010, less one percent. Effective February 1, 2011 through August 31, 2011, payment rates for non-state operated facilities will be equal to the rates in effect on August 31, 2010, less three percent. Effective September 1, 2011, payment rates for non-state operated facilities will be equal to the rates in effect on August 31, 2010, less five percent. These rates will be posted on the agency's website at <http://www.hhsc.state.tx.us/Medicaid/programs/rad/> on September 1, 2011.

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TN 11-20 Approval Date SEP - 6 2011 Effective Date 9-1-11  
Supersedes TN 10-73

## **Marks, Marsha L. (CMS/SC)**

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**From:** Cooley, Mark S. (CMS/CMCS)  
**Sent:** Wednesday, September 07, 2011 11:28 AM  
**To:** Dasheiff, Sandra (CMS/CMCHO)  
**Cc:** Marks, Marsha L. (CMS/SC); Goldstein, Stuart S. (CMS/CMCS); Brooks, Bill D. (CMS/CMCHO)  
**Subject:** Approval packages for TX 11-26 & 11-36  
**Attachments:** TX 11-026.pdf; TX 11-036.pdf

**Follow Up Flag:** Follow up  
**Flag Status:** Flagged

Approval packages for Texas 11-026 & 11-036