

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES		1. TRANSMITTAL NUMBER: 10-016	2. STATE: TEXAS
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE: March 15, 2010	
5. TYPE OF PLAN MATERIAL (Circle One): <input type="checkbox"/> COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment) <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
6. FEDERAL STATUTE/REGULATION CITATION: 42 USC 1396n(g)		7. FEDERAL BUDGET IMPACT: SEE ATTACHMENT a. FFY 2010 \$1,766,058 b. FFY 2011 \$3,112,792 c. FFY 2012 \$3,193,102	
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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): SEE ATTACHMENT TO BLOCKS 8 AND 9	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 is an update to the Early Childhood Intervention (ECI) Targeted Case Management rate (TCM).			
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:	
13. TYPED NAME: Billy R. Millwee		Billy R. Millwee State Medicaid Director Post Office Box 13247 MC: H-100 Austin, Texas 78711-5200	
14. TITLE: State Medicaid Director			
15. DATE SUBMITTED March 29, 2010			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: 30 March, 2010		18. DATE APPROVED: 28 June, 2010	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 15 March, 2010		20. SIGNATURE OF REGIONAL OFFICIAL:	
21. TYPED NAME: Bill Brooks		22. TITLE: Associate Regional Administrator Div of Medicaid & Children's Health	
23. REMARKS:			

STATE	<u>Texas</u>	A
DATE REC'D	<u>3-30-10</u>	
DATE APPV'D	<u>6-23-10</u>	
DATE EFF	<u>3-15-10</u>	
HCFA 179	<u>10-16</u>	

39. Case Management Services for Infants and Toddlers with Development Delays

(a) The recommended rate is determined in the following manner:

- (1) Each provider's total reported costs on the TAFI report are compared with their total reported costs on ECI financial reports.
- (2) Providers whose variance between reported costs on the TAFI report and the ECI financial reports exceed plus or minus two standard deviations of the mean provider variance are eliminated.
- (3) Total allowance case management costs for each provider are determined from the allowable historical costs reported on the TAFI report.
- (4) Each provider's total allowable case management cost is projected from the historical cost reporting period to the prospective rate period using inflation factors.
- (5) Each provider's total allowable case management cost is divided by their associated number of unduplicated case management contacts for the period, thus determining the provider's cost per contact.
- (6) The mean provider cost per contact is calculated, and the statistical outliers (those providers whose cost per contact exceeds plus or minus two standard deviations of the mean provider cost per contact) are eliminated. After removal of the statistical outliers, the mean cost per contact is calculated.
- (7) The mean cost per contact is the proposed reimbursement rate.

(b) Rate setting authority. The Commission establishes the reimbursement rate in an open meeting after consideration of financial and statistical information and public testimony. The Commission set rates which, in its opinion, are within budgetary constraints, adequate to reimburse the cost of operations for an efficient and economic provider, and justifiable given current economic conditions.

(c) All fee schedules are available through the agency's website as outlined on Attachment 4.19-B, Page 1.

(d) The current rate of \$141.83 per client per month, which was effective February 1, 2000, is adjusted by applying inflation from federal fiscal year 2000 to federal fiscal year 2010 of 24 percent to calculate a new rate of \$175.87 to be effective March 15, 2010. This monthly rate will end on September 30, 2011.

(e) The agency's fee schedule was revised with a new rate for case management services effective for services on or after March 15, 2010. The new rate will be posted within 30 days of approval of this amendment by CMS.

TN No. 10-16

Approval Date 6-23-10

Effective Date 3-15-10

Supersedes TN No. 00-03

SUPERSEDES: TN- 00-03