

## **Table of Contents**

### **State Plan Amendment**

#### **SPA 19-0012 NF Cost Report Reform - Effective 01/01/2019**

This file contains the following documents in order listed:

1. CMS Approval Letter
2. CMS Form 179
3. Superseding Page Listing (Attachment to Blocks 8 & 9 of CMS Form 179)
4. Approved SPA Page

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



---

**Financial Management Group**

June 3, 2019

Ms. Stephanie Muth  
State Medicaid/CHIP Director  
Health and Human Services Commission  
Mail Code: H100  
Post Office Box 13247  
Austin, Texas 78711

RE: TN 19-0012

Dear Ms. Muth:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 19-0012. The purpose of this amendment is to require biennial cost reports for nursing facilities, and they will submit cost reports every other year beginning with their fiscal year 2018 cost reports. During interim years, nursing facilities, who participate in the Direct Care Staff Compensation Program, will submit a Staffing and Compensation Report.

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.

Based upon the information provided by the State, Medicaid State plan amendment 19-0012 is approved effective January 1, 2019. We are enclosing the CMS-179 and the new plan pages.


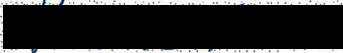


If you have any questions, please call Tamara Sampson at (214) 767-6431.

Sincerely,

A black rectangular redaction box covering the signature of Kristin Fan.

Kristin Fan  
Director

Enclosures

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b> <b>FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES</b>		1. TRANSMITTAL NUMBER: <b>19-0012</b>	2. STATE: <b>TEXAS</b>
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) Nursing Facilities	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE AND MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE: <b>January 1, 2019</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 440.155</b> <b>Section 1905(a)(4) of the Social Security Act</b>		7. FEDERAL BUDGET IMPACT: <b>SEE ATTACHMENT</b> a. FFY 2018 (\$0 00) b. FFY 2019 (\$0 00) c. FFY 2020 (\$0 00)	
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 amendment modifies the reimbursement methodology for the Nursing Facility (NF) program by requiring biennial, rather than annual, cost reports. NF providers will be required to submit cost reports every other year beginning with their fiscal year 2018 cost reports. During interim years, NF providers who participate in the Direct Care Staff Compensation Program will be required to submit a Staffing and Compensation Report.</b>			
11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: Sent to Governor's Office this date. Comments, if any, will be forwarded upon receipt. <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO:  <b>Stephanie Muth</b> <b>State Medicaid Director</b> <b>Post Office Box 13247, MC: H-100</b> <b>Austin, Texas 78711</b>	
13. TYPED NAME:  <b>Stephanie Muth</b>			
14. TITLE:  <b>State Medicaid Director</b>			
15. DATE SUBMITTED:  <b>5-27-19</b>			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED: <b>March 29, 2019</b>		18. DATE APPROVED: <b>JUN 03 2019</b>	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: <b>January 1, 2019</b>		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: 		22. TITLE: 	
23. REMARKS:			

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

**Transmittal Number 19-0012**

**Number of the  
Plan Section or Attachment**

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

Attachment 4.19-D (NF)

Page 1

Page 2

Attachment 4.19-D (NF)

Page 1 (TN 01-17)

Page 2 (TN 96-18)

**State: Texas**

**Date Received: March 29, 2019**

**Date Approved: JUN 03 2019**

**Date Effective: January 1, 2019**

**Transmittal Number: 19-0012**

## **Reimbursement Methodology for Nursing Facilities**

The Texas Health and Human Services Commission (HHSC), the Single State Medicaid Agency, has final approval authority of Medicaid payment rates. HHSC determines Nursing Facility (NF) Medicaid payment rates after consideration of analysis of financial and statistical information, and the effect of the payment rates on achievement of program objectives, including economic conditions and budgetary considerations.

### **(I) General**

- (A) **Uniform Rates.** Payment rates are uniform statewide for the same class of service.
- (B) **Prospective Rates with Retrospective Adjustments.** Payment rates are determined prospectively with retrospective adjustments for failure to meet staffing and/or spending requirements.
- (C) **Unit of Service.** The unit of service is a day of care provided to a Medicaid client by a Medicaid-contracted NF. A day is defined as a 24-hour period extending from midnight to midnight.
- (D) **Frequency of Rate Determination.** Rates are determined for a period of two years based upon cost reports, which are collected every two years.
- (E) **References in the text to the Texas Department of Human Services (DHS)** should be considered to be references to HHSC or its designee.

**TN No: 19-0012    Approval Date: JUN 03 2019**  
**Supersedes TN: 01-17**  
**Effective Date: 01/01/2019**

**State: Texas**  
**Date Received: March 29, 2019**  
**Date Approved: JUN 03 2019**  
**Date Effective: January 1, 2019**  
**Transmittal Number: 19-0012**

**Reimbursement Methodology for Nursing Facilities (continued)**

**(II) Cost Reporting.**

- (A) **Cost Reports.** To ensure adequate financial and statistical information upon which to base payment rates, HHSC requires that each contracted provider submit a cost report every other year and, if necessary, (a) supplemental report(s). It is the responsibility of the provider to submit accurate and complete information, in accordance with all pertinent HHSC cost reporting rules and cost report instructions.
- (B) **Pro Forma Costing.** When historical costs are unavailable, such as in the case of changes in program requirements, payment rates will be based on a pro forma approach. This approach involves using historical costs of delivering similar services and determining the types and costs of products and services necessary to deliver services meeting federal and state requirements.
- (C) **Audits and Desk Reviews.** HHSC conducts desk reviews and field audits of provider cost reports to ensure that the financial and statistical information reported in the cost reports conforms to all applicable rules and instructions.
- (D) **Informal Reviews and Appeals.** A contracted provider may request an informal review and, subsequently, an appeal of a desk review or field audit disallowance.

TN No: 19-0012    Approval Date: JUN 03 2019  
Supersedes TN: 96-18  
Effective Date: 01/01/2019

State: Texas  
Date Received: March 29, 2019  
Date Approved: JUN 03 2019  
Date Effective: January 1, 2019  
Transmittal Number: 19-0012