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| TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES | | 1. TRANSMITTAL NUMBER: 10-055 | 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: September 1, 2011 | |
| 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 2011 \$0 b. FFY 2012 \$0 c. FFY 2013 \$0 | |
| 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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): SEE ATTACHMENT TO BLOCKS 8 AND 9 | |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 eliminates the monthly rate for case management for individuals with mental retardation or a related condition or pervasive developmental disability effective August 31, 2011 and proposes to replace it with an encounter payment rate effective September 1, 2011. | | | |
| 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: <i>[Signature]</i> | | 16. RETURN TO: Billy R. Millwee State Medicaid Director Post Office Box 13247, MC: H-100 Austin, Texas 78711 | |
| 13. TYPED NAME: Billy R. Millwee | | | |
| 14. TITLE: State Medicaid Director | | | |
| 15. DATE SUBMITTED August 24, 2010 | | | |
| FOR REGIONAL OFFICE USE ONLY | | | |
| 17. DATE RECEIVED: 30 August, 2010 | | 18. DATE APPROVED: 19 November, 2010 | |
| PLAN APPROVED - ONE COPY ATTACHED | | | |
| 19. EFFECTIVE DATE OF APPROVED MATERIAL: 1 September, 2011 | | 20. SIGNATURE OF REGIONAL OFFICIAL: <i>[Signature]</i> | |
| 21. TYPED NAME: BILL BROOKS | | 22. TITLE: Associate Regional Administrator Div of Medicaid & Children's Health | |
| 23. REMARKS: | | | |

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| STATE | <u>Texas</u> |
| DATE REC'D | <u>8-30-10</u> |
| DATE APP'VD | <u>11-19-10</u> |
| DATE EFF | <u>9-1-10</u> |
| HCFA 179 | <u>10-55</u> |

22. Case Management for Individuals with Mental Retardation or a Related Condition or Pervasive Developmental Disability

- (a) Two statewide encounter rates are established for a comprehensive encounter and a follow-up encounter. The statewide encounter rate is a prospective rate without adjustment for individual provider cost. The encounter unit of service is established as follows:
- (1) **Comprehensive Encounter.** A comprehensive encounter is a face-to-face contact with the client. This comprehensive encounter rate is based on an average time of 45 minutes per contact to provide for assessment, monitoring of progress towards outcomes, plan review, and/or plan revision. A comprehensive encounter is limited to one billable encounter per client per calendar month.
 - (2) **Follow-up Encounter.** A follow-up encounter is a face-to-face, telephone, or telehealth contact which involves interface with the client or a collateral. This follow-up encounter rate is based on an average time of 15 minutes per contact. Activities on a follow-up encounter include follow-up activities related to the comprehensive encounter. The provider agency is allowed up to three follow-up encounters per calendar month for each comprehensive encounter that has occurred within the calendar month. They do not have to be provided to the client for whom the comprehensive encounter was provided.
 - (3) **Cap and Rollover.** A monthly cap will be established on the total number of follow-up encounters that can be billed by each provider agency during the calendar month. The monthly cap that the provider can bill is equal to three follow-up encounters for each comprehensive encounter delivered in the month. Any allowed follow-up encounters not billed during the calendar month will be rolled over to the following calendar month. The rollover of follow-up encounters will begin on September 1st and will end on July 31st with the final rollover into the month of August of each year.

Example:

Client A and Client B both had a comprehensive encounter in a calendar month. As a result, the agency is allowed and may bill up to six follow-up encounters for the month. Client A had one follow-up encounter within the same month and Client B had four follow-up encounters. All five follow-up encounters are allowable and billable. One allowable follow-up encounter was not billed and would roll over to the following month since six follow-up encounters were allowed for the two clients. If the same two clients both had a comprehensive encounter the next calendar month, the agency is allowed and may bill for six follow-up encounters and one roll over encounter for a total of seven follow-up encounters the following month.

TN 10-55

Approval Date 11-19-10

Effective Date 9-1-10

Supersedes TN 10-13

SUPERSEDES: TN 10-13

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|------------|-----------------|
| STATE | <u>Texas</u> |
| DATE REC'D | <u>8-30-10</u> |
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22. Case Management for Individuals with Mental Retardation or a Related Condition or Pervasive Developmental Disability (continued)

- (b) The initial encounter rates are determined by dividing the current annual cost to deliver the service divided by the maximum number of comprehensive and follow-up encounters anticipated to be delivered for the first year of implementation, with comprehensive encounters counting as three units and follow-up encounters counting as one unit.
- (c) Provider costs will be collected for use as a basis for updating reimbursement rates.
- (1) Inclusion of certain reported expenses. Provider agencies must ensure that all requested costs are included in the cost reporting system.
 - (2) Several different kinds of data are collected. These include the number of units of service. The cost data include direct costs, programmatic indirect costs, and general and administrative costs including salaries, benefits, and non-labor costs. Programmatic indirect costs include salaries, benefits and other costs of this case management program that are indirectly related to the delivery of case management services to clients. General and administrative overhead costs include the salaries, benefits and other costs that, while not directly part of the case management services program, constitute costs that support the operations of the case management services program.
 - (3) Provider agencies must eliminate unallowable expenses from the cost report. Unallowable expenses included in the cost report are omitted from the cost report database and appropriate adjustments are made to expenses and other information reported by providers. The purpose of the omission is to ensure that the database reflects costs and other information that are consistent with efficiency, economy, and quality of care; are necessary for the provision of covered case management services; and are consistent with federal and state Medicaid regulations. If there is doubt as to the accuracy or allowableness of a significant part of the information reported, individual cost reports may be eliminated from the database.
 - (4) Total costs are projected from the historical reporting period to the rate period. Cost projections adjust the allowable historical costs for significant changes in cost-related conditions anticipated to occur between the historical cost period and the prospective rate period. Significant conditions include, but are not necessarily limited to, wage and price inflation for deflation, changes in program utilization and efficiency, and modification of federal or state regulations and statutes. The Personal Consumption Expenditures (PCE) Chain-Type Index, which is based on data from the U.S. Department of Commerce, is the most general measure used to project costs.
- (d) All fee schedules are available through the agency's website as outlined on Attachment 4.19-B, Page 1.

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SUPERSEDES: TN- 10-13