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| TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES | | 1. TRANSMITTAL NUMBER: <div style="text-align: center; font-weight: bold;">12-015</div> | 2. STATE: <div style="text-align: center; font-weight: bold;">TEXAS</div> |
| | | 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: <div style="text-align: center; font-weight: bold;">March 1, 2012</div> | |
| 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: 42 CFR § 440.170(a) 42 CFR § 431.53 Section 1905(a)(29) of the Social Security Act | | 7. FEDERAL BUDGET IMPACT: SEE ATTACHMENT <div style="display: flex; justify-content: space-between;"> <div>a. FFY 2012</div> <div>\$ 0</div> </div> <div style="display: flex; justify-content: space-between;"> <div>b. FFY 2013</div> <div>\$ 0</div> </div> <div style="display: flex; justify-content: space-between;"> <div>c. FFY 2014</div> <div>\$ 0</div> </div> | |
| 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: SEE ATTACHMENT TO BLOCKS 8 & 9 | | 9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT <i>(If Applicable)</i> : SEE ATTACHMENT TO BLOCKS 8 & 9 | |
| 10. SUBJECT OF AMENDMENT: The proposed amendment deletes language in the Texas State Plan governing the methodology for computing supplemental Medicaid payments for ambulance services provided by governmental ambulance providers. | | | |
| 11. GOVERNOR'S REVIEW <i>(Check One)</i> : <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL </div> <div style="width: 45%;"> <input checked="" type="checkbox"/> OTHER, AS SPECIFIED: Sent to Governor's Office this date. Comments, if any, will be forwarded upon receipt. </div> </div> | | | |
| 12. SIGNATURE OF STATE AGENCY OFFICIAL: <div style="background-color: black; width: 200px; height: 40px; margin: 10px auto;"></div> | | 16. RETURN TO: Billy R. Millwee State Medicaid Director PO Box 13247, MC: H-100 Austin, Texas 78711 | |
| 13. TYPED NAME: Billy R. Millwee | | | |
| 14. TITLE: State Medicaid Director | | | |
| 15. DATE SUBMITTED: March 26, 2012 | | | |
| FOR REGIONAL OFFICE USE ONLY | | | |
| 17. DATE RECEIVED: 26 March, 2012 | | 18. DATE APPROVED: <div style="text-align: center;">26 April 2012</div> | |
| PLAN APPROVED – ONE COPY ATTACHED | | | |
| 19. EFFECTIVE DATE OF APPROVED MATERIAL: <div style="text-align: center;">1 March, 2012</div> | | 20. SIGNATURE OF REGIONAL OFFICIAL: <div style="background-color: black; width: 200px; height: 40px; margin: 10px auto;"></div> | |
| 21. TYPED NAME: <div style="text-align: center;">Bill Brooks</div> | | 22. TITLE: <div style="text-align: center;">Associate Regional Administrator Division of Medicaid & Children's Health</div> | |
| 23. REMARKS: | | | |