

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE AND MEDICAID SERVICES</b>		1. TRANSMITTAL NUMBER: <b>10-059</b>	2. STATE: <b>TEXAS</b>
		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: <b>September 1, 2010</b>	
5. TYPE OF PLAN MATERIAL ( <i>Circle One</i> ): <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 ( <i>Separate Transmittal for each amendment</i> )			
6. FEDERAL STATUTE/REGULATION CITATION: <b>42 CFR 447.252(b)</b>		7. FEDERAL BUDGET IMPACT: a. FFY 10      \$ 0 b. FFY 11      \$ 0 c. FFY 12      \$ 0	
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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT ( <i>If Applicable</i> ): <b>SEE ATTACHMENT TO BLOCKS 8 AND 9</b>	
10. SUBJECT OF AMENDMENT: <b>The purpose of the amendment is to update the website address where fee schedules and rates can be accessed.</b>			
11. GOVERNOR'S REVIEW ( <i>Check One</i> ): <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: <b>Billy R. Millwee State Medicaid Director Post Office Box 13247, MC-100 Austin, Texas 78711</b>	
13. TYPED NAME: <b>Billy R. Millwee</b>			
14. TITLE: <b>State Medicaid Director</b>			
15. DATE SUBMITTED: <b>September 17, 2010</b>			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED: <b>21 September, 2010</b>		18. DATE APPROVED: <b>30 September, 2010</b>	
<b>PLAN APPROVED – ONE COPY ATTACHED</b>			
19. EFFECTIVE DATE OF APPROVED MATERIAL: <b>1 September, 2010</b>		20. SIGNATURE OF REGIONAL OFFICIAL:	
21. TYPED NAME: <b>Bill Brooks</b>		22. TITLE: <b>Associate Regional Administrator Division of Medicaid &amp; Children's Health</b>	
23. REMARKS:			

All rates and fees can be found by accessing the agency's website at <http://www.hhsc.state.tx.us/medicaid/programs/rad/index.shtml>. The rates accessed at this website contain all annual or periodic adjustments to the fee schedule.

Except as otherwise noted in the plan, state developed fee schedules and rates are the same for both governmental and private providers.

SUPERSEDES: TN- 08-15

STATE	<u>Texas</u>	A
DATE REC'D	<u>9-21-10</u>	
DATE APPV'D	<u>9-30-10</u>	
DATE EFF	<u>9-1-10</u>	
HCFA 179	<u>10-59</u>	

TN 10-59 Approval Date 9-30-10 Effective Date 9-1-10

Supersedes TN 08-15