

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES		1. TRANSMITTAL NUMBER: 09-010	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: August 15, 2009	
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 §440.70 (Home health services, including skilled nursing and durable medical equipment and supplies) and Section 1905(a)(7) of the Social Security Act (home health care services)		7. FEDERAL BUDGET IMPACT: SEE ATTACHMENT a. FFY 2009 \$ 53,642 b. FFY 2010 \$1,784,936 c. FFY 2011 \$1,689,605	
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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): SEE ATTACHMENT TO BLOCKS 8 AND 9.	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 modifies the reimbursement methodology for in-home total parenteral hyperalimentation services by removing the reimbursement methodology page for these services. The payments for hyperalimentation nursing services are covered under the reimbursement methodology for home health services. The payments for the hyperalimentation nutritional products and associated medical supplies are covered under the reimbursement methodology for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). The requested effective date for the proposed amendment is July 1, 2009.			
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: 13. TYPED NAME: Chris Traylor		16. RETURN TO: Chris Traylor State Medicaid Director Post Office Box 13247 Austin, Texas 78711-3247	
14. TITLE: State Medicaid Director			
15. DATE SUBMITTED: July 9, 2009			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: 10 July, 2009		18. DATE APPROVED: 6 October, 2009	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 15 August, 2009		20. SIGNATURE OF REGIONAL OFFICIAL: Associate Regional Administrator	
21. TYPED NAME: Bill Brooks		22. TITLE: Div of Medicaid & Children's Health	
23. REMARKS:			

Attachment to Blocks 8 and 9 to CMS Form 179

Transmittal No. TX 09-010, Amendment No. 856

**Number of the
Plan Section or Attachment**

**Number of the Superseded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

Attachment 4.19-B
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Attachment 4.19-B
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