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

Division of Medicaid & Children's Health, Region VI

August 10, 2010

Our Reference: SPA TX 09-015

Mr. Billy Millwee
Associate Commissioner for Medicaid & CHIP
Health and Human Services Commission
Post Office Box 13247
Mail Code: H100
Austin, Texas 78711

Dear Mr. Millwee:

We have reviewed the State's proposed amendment to the Texas State Plan submitted under Transmittal Number 09-015, dated June 18, 2009. This amendment increases payment rates in for Day Activity Health Services (DAHS) by $0.30.

As previously communicated to the State, CMS issued a companion letter in conjunction with our approval of SPA 05-010B in which we requested the State to clarify coverage issues relating to Day Activity Health Services (DAHS). As referenced, that companion letter also applies to this SPA approval. It was determined that certain areas in the coverage section were not consistent with current guidance and regulations at 42 CFR 440.130(d). Please be mindful of the timeframes referenced in that companion letter.

Additionally, please note that when the State submits a State Plan Amendment (SPA) that may impact Indians or Indian health providers, CMS will look for evidence of the State's Tribal consultation process for that SPA. Pursuant to the new section 1902(a)(73) of the Act added by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009, the State must submit evidence to CMS regarding the solicitation of advice prior to submission of the State Plan Amendment. Such consultation must include all federally-recognized tribes, Indian Health Service and Urban Indian Organizations within the State.

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, 2009. A copy of the CMS-179 and the approved plan pages are enclosed with this letter.

If you have any questions, please contact Ford J. Blunt at (214) 767-6381.

Sincerely,

Bill Brooks
Associate Regional Administrator

Enclosures
Cc: Emily Zalkovsky, Policy Development Support

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICAIRE AND MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICAIRE AND MEDICAID

1. TRANSMITTAL NUMBER: **09-015**

2. STATE: **TEXAS**

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: **September 01, 2009**

5. TYPE OF PLAN MATERIAL *(Circle One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 440.130(d)
Section 1905(a)(13) of the Social Security Act

7. FEDERAL BUDGET IMPACT: SEE ATTACHMENT
a. FFY 2009 $ **127,764**
b. FFY 2010 **$ 1,562,444**
c. FFY 2011 **$ 1,617,060**

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 proposed amendment will adjust payment rates for the Day Activities and Health Services (DAHS) program to be equal to the payment rates in effect August 31, 2009 plus $0.30.

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Sent to Governor's Office this date. Comments, if any, will be forwarded upon receipt.

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Chris Traylor

14. TITLE:
State Medicaid Director

15. DATE SUBMITTED:
June 18, 2009

16. RETURN TO:
Chris Traylor
State Medicaid Director
Post Office Box 85200
Austin, Texas 78711-5200

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 16 June, 2009

18. DATE APPROVED: 10 August, 2010

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: 1 September, 2009

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Bill Brooks

22. TITLE: Associate Regional Administrator Div of Medicaid & Children's Health

23. REMARKS:

FORM CMS – 179 (07-92)

(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 August 1, 2009, the attendant cost area from X is equal to the rate in effect July 31, 2009 plus $0.30. These rates will be posted on the agency's website on September 1, 2009. All rates are available through the agency's website as outlined on Attachment 4.19-B, Page 1.

SUPERSEDES: TN- 08-16

STATE Texas
DATE REC'D 6-16-09
DATE APP'D 8-10-10
DATE EFF 9-1-09
HCFA 179 09-15

A