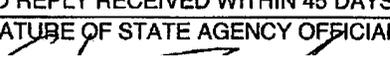
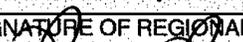


TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE AND MEDICAID		1. TRANSMITTAL NUMBER: TX 07-035	2. STATE: TEXAS
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE AND MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE: September 1, 2007	
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 2007 \$ 165,653 b. FFY 2008 \$ 1,508,393	
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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): SEE ATTACHMENT	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: This amendment revises the plan language in the Reimbursement Methodology for Day Activity and Health Services (DAHS) to change the method for determining the rates for the period of September 1, 2007, through August 31, 2008.			
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: Chris Traylor State Medicaid Director Post Office Box 85200 Austin, Texas 78711-5200	
13. TYPED NAME: Chris Traylor		14. TITLE: State Medicaid Director	
15. DATE SUBMITTED: 8/28/07			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: 28 August, 2007		18. DATE APPROVED: 10 August, 2010	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 1 September, 2007		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Bill Brooks		22. TITLE: Associate Regional Administrator Div 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 rates effective August 1, 2007 through August 31, 2007, the attendant cost area from X is equal to the rate in effect July 31, 2007 plus \$0.09. These rates were posted on the agency's website on August 1, 2007.
- (5) For rates effective September 1, 2007 through August 31, 2008, the total recommended payment rate will be equal to the rates in effect July 31, 2007 plus 3.0%. These rates were posted on the agency's website on September 1, 2007. All rates are available through the agency's website as outlined on Attachment 4.19-B, Page 1.

SUPERSEDES: TN- 07-34

STATE	<u>TEXAS</u>	A
DATE REC'D	<u>8-28-07</u>	
DATE APPV'D	<u>8-10-10</u>	
DATE EFF	<u>9-1-07</u>	
HCFA 179	<u>07-35</u>	

TN No. 07-35

Approval Date 8-10-10

Effective Date 9-1-07

Supersedes TN No. 07-34