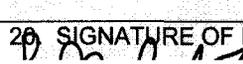


TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICAID AND MEDICAID		1. TRANSMITTAL NUMBER: 08-017	2. STATE: TEXAS
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE AND MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE: August 01, 2008	
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 440.167		7. FEDERAL BUDGET IMPACT: SEE ATTACHMENT a. FFY 2008 \$ 6,180,186 b. FFY 2009 \$ 37,356,505 c. FFY 2010 \$ 36,822,302	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: SEE ATTACHMENT to BLOCKS 8 and 9		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): SEE ATTACHMENT to BLOCKS 8 and 9	
10. SUBJECT OF AMENDMENT: The proposed amendment will adjust payment rates for the Primary Home Care program effective August 1, 2008, in response to the new federal minimum wage provisions contained in the Fair Labor Standards Act (FLSA).			
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 forwarded upon receipt. <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO: Chris Traylor State Medicaid Director Post Office Box 85200 Austin, Texas 78711-5200	
13. TYPED NAME: Chris Traylor			
14. TITLE: State Medicaid Director			
15. DATE SUBMITTED: September 26, 2008			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: 26 Sept, 2008		18. DATE APPROVED: 20 July, 2009	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 1 August, 2009		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Bill Brooks		22. TITLE: Associate Regional Administrator Div of Medicaid & Children's Health	
23. REMARKS:			

(D) Recommended payment rate for the service support cost area. The total units of service for each provider agency are summed until the median hour of service is reached. The corresponding projected expense is the weighted median cost component. The weighted median cost component is multiplied by 1.044 to calculate the recommended payment rate for the service support cost area.

(3) Total recommended payment rate.

(A) For nonpriority clients. The recommended payment rate is determined by summing the recommended payment rate described in 14.IX (2) and the cost area component from 14.IX (1)(B).

(B) For Priority 1 clients. The recommended payment rate is determined by summing the recommended payment rate described in 14.IX (2) and the cost area component from 14.IX (1)(C).

(4) For rates effective September 1, 2007, through July 31, 2008, the recommended payment rate for nonpriority clients will equal the total payment rate for nonpriority clients in effect July 31, 2007, plus 5.56%. The total payment rate for priority clients will equal the total payment rate for priority clients in effect July 31, 2007, plus 3.62%.

(5) For services provided on or after August 1, 2008, the rate for the non-priority attendant cost area described in 14.IX(1)(B) equals the rate in effect July 31, 2008, plus \$0.79. The priority attendant cost area described in 14.IX(1)(C) is equal to the rate in effect July 31, 2008, plus \$0.38. These rates were posted on the agency's website on July 16, 2008. All rates are available through the agency's website, as outlined on Attachment 4.19-B, page 1.

PROCESSED IN 07-36

STATE	Texas	
DATE REC'D	9-26-08	
DATE APP'D	7-20-09	A
DATE EFF	8-1-08	
HCFA 179	08-17	