

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES		1. TRANSMITTAL NUMBER: TX 07-024	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: October 1, 2007	
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: 42 USC § 1396n(g)		7. FEDERAL BUDGET IMPACT: SEE ATTACHMENT b. FFY 2008 \$ 0 c. FFY 2009 \$ 0	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: See attachment		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): See attachment	
10. SUBJECT OF AMENDMENT: The amendment provides for the Early Childhood Intervention Targeted Case Management reimbursement rate in effect for September 30, 2007, to continue to be in effect from October 1, 2007, through September 30, 2009.			
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: <i>[Signature]</i>		16. RETURN TO: Chris Traylor State Medicaid Director Post Office Box 85200 Austin, Texas 78708	
13. TYPED NAME: Chris Traylor			
14. TITLE: State Medicaid Director			
15. DATE SUBMITTED: 10-5-2007			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: 5 October, 2007		18. DATE APPROVED: 23 June, 2010	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 1 October, 2007		20. SIGNATURE OF REGIONAL OFFICIAL: <i>[Signature]</i>	
21. TYPED NAME: Bill Brooks		22. TITLE: Associate Regional Administrator Div of Medicaid & Children's Health	
23. REMARKS:			

39. Case Management Services for Infants and Toddlers with Developmental Delays

3. The reimbursement rate in effect on September 30, 2007, will remain in effect from October 1, 2007 through March 14, 2010.
4. The agency's fee schedule was not revised with new fees for case management services for infants and toddlers with developmental delays effective for services on or after September 1, 2007 because the rates were not changed. The fee schedule was posted by September 1, 2007.
5. All fee schedules are available through the agency's website as outlined on Attachment 4.19-B, Page 1.

STATE	<u>Texas</u>	A
DATE REC'D	<u>10-5-07</u>	
DATE APPV'D	<u>6-23-10</u>	
DATE EFF	<u>10-1-07</u>	
HCFA 179	<u>07-24</u>	

SUPERSEDES: NONE - NEW PAGE