

## **Table of Contents**

**State/Territory Name: Texas**

**State Plan Amendment (SPA) #: 13-04**

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form
- 3) Superseding Page Listing
- 4) Approved SPA Page

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
Dallas Regional Office  
1301 Young Street, Suite 833  
Dallas, Texas 75202



**DIVISION OF MEDICAID & CHILDREN'S HEALTH - REGION VI**

---

June 24, 2013

Our Reference: SPA TX 13-004

Ms. Kay Ghahremani  
State Medicaid Director  
Health and Human Services Commission  
Post Office Box 13247  
Mail Code H100  
Austin, Texas 78711

Dear Ms. Ghahremani:

We have reviewed the State's proposed amendment to the Texas State Plan submitted under Transmittal Number 13-04, dated March 29, 2013. This state plan amendment updates the fee schedule for ambulance services.

Based on the information submitted, we have approved the amendment for incorporation into the official Texas State Plan with an effective date change of January 1, 2013. A copy of the CMS-179 and approved plan pages are enclosed with this letter.

If you have questions, please contact Cheryl Rupley at (214) 767-6278.

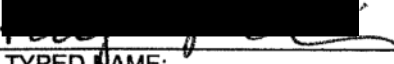

Sincerely,

A black rectangular box redacting the signature of Bill Brooks.

Bill Brooks  
Associate Regional Administrator

cc: Becky Brownlee, Policy Development Support

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b> <b>FOR: CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>		1. TRANSMITTAL NUMBER:  <b>13-004</b>	2. S
		3. PROGRAM IDENTIFICATION: TITLE XIX SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE:  <b>January 1, 2013</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 TO EXISTING PLAN			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: <b>42 CFR §440.170(a)</b> <b>42 CFR §431.53</b> <b>Section 1905(a)(xvii)(29) of the Social Security Act</b>		7. FEDERAL BUDGET IMPACT: SEE ATTACHMENT  a. FFY 2013      \$ (34,861) b. FFY 2014      \$ (48,411) c. FFY 2015      \$ (50,261)	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  <b>SEE ATTACHMENT TO BLOCKS 8 &amp; 9</b>		9. PAGE NUMBER OF THE SUPERSEDED OR ATTACHMENT (If Applicable):  <b>SEE ATTACHMENT TO BLOCKS 8 &amp; 9</b>	
10. SUBJECT OF AMENDMENT:  <b>The proposed amendment updates the ambulance services fee schedule.</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 <b>Sent to Governor's Office this date. Comments</b> <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL <b>be forwarded upon receipt.</b>			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO:  <b>Kay Ghahremani</b> <b>State Medicaid Director</b> <b>Post Office Box 13247, MC: H-100</b> <b>Austin, Texas 78711</b>	
13. TYPED NAME: <b>Kay Ghahremani</b>			
14. TITLE: <b>State Medicaid Director</b>			
15. DATE SUBMITTED <b>March 29, 2013</b>			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED: <b>29 MARCH 2013</b>		18. DATE APPROVED: <b>24 June 2013</b>	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL:  <b>1 JANUARY 2013</b>		20. SIGNATURE OF REGIONAL ADMINISTRATOR: 	
21. TYPED NAME: <b>D. H. D.</b>		22. TITLE: <b>Associate Regional Administrator</b>	

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

**Transmittal Number 13-004**

**Number of the  
Plan Section or Attachment**

Attachment 4.19-B  
Page 1b

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

Attachment 4.19-B  
Page 1b (TN 10-076)

State: Texas  
Date Approved: 24 June, 2013  
Date Received: 29 March, 2013  
Date Effective: 1 January, 2013  
Transmittal Number: 13-04

**2. Ambulance Services.**

- (a) Ground and air ambulance services are reimbursed based on the lesser of the provider's billed charges or fees established by the Texas Health and Human Services Commission (HHSC). Fees established by HHSC are based on a review of the Medicare fee schedule and/or an analysis of other data available to HHSC such as relevant fee schedules.
- (b) All fee schedules are available through the agency's website as outlined on Attachment 4.19-B, page 1.
- (c) The agency's fee schedule was revised with new fees for providers of ambulance services effective January 1, 2013, and this fee schedule was posted on the agency's website on January 11, 2013.

State: Texas  
Date Approved: 24 June, 2013  
Date Received: 29 March, 2013  
Date Effective: 1 January, 2013  
Transmittal Number: 13-04

---

TN: 13-04

Approval Date: 6/24/13

Effective Date: 1/1/13

Supersedes TN: 10-76