

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES		1. TRANSMITTAL NUMBER: 10-076	2. STATE: TEXAS
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE: February 1, 2011	
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: 42 CFR §440.170(a) 42 CFR §431.53 Section 1905(a)(28) of the Social Security Act		7. FEDERAL BUDGET IMPACT: SEE ATTACHMENT a. FFY 2011 (\$561,371) b. FFY 2012 (\$780,955) c. FFY 2013 (\$807,195)	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: SEE ATTACHMENT TO BLOCKS 8 & 9		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): SEE ATTACHMENT TO BLOCKS 8 & 9	
10. SUBJECT OF AMENDMENT: The proposed amendment implements a one percent payment reduction for reimbursements paid to ambulance providers.			
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 Sent to Governor's Office this date. Comments, if any, will be <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL forwarded upon receipt.			
12. SIGNATURE OF STATE AGENCY OFFICIAL: _____ Billy R. Millwee		16. RETURN TO: Billy R. Millwee State Medicaid Director Post Office Box 85200 Austin, Texas 78708	
13. TYPED NAME: Billy R. Millwee			
14. TITLE: State Medicaid Director			
15. DATE SUBMITTED: December 27, 2010			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: 28 December, 2010		18. DATE APPROVED: 11 March, 2011	
PLAN APPROVED – ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 1 February, 2011		20. SIGNATURE OF REGIONAL OFFICIAL: _____	
21. TYPED NAME: Bill Brooks		22. TITLE: Associate Regional Administrator Division of Medicaid & Children's Health	
23. REMARKS:			

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 February 1, 2011, and this fee schedule was posted on the agency's website on April 8, 2011.

The reimbursement for services effective September 1, 2010 through January 31, 2011 will be equal to the reimbursement on August 31, 2010, less one percent.

The reimbursement for services effective February 1, 2011 will be equal to the reimbursement on August 31, 2010, less two percent.

SUPERSEDES: TN- 10-31

STATE <u>Texas</u>	A
DATE REC'D <u>12-28-10</u>	
DATE APPV'D <u>3-11-11</u>	
DATE EFF <u>2-1-11</u>	
HCFA 179 <u>10-76</u>	

TN 10-76

Approval Date 3-11-11

Effective Date 2-1-11

Supersedes TN 10-31