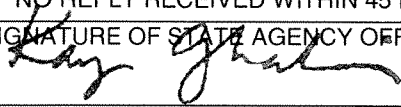


<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b> <b>FOR: CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>		1. TRANSMITTAL NUMBER:  <b>13-022</b>	2. STATE:  <b>TEXAS</b>
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE:  <b>April 1, 2013</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 §§ 440.40, 441.56(b)(vi); §1905(r)(3) of Social Security Act, relating to Early and Periodic Screening, Diagnosis and Treatment.</b>		7. FEDERAL BUDGET IMPACT: SEE ATTACHMENT  a. FFY 2013      \$(327,005) b. FFY 2014      \$(693,905) c. FFY 2015      \$(738,183)	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  <b>SEE ATTACHMENT TO BLOCKS 8 &amp; 9</b>		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):  <b>SEE ATTACHMENT TO BLOCKS 8 &amp; 9</b>	
10. SUBJECT OF AMENDMENT:  <b>The proposed amendment updates the Medicaid fee schedule for the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program for fee-for-service dental claims.</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: 		16. RETURN TO:  <b>Kay Ghahremani State Medicaid Director PO Box 13247 MC H-100 Austin, Texas 78711</b>	
13. TYPED NAME: <b>Kay Ghahremani</b>			
14. TITLE: <b>State Medicaid Director</b>			
15. DATE SUBMITTED <b>July 2, 2013</b>			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED: 28 June, 2013		18. DATE APPROVED: 28 August, 2013	
PLAN APPROVED – ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 1 April, 2013		20. SIGNATURE OF REGIONAL OFFICIAL:	
21. TYPED NAME: Bill Brooks		22. TITLE: Associate Regional Administrator Division of Medicaid & Children's Health	
23. REMARKS:			