



TEXAS HEALTH AND HUMAN SERVICES COMMISSION

ALBERT HAWKINS
EXECUTIVE COMMISSIONER

March 31, 2008

Mr. Bill Brooks
Associate Regional Administrator
Division of Medicaid and Children's Health
Department of Health and Human Services
Centers for Medicare and Medicaid Services
1301 Young Street, Room 714
Dallas, Texas 75202

Dear Mr. Brooks:

The purpose of this letter is to submit Transmittal Number 08-010, Amendment Number 814, to the Texas State Plan for Medical Assistance under Title XIX of the Social Security Act. The purpose of the amendment is to ensure that the State is in compliance with the Interim Final Rule on Optional State Plan Case Management Services (CMS-2237-IFC), published in the December 4, 2007 *Federal Register* (72 Fed.Reg. 68077) for the Centers for Medicare and Medicaid Services. The requested effective date for the proposed amendment to case management for pregnant women is March 3, 2008.

Please let me know if you have any questions or need additional information. Tamela Griffin, in the Medicaid and CHIP Division, serves as the lead staff on this matter and can be reached at (512) 491-1341 or by e-mail at tamela.griffin@hhsc.state.tx.us.

Sincerely,

A handwritten signature in black ink that reads "Chris Traylor".

Chris Traylor
State Medicaid Director

cc: Ford Blunt, CMS
Billy Bob Farrell, CMS

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES		1. TRANSMITTAL NUMBER: 08-010	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 3, 2008	
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 2008 \$ 0 b. FFY 2009 \$ 0 c. FFY 2010 \$ 0	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: See attachment.		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): See attachment.	
10. SUBJECT OF AMENDMENT: The amendment is to ensure that the State is in compliance with the Interim Final Rule on Optional State Plan Case Management Services published in the December 4, 2007 <i>Federal Register</i> (72 Fed.Reg. 68077) (CMS-2237-IFC), as well as other federal guidance on case management. The amendment will modify the current Texas Medicaid State Plan for case management for pregnant women.			
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: Chris Traylor State Medicaid Director Post Office Box 13247 Austin, Texas 78711	
13. TYPED NAME: Chris Traylor			
14. TITLE: State Medicaid Director			
15. DATE SUBMITTED: March 31, 2008			

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED:
PLAN APPROVED – ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL:	20. SIGNATURE OF REGIONAL OFFICIAL:
21. TYPED NAME:	22. TITLE:
23. REMARKS:	

State of Texas
Attachment to Block 7 of CMS Form 179
Transmittal No. TX 08-010 , Amendment No. 814

	Total Fiscal Impact	Federal	State
FFY2008	\$0	\$0	\$0
FFY2009	\$0	\$0	\$0

This SPA is being implemented to ensure that the State is in compliance with the Interim Final Rule on Optional State Plan Case Management Services published at 72 *Federal Register* 68077 (2007) (CMS-2237-IFC). Therefore, there is no fiscal impact that will result from implementation of this SPA.

State of Texas
Attachment to Blocks 8 & 9 of CMS Form 179
Transmittal No. TX 08-010 , Amendment No. 814

Number of the
Plan Section or Attachment

Number of the Superseded
Plan Section or Attachment

Supplement 1 to Attachment 3.1A

Page 1D.4	New Page
Page 1D.5	New Page
Page 1D.6	New Page
Page 1D.7	New Page

Attachment 4.19-B

Page 31c	New Page
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- 1) Target Group:
 - a) Women who are pregnant, over age 21, have one or more high risk medical and/or personal/psychosocial condition(s) during pregnancy, and are in need of services to prevent illness(es) or medical condition(s), or to maintain function or slow further deterioration.

- 2) Areas of state in which services will be provided:
 - a) Entire State

- 3) Comparability of services:
 - a) Services are not comparable in amount duration and scope. Under section 1915(g) of the Social Security Act, a state may provide services without regard to the comparability requirements of section 1902(a)(10)(B) of the Act.

- 4) Definition of services:
 - a) Case management services are services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational, and other services. Case Management includes the following assistance:
 - i) Comprehensive face-to-face assessment of individual needs to determine the need for any medical, educational, social, or other services required to address short- and long-term health and well being. These assessment activities include:
 - (1) taking a client's history;
 - (2) identifying the individual's needs and assessing and addressing family issues that impact the client's health condition/risk or high risk condition and completing related documentation; and
 - (3) gathering information from other sources, such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.
 - ii) Development (and periodic revision) of a specific care plan that:
 - (1) is based on the information collected through the face-to-face needs assessment, face-to-face follow up contacts, or telephone follow up contacts;
 - (2) specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
 - (3) includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
 - (4) identifies a course of action to respond to the assessed needs of the eligible individual, including identifying the individual responsible for contacting the appropriate health and human service providers; and designating the time frame within which the eligible recipient should access services.

- iii) Referral and related activities to help an eligible individual obtain needed services, including activities that help link an individual with:
 - (1) medical, social, and educational providers, and
 - (2) other programs and services that can provide needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.
 - iv) Monitoring and follow-up activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the individual's needs.
 - (1) Such activities may be with the individual, family members, providers, or other entities or individuals and conducted as frequently as necessary up to the 59th day postpartum, and including at least one annual monitoring for clients with eligibility continuing past 12 months, to determine whether the following conditions are met:
 - (a) services are being furnished in accordance with the individual's care plan;
 - (b) services in the care plan are adequate; and
 - (c) the care plan and service arrangement are modified when the individual's needs or status change.
 - (2) Case management may include contacts with non-eligible individuals that are directly related to identifying the needs and supports for helping the eligible individual access services.
 - b) Qualifications of providers:
 - i) Registered nurse (with a diploma, an associate's, bachelor's or advanced degree) or Social Worker (with bachelor's or advanced degree), currently licensed by the respective Texas licensure board and whose license is not temporary or provisional in nature; and
 - ii) Completion of a standardized Department of State Health Services case management training.
- 5) Freedom of choice
- a) The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.
 - i) Eligible recipients will have free choice of the providers of case management services within the specified geographic area identified in this plan.
 - b) Eligible recipients will have free choice of the providers of other medical care under the plan.

- 6) Access to Services
 - a) The State assures that case management services will not be used to restrict an individual's access to other services under the plan.
 - b) The State assures that individuals will not be compelled to receive case management services, condition receipt of case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services.
 - c) The State assures that individuals will receive comprehensive case management services, on a one-to-one basis, through one case manager by March 2010.
 - d) The State assures that providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

- 7) Case Records:
 - a) Providers maintain case records that document for all individuals receiving case management:
 - i) the name of the individual;
 - ii) dates of the case management services;
 - iii) the name of the provider agency (if relevant) and the person providing the case management service;
 - iv) the nature, content, units of case management services received, including:
 - (1) whether goals specified in the care plan have been achieved;
 - (2) whether the individual has declined services in the care plan;
 - (3) the need for, and occurrence(s) of, coordination with other case managers;
 - (4) the timeline for obtaining needed services; and
 - (5) a timeline for reevaluation of the plan.

- 8) Payment
 - a) Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.
 - b) Case management providers are paid based on the reimbursement methodology described in Attachment 4.19 B, Page 31(c).

- 9) Limitations
- a) Case Management does not include:
 - i) Case management activities that are an integral component of another covered Medicaid service;
 - ii) The direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred; or
 - iii) Services beyond the 59th day post partum.
 - b) Case management services are prior authorized by the Department of State Health Services. The number of billable contacts that are prior authorized is based on the client's level of need, level of medical involvement, and complicating psychosocial factors.
 - c) Implementation of this state plan amendment is contingent on the continued effectiveness of the interim final rule published at 72 Federal Register 68077 (2007) [CMS-2237-IFC].

38. Case Management for Pregnant Women.

Reimbursement for case management services for pregnant women will be developed utilizing a CMS-approved targeted case management rate methodology, including 15-minute increment units of service. HHSC will work with CMS to develop a CMS-approved milestone document, which will identify the actions to be completed by the State and the dates by which the actions are to be completed to implement the revised methodology. The current rates in effect for these services as of March 2, 2008, will remain in effect until the actions identified in the milestone document are completed.

Implementation of this state plan amendment is contingent on the continued effectiveness of the interim final rule published at 72 Federal Register 68077 (2007) [CMS-2237-IFC].

State of Texas
Transmittal No. TX 08-010, Amendment No. 814
Case Management For Pregnant Women

Standard Funding Questions

The following questions are being asked and should be answered in relation to all payments made to all providers reimbursed pursuant to a methodology described in Attachment 4.19-B of this SPA. For SPAs that provide for changes to payments for clinic or outpatient hospital services or for enhanced or supplemental payments to physician or other practitioners, the questions must be answered for all payments made under the state plan for such service.

1. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State plan. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, supplemental, enhanced payments, other) or is any portion of the payments returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of payments, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.)

All Medicaid providers of these services retain all of the Medicaid payments and no portion of any payment is returned to the state, a local governmental entity, or any other intermediary organization.

2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either through an IGT or CPE. In this case, please identify the agency to which the funds are appropriated. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including

when the state agency receives the transferred amounts from the local governmental entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:

- (i) a complete list of the names of entities transferring or certifying funds;
- (ii) the operational nature of the entity (state, county, city, other);
- (iii) the total amounts transferred or certified by each entity;
- (iv) clarify whether the certifying or transferring entity has general taxing authority: and,
- (v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

The Department of State Health Services (DSHS) as a Medicaid operating agency of HHSC provides the state share of the Medicaid payments made to the providers through appropriations from the Texas Legislature.

3. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

No supplemental or enhanced payments are made to these Medicaid providers of service.

4. For clinic or outpatient hospital services please provide a detailed description of the methodology used by the state to estimate the upper payment limit (UPL) for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated). Please provide a current (i.e., applicable to the current rate year) UPL demonstration.

Service are not clinic or outpatient hospital services. This question does not apply.

5. Does any governmental provider receive payments that in the aggregate (normal per diem, supplemental, enhanced, other) exceed their reasonable costs of providing services? If payments exceed the cost of services, do you recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

All providers are paid on the same basis and there is no cost reconciliation. No portion of any payments are recouped from the providers.