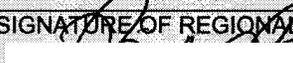


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|---|--|---|-------------------------------|
| TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICAID AND MEDICAID | | 1. TRANSMITTAL NUMBER: 09-015 | 2. STATE: TEXAS |
| | | 3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) | |
| TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICAID AND MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES | | 4. PROPOSED EFFECTIVE DATE: September 01, 2009 | |
| 5. TYPE OF PLAN MATERIAL (<i>Circle One</i>): <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 (<i>Separate Transmittal for each amendment</i>) | | | |
| 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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (<i>If Applicable</i>): 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 (<i>Check One</i>): <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 | | | |
| 12. SIGNATURE OF STATE AGENCY OFFICIAL: | | 16. RETURN TO: | |
| 13. TYPED NAME: Chris Traylor | | Chris Traylor State Medicaid Director Post Office Box 85200 Austin, Texas 78711-5200 | |
| 14. TITLE: State Medicaid Director | | | |
| 15. DATE SUBMITTED: June 18, 2009 | | | |
| 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 Dn of Medicaid & Children's Health | |
| 23. REMARKS: | | | |

- (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 | <u>Texas</u> | A |
| DATE REC'D | <u>6-16-09</u> | |
| DATE APP'D | <u>8-10-10</u> | |
| DATE EFF | <u>9-1-09</u> | |
| HCFR 179 | <u>09-15</u> | |

TN No. 09-15

Approval Date 8-10-10

Effective Date 9-1-09

Supersedes TN No. 08-16