

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES		1. TRANSMITTAL NUMBER: 05-010B	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: September 1, 2005	
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 §440.130(d)		7. FEDERAL BUDGET IMPACT: SEE ATTACHMENT a. FFY 2005 \$57,929 b. FFY 2006 \$696,834 c. FFY 2007 \$743,239	
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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): SEE ATTACHMENT TO BLOCKS 8 AND 9	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 revises the reimbursement methodology for Day Activity and Health Services to change the method for determining the rates for the period of September 1, 2005, through August 31, 2007.			
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:		16. RETURN TO:	
13. TYPED NAME: Billy Millwee		Billy Millwee State Medicaid Director Post Office Box 13247, MC: H-100 Austin, Texas 78711-5200	
14. TITLE: State Medicaid Director			
15. DATE SUBMITTED: September 28, 2005			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: 29 September, 2005		18. DATE APPROVED: 10 August, 2010	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 1 September, 2005		20. SIGNATURE OF REGIONAL OFFICIAL:	
21. TYPED NAME: Bill Brooks		22. TITLE: Associate Regional Administrator Div of Medicare & 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 rates effective September 1, 2003 through August 31, 2005, the total recommended payment rate will be equal to the rates in effect August 31, 2003 less 1.1%.
- (5) For rates effective September 1, 2005 through August 31, 2007, the total recommended payment rate will be equal to the rates in effect August 31, 2003. All rates are available through the agency's website as outlined on Attachment 4.19-B, Page 1.

SUPERSEDES: TN- 03-19

STATE	<u>Texas</u>	A
DATE REC'D	<u>9-29-05</u>	
DATE APPV'D	<u>8-10-10</u>	
DATE EFF	<u>9-1-05</u>	
HOEA 179	<u>05-10(B)</u>	

TN No. 05-10(B) Approval Date 8-10-10 Effective Date 9-1-05
Supersedes TN No. 03-19