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State/Territory Name: Texas

State Plan Amendment (SPA) #: 14-41

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) CMS 179 Form
- 3) Superseding Page List
- 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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November 19, 2014

Our Reference: SPA TX 14-041

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

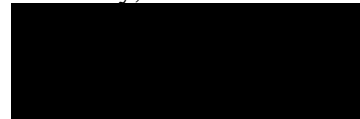
Dear Ms. Ghahremani:

We have reviewed the State's proposed amendment to the Texas State Plan submitted under Transmittal Number 14-041, dated September 24, 2014. This state plan amendment adjusts the payment rates for the Day Activities and Health Services (DAHS) program to be equal to the payment rates in effect on August 31, 2014 plus an additional \$0.15 increase to the base rate.

Based on the information submitted, we have approved the amendment for incorporation into the official Texas State Plan with an effective date change of September 1, 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,



Bill Brooks  
Associate Regional Administrator

cc: Becky Brownlee, Policy Development Support

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICAIRE AND MEDICAID</b>		1. TRANSMITTAL NUMBER:  <b>14-041</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>September 1, 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>42 CFR §440.130(d) , 42 CFR §440.255 §1905(a)(13) of the Social Security Act</b>		7. FEDERAL BUDGET IMPACT: <b>SEE ATTACHMENT</b> a. FFY 2014      \$ 3,416 b. FFY 2015      \$ 40,600 c. FFY 2016      \$ 40,034	
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 will revise the rate methodology for the for the Day Activities and Health Services program to increase the base rate by \$0.15.</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, if any, will be forwarded upon receipt.</b> <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 24, 2014</b>			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED:      24 September, 2014		18. DATE APPROVED:      19 November, 2014	
PLAN APPROVED – ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL:  1 September, 2014		20. SIGNATURE OF REGIONAL ADMINISTRATOR: 	
21. TYPED NAME:      Bill Brooks		22. TITLE: Associate Regional Administrator Division of Medicaid & Children's Health	
23. REMARKS:			

**Attachment to Blocks 8 and 9 to CMS Form 179**

**Transmittal Number 14-041**

**Number of the  
Plan Section or Attachment**

Attachment 4.19-B  
Page 7c

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

Attachment 4.19-B  
Page 7c (TN 13-030)

State: Texas  
Date Received 9-24-14  
Date Approved: 11-19-14  
Date Effective: 9-1-14  
Transmittal Number: 14-41

**15. Reimbursement Methodology for Day Activity and Health Services,  
continued.**

- (D) Recommended payment rate for each cost area component. The median projected unit of service from each cost area is determined. The median cost component for each of the three cost areas is multiplied by 1.044 to calculate the recommended payment rate for each cost area.
- (3) Total recommended payment rate. The recommended payment rate is determined by summing the recommended payment rates described in IX (2) and the cost area component from IX (1)(A).
- (4) For services provided on or after September 1, 2013, the attendant cost area from X is equal to the rate in effect August 31, 2013 plus \$0.10. These rates will be posted on the agency's website on September 1, 2013. All rates are available through the agency's website as outlined on Attachment 4.19-B, page 1.
- (5) For services provided on or after September 1, 2014, the attendant cost area from X is equal to the rate in effect August 31, 2014, plus \$0.15. These rates were posted on the agency's website on September 1, 2014. All rates are available through the agency's website as outlined on Attachment 4.19-B, page 1.

State: Texas  
Date Received 9-24-14  
Date Approved: 11-19-14  
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