

## **Table of Contents**

**State/Territory Name: Texas**

**State Plan Amendment (SPA) #: 14-30**

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**

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October 29, 2014

Our Reference: SPA 14-030

Ms. Kay Ghahremani  
State Medicaid/CHIP 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 14-030, dated September 30, 2014. This state plan amendment updates the state plan provisions against reassignment of provider claims by including an exception for substitute physician arrangements.

Based on the information submitted, we have approved the amendment for incorporation into the official Texas State Plan with an effective date change of July 14, 2014. A copy of the CMS-179 and approved plan pages are enclosed with this letter.

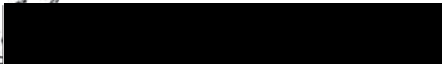
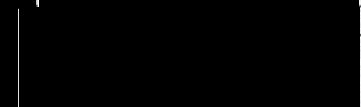
If you have questions, please contact Cheryl Rupley at (214) 767-6278.

Sincerely,

A black rectangular box redacting the signature of Bill Brooks.

Bill Brooks  
Associate Regional Administrator

cc: Becky Brownlee, Policy Development Support

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES</b>		1. TRANSMITTAL NUMBER:  <b>14-030</b>	2. STATE:  <b>TEXAS</b>
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE AND MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE:  <b>July 14, 2014</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>§1902(a)(32) of Social Security Act</b>		7. FEDERAL BUDGET IMPACT: <b>SEE ATTACHMENT</b> a. FFY 2014      \$0 b. FFY 2015      \$0 c. FFY 2016      \$0	
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 proposed amendment would update the state plan's substitute physicians arrangements to clarify that no payment under the plan for any care or service provided to an individual shall be made to anyone other than the person providing service, except in cases where a substitute physician sees a billing physician's patients for 14 continuous days or less under an informal reciprocal arrangement or for up to 90 continuous days under a formal locum tenans arrangement.</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>Kay Ghahremani State Medicaid Director Post Office Box 13247, MC: H-100 Austin, Texas 78711</b>	
13. TYPED NAME: <b>Kay Ghahremani</b>			
14. TITLE: <b>State Medicaid Director</b>			
15. DATE SUBMITTED: <b>September 30, 2014</b>			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED:      30 September, 2014		18. DATE APPROVED:      29 October, 2014	
PLAN APPROVED – ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL:  14 July, 2014		20. SIGNATURE: 	
21. TYPED NAME:  Bill Brooks		22. TITLE: Associate Regional Administrator division of Medicaid & Children's Health	
23. REMARKS:			

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

**Transmittal Number 14-030**

**Number of the  
Plan Section or Attachment**

Basic State Plan  
Page 68

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

Basic State Plan  
Page 68 (TN 81-009)

State: Texas  
Date Received: 30 September, 2014  
Date Approved: 29 October, 2014  
Date Effective: 14 July, 2014  
Transmittal Number: TX 14-30

State TexasCitation

4.21

Prohibition Against Reassignment of Provider Claims

42 CFR 447.10(c)  
AT-78-90  
46 FR 42699  
SSA §1902(a)(32)

Payment for Medicaid services furnished by any provider under this plan is made in accordance with the requirements of 42 CFR 447.10 and Social Security Act §1902(a)(32).

State: Texas

Date Received: 30 September, 2014

Date Approved: 29 October, 2014

Date Effective: 14 July, 2014

Transmittal Number: TX 14-30

TN: 14-30Approval Date: 10-29-14Effective Date: 7-14-14Supersedes TN: 81-09