

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b> <b>FOR: CENTERS FOR MEDICAIRE AND MEDICAID</b>	1. TRANSMITTAL NUMBER:  <b>TX 08-016</b>	2. STATE:  <b>TEXAS</b>
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICAIRE AND MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE:  <b>August 01, 2008</b>	
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: <b>42 CFR 440.130(d)</b>	7. FEDERAL BUDGET IMPACT: SEE ATTACHMENT a. FFY 2008      \$ 64,862 b. FFY 2009      \$ 389,217 c. FFY 2010      \$ 383,651	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  <b>SEE ATTACHMENT TO BLOCKS 8 AND 9</b>	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):  <b>SEE ATTACHMENT TO BLOCKS 8 AND 9</b>	
10. SUBJECT OF AMENDMENT:  <b>The proposed amendment will adjust payment rates for the Day Activity and Health Services program effective August 1, 2008, in response to the new federal minimum wage provisions contained in the Fair Labor Standards Act (FLSA).</b>		
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 <b>Sent to Governor's Office this date. Comments, if any, will be forwarded upon receipt.</b> <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL		
12. SIGNATURE OF STATE AGENCY OFFICIAL:  <i>[Signature]</i>	16. RETURN TO:  <b>Chris Traylor State Medicaid Director Post Office Box 85200 Austin, Texas 78711-5200</b>	
13. TYPED NAME: <b>Chris Traylor</b>		
14. TITLE: <b>State Medicaid Director</b>		
15. DATE SUBMITTED: September 26, 2008		
<b>FOR REGIONAL OFFICE USE ONLY</b>		
17. DATE RECEIVED: <b>26 Sept, 2008</b>	18. DATE APPROVED: <b>10 August, 2010</b>	
PLAN APPROVED - ONE COPY ATTACHED		
19. EFFECTIVE DATE OF APPROVED MATERIAL: <b>1 August, 2008</b>	20. SIGNATURE OF REGIONAL OFFICIAL:  <i>[Signature]</i>	
21. TYPED NAME: <b>Bill Brooks</b>	22. TITLE: <b>Associate Regional Administrator Div of Medicaid &amp; Children's Health</b>	
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, 2007 through July 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.
- (5) For services provided on or after August 1, 2008, the attendant cost area from 15.X is equal to the rate in effect July 31, 2008, plus \$0.09. These rates were posted on the agency's website on July 16, 2008. All rates are available through the agency's website as outlined on Attachment 4.19-B, Page 1.

SUPERSEDES: TN- 07-35

STATE	<u>Texas</u>	A
DATE REC'D	<u>9-26-08</u>	
DATE APP'VD	<u>8-10-10</u>	
DATE EFF	<u>8-1-08</u>	
HCFA 179	<u>08-16</u>	

TN No. 08-16

Approval Date 8-10-10

Effective Date 8-1-08

Supersedes TN No. 07-35