

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES		1. TRANSMITTAL NUMBER: 09-030	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: July 1, 2009	
5. TYPE OF PLAN MATERIAL (Circle One): <input type="checkbox"/> COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment) <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
6. FEDERAL STATUTE/REGULATION CITATION: Eyeglasses: §1905(a)(12) of the Social Security Act; 42 CFR § 440.120		7. FEDERAL BUDGET IMPACT: SEE ATTACHMENT a. FFY 2009 \$ 963,078 b. FFY 2010 \$4,027,407 c. FFY 2011 \$3,651,443	
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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): SEE ATTACHMENT TO BLOCKS 8 AND 9	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 updates the Vision Services section of the state plan.			
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			
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 78708	
14. TITLE: State Medicaid Director			
15. DATE SUBMITTED: September 25, 2009			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: 25 September 2009		18. DATE APPROVED: 20 October, 2009	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 1 July, 2009		20. SIGNATURE OF REGIONAL OFFICIAL: <i>[Signature]</i>	
21. TYPED NAME: Bill Brooks		22. TITLE: Associate Regional Administrator Dir of Medicaid (+) Children's Health	
23. REMARKS:			

10. Vision Care Services.

- a) Providers of professional vision services are reimbursed based on the lesser of the provider's billed charges or fees determined by HHSC.
- b) Providers of eyeglasses and contact lenses are reimbursed the lesser of the provider's billed charges or fees determined by HHSC, which are based on a review of Medicare fees and/or other data available to HHSC.
- c) All fee schedules are available through the agency's website as set out on Attachment 4.19-B, page 1.
- d) The agency's fee schedule was revised with new fees for Vision Care Services effective for services on or after July 1, 2009. The fee schedule is to be posted on October 8, 2009.

SUPERSEDES: TN 07-25

STATE	<u>Texas</u>	A
DATE REC'D	<u>9-25-09</u>	
DATE APPV'D	<u>10-20-09</u>	
DATE EFF	<u>7-1-09</u>	
HCFA 179	<u>09-30</u>	

TN No. 09-30 Approval Date 10-20-09 Effective Date 7-1-09
Supersedes TN No. 07-25