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<tr>
<td>6.2</td>
<td>Cost Allocation</td>
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<tr>
<td>6.3</td>
<td>State Financial Participation</td>
</tr>
<tr>
<td><strong>SECTION 7</strong></td>
<td></td>
</tr>
<tr>
<td>7.2</td>
<td>A Methods of Administration–Civil Rights</td>
</tr>
</tbody>
</table>
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State of Texas

ATTORNEY GENERAL’S CERTIFICATION

I certify that:

Health and Human Services Commission is the single state agency responsible for:

☐ Administering the plan.

The legal authority under which the agency administers the plan on a statewide basis is:

Texas Government Code, Section 531.021(b)
(statutory citation)

☐ Supervising the administration of the plan by local political subdivisions.

The legal authority under which the agency supervises the administration of the plan on a Statewide basis is contained in

(statutory citation)

The agency’s legal authority to make rules and regulations that are binding on the political subdivision administering the plan is:

(statutory citation)

Date

Chip Roy
Printed Name

Signature

First Assistant Attorney General
Title

State: Texas
Date Received: 11 December, 2015
Date Approved: 8 January 2016
Date Effective: 1 October, 2015
Transmittal Number: TX 15-0035

TN: 15-0035 Approval Date: 1/08/16 Effective Date: 10/01/15
Supersedes TN: 13-0057MM4
The Health and Human Services Commission (HHSC) is the state agency with primary responsibility for overseeing the delivery of state health and human services. HHSC is governed by the Executive Commissioner of Health and Human Services, who is appointed by the Governor of the State of Texas.

Per H.B. 2292, 78th Legislature, Regular Session, 2003, the various health and human services agencies were reorganized into four new departments and placed under the authority of HHSC. These departments include the Department of State Health Services (DSHS), the Department of Aging and Disability Services (DADS), the Department of Assistive and Rehabilitative Services (DARS), and the Department of Family and Protective Services (DFPS). HHSC is directed by state law to oversee the operations of these four operating departments.

Section 531.021 of the Texas Government Code designates HHSC as the single state agency for administering federal medical assistance funds. Under this authority, the federal medical assistance funds are granted to HHSC by the Centers for Medicare & Medicaid Services (CMS). As the single state agency, HHSC has final authority over the Medicaid programs that are administered by HHSC or carried out by the other operating departments subject to the approval of HHSC. Within HHSC, the State Medicaid Director administers the Medicaid program.

HHSC's Medicaid responsibilities as the single state agency include:

- Primary point of contact with CMS;
- Administration of the state plan;
- Determination of Medicaid eligibility;
- Policy development and rule-making;
- System planning and evaluation;
- Determination of fees, charges, and rates;
- Management of federal funds;
- Prevention and detection of fraud and abuse; and
- Administration of the Medical Care Advisory Committee (MCAC) mandated by federal Medicaid law. The MCAC reviews and makes recommendations to the State Medicaid Director on proposed Medicaid rules.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State of Texas

DESCRIPTION OF THE ORGANIZATION AND FUNCTION OF THE MEDICAL ASSISTANCE UNIT AND AN ORGANIZATIONAL CHART OF THE UNIT

The Health and Human Services Commission (HHSC) established the Medicaid and Children's Health Insurance Program Division (MCD), which is headed by the State Medicaid Director. MCD plans and directs the scope, content, and priorities of the Medicaid program according to federal and state direction and within available financial resources.

MCD directly administers and is responsible for the daily operations of the Medicaid program. This includes maintenance of the Medicaid state plan and waivers, support of the Medical Care Advisory Committee, and serving as the liaison between the State and the Centers for Medicare & Medicaid Services. MCD utilizes contractors and the HHSC operating departments for certain aspects of the Medicaid program that require specialized in-depth knowledge and skills. Through contracts and executive directives, the division ensures the contractors and operating departments are implementing the Medicaid program according to the MCD's policies, federal and state statutes and rules, and operational directions.

SUPERSEDES: TN: 92-38

STATE: TEXAS
DATE REC'D: 3-30-12
DATE APPVD: 4-26-12
DATE EFF: 3-1-12

SUPERSEDES: TN: 92-38

TN: 12-01 Approval Date: 4-26-12 Effective Date: 3-1-12
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM
State of Texas

PROFESSIONAL MEDICAL AND SUPPORTING STAFF

The following professional medical personnel and supporting staff of the Health and Human Services Commission (HHSC) Medicaid and CHIP Division (MCD), Office of the Medical Director (OMD), and regional eligibility offices are used in the administration and daily operations of the Medicaid program.

State Medicaid Office

Deputy Executive Commissioner 01
Administrative Assistants 25
Contract Specialists 02
Directors 17
Financial Analysts 12
Grant Coordinator 01
Information Specialists 02
Managers 14
Nurses 09
Pharmacists 14
Physicians 03
Program Specialists 185
Project Manager 01
Public Health Technicians 20
Research Specialists 01
Staff Services Officer 01

Regional Medicaid Staff

Administrative Assistants 78
Clerks 1419
Eligibility Workers 4498
Hospital Based Workers 362
Program Specialists 63

SUPERSEDES: TN 92-38

STATE: Texas
DATE REC'D 3-30-12
DATE APPV'D 4-26-12
DATE EFF 3-1-12
HCPA 179 12-01

TN: 12-01
Approval Date: 4-26-12
Effective Date: 3-1-12

Supersedes TN: 92-38
State Plan Administration
Designation and Authority

42 CFR 431.10

Designation and Authority

State Name: Texas

As a condition for receipt of Federal funds under title XIX of the Social Security Act, the single state agency named below submits the following state plan for the medical assistance program, and hereby agrees to administer the program in accordance with the provisions of this state plan, the requirements of titles XI and XIX of the Act, and all applicable Federal regulations and other official issuances of the Department.

Name of single state agency: Texas Health and Human Services Commission

Type of Agency:

☐ Title IV-A Agency
☐ Health
☐ Human Resources
☐ Other

Type of Agency: Title IV-A and Health Agency

The above named agency is the single state agency designated to administer or supervise the administration of the Medicaid program under title XIX of the Social Security Act. (All references in this plan to "the Medicaid agency" mean the agency named as the single state agency.)

The state statutory citation for the legal authority under which the single state agency administers the state plan is:

Section 531.021 of the Texas Government Code

The single state agency supervises the administration of the state plan by local political subdivisions.

☐ Yes ☐ No

The certification signed by the state Attorney General identifying the single state agency and citing the legal authority under which it administers or supervises administration of the program has been provided.

An attachment is submitted.

The state plan may be administered solely by the single state agency, or some portions may be administered by other agencies.

The single state agency administers the entire state plan under title XIX (i.e., no other agency or organization administers any portion of it).

☐ Yes ☐ No
The entity or entities that have responsibility for determinations of eligibility for families, adults, and for individuals under 21 are:

- The Medicaid agency
- Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
- An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act

The entity that has responsibility for determinations of eligibility for the aged, blind, and disabled are:

- The Medicaid agency
- Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
- An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- The Federal agency administering the SSI program

Indicate which agency determines eligibility for any groups whose eligibility is not determined by the Federal agency:

- Medicaid agency
- Title IV-A agency
- An Exchange

The entity or entities that have responsibility for conducting fair hearings with respect to denials of eligibility based on the applicable modified adjusted gross income standard are:

- The Medicaid agency
- An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- An Exchange appeals entity, including an entity established under section 1411(f) of the Affordable Care Act

The agency has established a review process whereby the agency reviews appeals decisions made by the Exchange or Exchange appeals entity or other state agency, but only with respect to conclusions of law, including interpretations of state or federal policies.

○ Yes  ○ No

### State Plan Administration

#### Organization and Administration

State: Texas
Date Received: 12-31-13
Date Approved: 9-25-14
Date Effective: 1-18-14
Transmittal Number: TX 13-0057 MM4

Supersedes TN 13-0047 MM4

#### Organization and Administration

Provide a description of the organization and functions of the Medicaid agency.

The Health and Human Services Commission (HHSC) is the state agency with primary responsibility for overseeing the delivery of state health and human services. HHSC is governed by the Executive Commissioner of Health and Human Services, who is appointed by the Governor of the State of Texas.

Section 531.021 of the Texas Government Code designates HHSC as the single state agency for administering federal medical assistance funds. Under this authority, the federal medical assistance funds are granted to HHSC by the Centers for Medicare &
Medicaid Administration

Medicaid Services (CMS). As the single state agency, HHSC has final authority over the Medicaid programs that are administered by HHSC or carried out by the other operating departments subject to the approval of HHSC. Within HHSC, the State Medicaid Director has primary responsibility for administering the Medicaid program and overseeing the administration of the program.

The Medicaid & CHIP Division (MCD) directly administers and is responsible for the daily operations of the Medicaid program. MCD utilizes contractors and the HHSC operating departments for certain aspects of the Medicaid program that require specialized in-depth knowledge and skills. Through contracts and executive directives, the division ensures the contractors and operating departments are implementing the Medicaid program according to the MCD’s policies, federal and state statutes and rules, and operational directions.

As the single state agency, HHSC’s Medicaid responsibilities include:

- Serving as the primary point of contact with the federal government,
- Establishing policy direction for the Medicaid program,
- Administering the Medicaid state plan,
- Working with the various agencies in the HHS Enterprise to carry out certain operations of the Medicaid programs,
- Providing oversight and monitoring of contractors,
- Operating the state’s acute care, vendor drug, 1115 Transformation Waiver, and managed care programs (except NorthSTAR, a managed care program overseen by the Department of State Health Services (DSHS) that provides integrated behavioral health care to eligible residents in Dallas and contiguous counties),
- Determining Medicaid eligibility for children, pregnant women, former foster care youth, parents and caretakers, individuals over age 65, and individuals who have disabilities,
- Conducting fair hearings and appeals,
- Approving Medicaid policies, rules, reimbursement rates, and oversight of operations of the state departments’ operating Medicaid programs,
- Organizing and coordinating initiatives to maximize federal funding, and
- Administering the Medical Care Advisory Committee (MCAC) mandated by federal Medicaid law. The MCAC reviews and makes recommendations to the State Medicaid/CHIP Director on proposed Medicaid rules.

The Texas health and human services system comprises five agencies. All five of the agencies (the HHS Enterprise) operate under the oversight of the Executive Commissioner of the Health and Human Services Commission (HHSC), and HHSC provides administrative support services for all Enterprise agencies. This consolidated organizational structure enhances delivery of services, improves efficiency, and generates cost savings for Texas. The operating agencies within the Texas HHS Enterprise are:

**Department of Aging and Disability Services (DADS) –** The Medicaid operating department responsible for administering the Medicaid nursing facility program; long-term care licensing, survey, and certification; and a wide range of home and community-based, long-term services and supports, including the state’s Medicaid 1915(c) waiver programs. DADS also administers the intermediate care facility/individuals with intellectual disability program and owns/operates Texas’ state schools.

**Department of Assistive and Rehabilitative Services (DARS) –** The Medicaid operating department responsible for administering targeted case management services for the Blind Children’s Program and Early Childhood Intervention.

**Department of Family and Protective Services (DFPS) –** DFPS is charged with protecting children and adults who are older or have disabilities living at home or in state facilities, and licensing group day-care homes, day-care centers, and registered family homes. The agency is also charged with managing community-based programs that prevent delinquency, abuse, neglect and exploitation of Texas children, adults age 65 and older and those adults with disabilities.

**Department of State Health Services (DSHS) –** The Medicaid operating department responsible for administration of the Early and Periodic Screening, Diagnosis, and Treatment Program/Texas Health Steps; case management for pregnant women and children services; newborn screening, newborn hearing screening, and Program for Amplification for Children; family planning services; targeted case management and rehabilitative services for people with mental illness; and the NorthSTAR program. DSHS also owns/operates Texas’ state hospitals.

**Health and Human Services Commission (HHSC) –** Various divisions within HHSC handle generally discrete Medicaid functions. The Medicaid CHIP division establishes and implements Medicaid policy. The Office of Social Services establishes and
Medicaid Administration implements eligibility policies and procedures and determines Medicaid eligibility for children, pregnant women, former foster care youth, parents and caretakers, individuals over age 65, and individuals who have disabilities, except those determined eligible by the Social Security Administration under the 1634 agreement. The Office of Inspector General monitors provider and client compliance with Medicaid statutes and rules. The legal division houses the fair hearings department.

Upload an organizational chart of the Medicaid agency.

An attachment is submitted.

Provide a description of the structure of the state's executive branch which includes how the Medicaid agency fits in with other health, human service and public assistance agencies.

Texas has a plural executive branch system. The executive branch consists of the Governor, Lieutenant Governor, Comptroller of Public Accounts, Land Commissioner, Attorney General, Agriculture Commissioner, the three-member Texas Railroad Commission, the State Board of Education, and the Secretary of State. Except for the Secretary of State (a gubernatorial appointee), all executive officers are elected independently. There are also many state agencies and numerous boards and commissions, including the Texas Health and Human Services Commission (HHSC). As described above, the Executive Commissioner of HHSC, who is appointed by the Governor with the consent of the Senate, is responsible for managing and directing the operations of all of the health and human services agencies (Department of Aging and Disability Services; Department of Assistive and Rehabilitative Services; Department of Family and Protective Services; Department of State Health Services; and Health and Human Services Commission) and appoints, supervises, and directs the activities of the directors of all agencies. (The Executive Commissioner is the head of HHSC.) HHSC provides administrative support services to the four other agencies and is the only agency with authority to administer the Medicaid program. No other agency has a role in the administration of the Medicaid program.

Entities that determine eligibility other than the Medicaid Agency (if entities are described under Designation and Authority)

Type of entity that determines eligibility:

- Single state agency under Title IV-A (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
- An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- The Federal agency administering the SSI program

Provide a description of the staff designated by the entity and the functions they perform in carrying out their responsibility.

Pursuant to a 1634 agreement, the Social Security Administration determines Medicaid eligibility for Supplemental Security Income recipients.

Entities that conduct fair hearings other than the Medicaid Agency (if are described under Designation and Authority)

Type of entity that conducts fair hearings:

- An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
- An Exchange appeals entity, including an entity established under section 1411(f) of the Affordable Care Act

Provide a description of the staff designated by the entity and the functions they perform in carrying out their responsibility.
Supervision of state plan administration by local political subdivisions (if described under Designation and Authority)

Is the supervision of the administration done through a state-wide agency which uses local political subdivisions?

☐ Yes  ☒ No

The types of the local subdivisions that administer the state plan under the supervision of the Medicaid agency are:

☐ Counties

☐ Parishes

☐ Other

Are all of the local subdivisions indicated above used to administer the state plan?

☐ Yes  ☐ No

**State Plan Administration Assurances**

<table>
<thead>
<tr>
<th>42 CFR 431.10</th>
<th>42 CFR 431.12</th>
<th>42 CFR 431.50</th>
</tr>
</thead>
</table>

**Assurances**

☑ The state plan is in operation on a statewide basis, in accordance with all the requirements of 42 CFR 431.50.

☑ All requirements of 42 CFR 431.10 are met.

☑ There is a Medical Care Advisory Committee to the agency director on health and medical services established in accordance with meeting all the requirements of 42 CFR 431.12.

☑ The Medicaid agency does not delegate, to other than its own officials, the authority to supervise the plan or to develop or issue policies, rules, and regulations on program matters.

Assurance for states that have delegated authority to determine eligibility:

☐ There is a written agreement between the Medicaid agency and the Exchange or any other state or local agency that has been delegated authority to determine eligibility for Medicaid eligibility in compliance with 42 CFR 431.10(d).

Assurances for states that have delegated authority to conduct fair hearings:

☐ There is a written agreement between the Medicaid agency and the Exchange or Exchange appeals entity that has been delegated authority to conduct Medicaid fair hearings in compliance with 42 CFR 431.10(d).

☐ When authority is delegated to the Exchange or an Exchange appeals entity, individuals who have requested a fair hearing are given the option to have their fair hearing conducted instead by the Medicaid agency.

Assurance for states that have delegated authority to determine eligibility and/or to conduct fair hearings:

**State:** Texas  
**Date Received:** 12-31-13  
**Date Approved:** 9-25-14  
**Date Effective:** 1-18-14  
**Transmittal Number:** TX 13-0057 MM4
The Medicaid agency does not delegate authority to make eligibility determinations or to conduct fair hearings to entities other than government agencies which maintain personnel standards on a merit basis.

PRA Disclosure Statement
According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Notwithstanding the election that only the Medicaid agency is responsible for conducting fair hearings with respect to denials of eligibility based on the applicable modified adjusted gross income standard on A1 on page 2, the single state agency delegates to the Office of Marketplace Eligibility Appeals the limited authority to conduct Medicaid fair hearings with respect to eligibility determinations made by the Federally Facilitated Marketplace prior to 1/18/14.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of Texas

Citation 1.6 Tribal Consultation

SSA 1902(a)(73) Section 1902(a)(73) of the Social Security Act (the Act) requires a state in which one or more Indian health programs or urban Indian organizations furnish health care services to establish a process for the state Medicaid agency to seek advice on a regular, ongoing basis from designees of Indian health programs, whether operated by the Indian Health Service (IHS), tribes or tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA), or Urban Indian Organizations under the Indian Health Care Improvement Act (IHCIA). Section 2107(e)(I) of the Act was also amended to apply these requirements to the Children's Health Insurance Program (CHIP). Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and urban Indian organizations.

(A) Designees of the federally-recognized tribes in Texas, Indian health programs in Texas, urban Indian organizations in Texas, and the state Medicaid agency have formally agreed to the following process for seeking advice on a regular, ongoing basis on matters related to Medicaid programs and for consultation on state plan amendments (SPAs) prior to submission to CMS:

- The state Medicaid agency will send a request for feedback to designees of Indian health programs and urban Indian organizations in Texas on Medicaid SPAs that have a direct impact to Indian health programs on client eligibility, acute care services, and acute care providers. This will include any direct impact to Indian health programs on pharmacy services, Federally Qualified Health Centers, and provider requirements.

- Acute care provider reimbursement, including clinic or office reimbursement, rate reduction SPAs, and corresponding rate hearing information will be sent to the Indian health programs and urban Indian organizations in Texas only if a reduction of one million dollars or more, all funds, is proposed for a program or state plan rate category.
- Requests for feedback on Medicaid changes will be sent to the designees of the Indian health programs and the urban Indian organization in Texas at least 30 calendar days prior to the submission of the SPA to the CMS for approval. These timeframes may change if the state is required to submit these documents to CMS in less time. The minimum timeframe would be no less than one calendar week, reserved for certain instances when direction to implement a state plan change requires an expedited process. Examples of these instances include direction from Texas state leadership; direction from CMS; a court order; a settlement agreement; federal rules, regulations, or laws; or state or federal legislation.

- Medicaid staff will hold regular conference calls with designees from the Ysletta Del Sur Pueblo, the Alabama-Coushatta Tribe, the Kickapoo Traditional Tribe of Texas, and the Urban Inter-Tribal Center of Texas. These calls will foster continued communication, and provide an opportunity to ask questions, ask for assistance, and express concerns.

(B) The consultation process that occurred specifically for the development and submission of this SPA is as follows:

- On April 28, 2010, state Medicaid agency staff met face-to-face with the health services designees from the federally-recognized tribes in Texas at the Urban Inter-Tribal Center of Texas (UITCT). Designees from the UITCT, the Alabama-Coushatta Tribe, and the Ysletta Del Sur Pueblo attended the meeting. The state Medicaid agency staff facilitated discussion regarding a potential consultation process on changes made to the Texas Medicaid state plan. On May 21, 2010, state Medicaid agency staff held a conference call with designees from the Kickapoo Traditional Tribe of Texas to ensure that all Indian health programs were consulted and given the opportunity to provide feedback on the potential consultation process discussed at the face-to-face meeting.

- A letter of agreement outlining the proposed consultation process was mailed to each Indian health program and urban Indian organization designee in Texas for review and no changes were suggested. All parties signed a tribal consultation agreement form to verify the consultation process outlined above.
The Medicaid agency elects to enter into a risk contract with a Health Maintenance Organization (HMO) that is not federally qualified, but meets the requirements of 42 C.F.R. §434.20(c) and the following:

1. Is organized primarily for the purpose of providing health care services;

2. Makes the services it provides to its Medicaid enrollees as accessible to them (in terms of timeliness, amount, duration, and scope) as those services are to nonenrolled Medicaid recipients within the area served by the HMO;

3. Makes provision, satisfactory to the Medicaid agency, against the risk of insolvency, and assures that Medicaid enrollees will not be liable for the HMO’s debts if it does become insolvent; and

4. Is operating under a current certificate of authority issued by the Texas Department of Insurance in accordance with Texas Insurance Code, Article 20A.05, relating to Health Maintenance Organizations; or

5. Is operating under a current certificate of authority issued by the Texas Department of Insurance in accordance with Texas Insurance Code, Article 21.52F, relating to nonprofit health corporations.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATION

<table>
<thead>
<tr>
<th>Agency*</th>
<th>Citation(s)</th>
<th>Groups Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Texas Department of Human Services (TDHS)</td>
<td>42 CFR 435.110</td>
<td>A. Mandatory Coverage - Categorically Needy and Other Required Special Groups</td>
</tr>
<tr>
<td>TDHS</td>
<td>42 CFR 435.115</td>
<td>2. Deemed Recipients of AFDC</td>
</tr>
</tbody>
</table>

The following groups are covered under this plan.

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups

1. Recipients of AFDC

The approved State AFDC plan includes:

- Families with an unemployed parent for the mandatory 6-month period and an optional extension of ___ months.
- Pregnant women with no other eligible children.
- AFDC children age 18 who are full-time students in a secondary school or in the equivalent level of vocational or technical training.

The standards for AFDC payments are listed in Supplement 1 of ATTACHMENT 2.6-A.

2. Deemed Recipients of AFDC

a. Individuals denied a title IV-A cash payment solely because the amount would be less than $10.

*Agency that determines eligibility for coverage.

TN No. 91-34 Approval Date JAN 14 1992 Effective Date OCT 01 1991
Supersedes TN No. 90-48

HCFA ID: 7983E

Deleted from State's Letter Dated 10-4-2016 under Transmittal Number TX 16-0024, with Effective Date of 10-1-2016. This action was approved on 12-21-2016.
**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**  
**MEDICAL ASSISTANCE PROGRAM**

State: __________ Texas________

<table>
<thead>
<tr>
<th>Agency*</th>
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<th>Groups Covered</th>
</tr>
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<tbody>
<tr>
<td>HHSC</td>
<td>1902(a)(10)(A)(i)(I) of the Act</td>
<td>A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)</td>
</tr>
<tr>
<td>HHSC</td>
<td>402(a)(22) of the Act</td>
<td>2. Deemed Recipients of AFDC</td>
</tr>
<tr>
<td>HHSC</td>
<td>406(h) and 1902(a)(10)(A)(i)(I) of the Act</td>
<td>b. Effective October 1, 1990, participants in a work supplementation program under title IV-A and any child or relative of such individual (or other individual living in the same household as such individuals) who would be eligible for AFDC if there were no work supplementation program, in accordance with section 482(e)(6) of the Act.</td>
</tr>
<tr>
<td>HHSC</td>
<td>1902(a)(10)(A)(i)(I) of the Act</td>
<td>c. Individuals whose AFDC payments are reduced to zero by reason of recovery of overpayment of AFDC funds.</td>
</tr>
<tr>
<td>HHSC</td>
<td>1902(a)(10)(A)(i)(I) of the Act</td>
<td>d. An assistance unit deemed to be receiving AFDC for a period of four calendar months because the family becomes ineligible for AFDC as a result of collection or increased collection of support and meets the requirements of section 406(h) of the Act.</td>
</tr>
<tr>
<td>HHSC</td>
<td>1902(a)(10)(A)(i)(I) of the Act</td>
<td>e. Individuals deemed to be receiving AFDC who meet the requirements of section 42 USC 673(b) for whom an adoption assistance agreement is in effect, foster care maintenance payments are being made, or kinship guardianship assistance payments are being made under title IV-E of the Act.</td>
</tr>
</tbody>
</table>

* Agency that determines eligibility for coverage.

SUPERSEDES: TN- 91-34

TN No. 10-03 Approval Date 7-9-10 Effective Date 10-1-10

Supersedes TN No. 91-34
### A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

<table>
<thead>
<tr>
<th>Agency</th>
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<th>Groups Covered</th>
</tr>
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<tbody>
<tr>
<td>TDHS</td>
<td>407(b), 1902 (a)(10)(A)(1) and 1905(m)(1) of the Act</td>
<td>3. Qualified Family Members</td>
</tr>
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<td>Effective October 1, 1990, qualified family members who would be eligible to receive AFDC under section 407 of the Act because the principal wage earner is unemployed. Qualified family members are not included because cash assistance payments may be made to families with unemployed parents for 12 months per calendar year.</td>
</tr>
<tr>
<td>TDHS</td>
<td>1902(a)(52) and 1925 of the Act</td>
<td>4. Families terminated from AFDC solely because of earnings, hours of employment, or loss of earned income disregards entitled up to twelve months of extended benefits in accordance with section 1925 of the Act. (This provision expires on September 30, 1998.)</td>
</tr>
</tbody>
</table>

*Agency that determines eligibility for coverage.*

<table>
<thead>
<tr>
<th>TN No.</th>
<th>Approval Date</th>
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<th>HCFA ID:</th>
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<tr>
<td>91-34</td>
<td>JAN 1 1991</td>
<td>OCT 1 1991</td>
<td>7983E</td>
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<tr>
<td>Supersedes</td>
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<tr>
<td>90-48, Attachment 2.2-A, pg 4a, item 8b</td>
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<td>90-25, Attachment 2.2-A, pg 2, item 3</td>
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<tr>
<td>90-25, Attachment 2.2-A, pg 2, item 6</td>
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</tr>
</tbody>
</table>
Agency* Citation(s) Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

TDHS 42 CFR 435.113

5. Individuals who are ineligible for AFDC solely because of eligibility requirements that are specifically prohibited under Medicaid. Included are:

a. Families denied AFDC solely because of income and resources deemed to be available from--

   (1) Stepparents who are not legally liable for support of stepchildren under a State law of general applicability;

   (2) Grandparents;

   (3) Legal guardians; and

   (4) Individual alien sponsors (who are not spouses of the individual or the individual's parent);

b. Families denied AFDC solely because of the involuntary inclusion of siblings who have income and resources of their own in the filing unit.

c. Families denied AFDC because the family transferred a resource without receiving adequate compensation.

*Agency that determines eligibility for coverage.

TN No. 91-34 Approval Date JAN 1 1992 Effective Date OCT 1 1 1991
Supersedes TN No. 90-25 Attachment 2.2-A pg 2a JAN 4 HCFA ID: 7983E

Deleted from State's Letter Dated 10-4-2016 under Transmittal Number TX 16-0024, with Effective Date of 10-1-2016. This action was approved on 12-21-2016.
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<tr>
<td>TDHS</td>
<td>42 CFR 435.114</td>
<td>A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)</td>
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<td>6. Individuals who would be eligible for AFDC except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972.</td>
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<td>- Includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in this State's August 1972 plan).</td>
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<td></td>
<td>- Includes persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care facility (this group was included in this State's August 1972 plan).</td>
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<td></td>
<td>- Not applicable with respect to intermediate care facilities; State did or does not cover this service.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. A pregnant woman whose pregnancy has been medically verified who--</td>
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<td>(1) Would be eligible for an AFDC cash payment if the child had been born and was living with her;</td>
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*Agency that determines eligibility for coverage.*

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Deleted from State's Letter Dated 10-4-2016 under Transmittal Number TX 16-0024, with Effective Date of 10-1-2016. This action was approved on 12-21-2016.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Texas

COVERAGE AND CONDITIONS OF ELIGIBILITY

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<td>TDHS</td>
<td>1902(a)(10)(A) (i)(III) and 1905(n) of the Act</td>
<td>A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)</td>
</tr>
</tbody>
</table>

7. a. (2) Is a member of a family that would be eligible for aid to families with dependent children of unemployed parents; 

(3) Would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan.

b. Children born after September 30, 1983 who are under age 19 and who would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan.

Children born after (specify optional earlier date) who are under age 19 and who would be eligible for an AFDC cash payment on the basis of the income and resource requirements of the State's approved AFDC plan.

*Agency that determines eligibility for coverage.

STATE: Texas
DATE REC'D: APR 09 1992
DATE APPVD: APR 29 1992
DATE EFF: APR 01 1992

Deleted from State's Letter Dated 10-4-2016 under Transmittal Number TX 16-0024, with Effective Date of 10-1-2016. This action was approved on 12-21-2016.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE:

COVERAGE AND CONDITIONS OF ELIGIBILITY

Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

8. Pregnant women and infants under 1 year of age with family incomes up to 133 percent of the Federal poverty level who are described in section 1902(a)(10)(A')(IV) and 1902(1)(A) and (B) of the Act. The income level for this group is specified in Supplement 1 to ATTACHMENT 2.6-A.

The State uses a percentage greater than 133 but not more than 185 percent of the Federal poverty level, as established in its State plan, State legislation, or State appropriations as of December 19, 1989.

9. Children:

a. who have attained 1 year of age but have not attained 6 years of age, with family incomes at or below 133 percent of the Federal poverty levels.

b. born after September 30, 1983, who have attained 6 years of age but have not attained 19 years of age, with family incomes at or below 100 percent of the Federal poverty levels.

Children born after 6-30-79 (specify optional earlier date)

who have attained 6 years of age but have not attained 19 years of age, with family incomes at or below 100 percent of the Federal poverty levels.

Income levels for these groups are specified in Supplement 1 to ATTACHMENT 2.6-A.

TN No. 92-10

Approval Date 4/15/98 Effective Date 7/1/98

STATE: Texas

DATE REC'D 4/1/98

DATE APV'D 6/15/98

DATE ON 7/1/98

HCFA 179 98-09

Deleted from State's Letter Dated 10-4-2016 under Transmittal Number TX 16-0024, with Effective Date of 10-1-2016. This action was approved on 12-21-2016.
### STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

**State:** Texas

**COVERAGE AND CONDITIONS OF ELIGIBILITY**

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<td>TDHS</td>
<td>1902(e)(5) of the Act</td>
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<tr>
<td>TDHS</td>
<td>1902(e)(6) of the Act</td>
<td>11. a. A woman who, while pregnant, was eligible for, applied for, and receives Medicaid under the approved State plan on the day her pregnancy ends. The woman continues to be eligible, as though she were pregnant, for all pregnancy-related and postpartum medical assistance under the plan for a 60-day period (beginning on the last day of her pregnancy) and for any remaining days in the month in which the 60th day falls.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. A pregnant woman who would otherwise lose eligibility because of an increase in income (of the family in which she is a member) during the pregnancy or the postpartum period which extends through the end of the month in which the 60-day period (beginning on the last day of pregnancy) ends.</td>
</tr>
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*Agency that determines eligibility for coverage.

**TN No.**

**Supersedes** Approval Date **Effective Date**
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Texas

Citations | Groups Covered
---|---
1902(e)(4) of the Act 42 CFR 435.117 | A. Mandatory Coverage – Categorically Needy and Other Required Special Groups (Continued)

12. A child born in the United States to a woman who was eligible for and receiving Medicaid (including coverage of an alien for labor and delivery as emergency medical services) for the date of the child’s birth, including retroactively. The child is deemed eligible for one year from birth.

42 CFR 435.120 | 13. Aged, Blind, and Disabled Individuals Receiving Cash Assistance.

- **a.** Individuals receiving SSI.

This includes beneficiaries’ eligible spouses and persons receiving SSI benefits pending a final determination of blindness or disability or pending disposal of excess resources under an agreement with the Social Security Administration; and beginning January 1, 1981 persons receiving SSI under section 1619(a) of the Act or considered to be receiving SSI under section 1619(b) of the Act.

- **X** Aged
- **X** Blind
- **X** Disabled

SUPERSEDES: TN. 92-10

TN No. 09-35 Approval Date 12-14-09 Effective Date 12-1-09

Supersedes TN No. 92-10
A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

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<td>435.121</td>
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<tr>
<td></td>
<td>1619(b)(3)</td>
<td></td>
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13. **b.** Individuals who meet more restrictive requirements for Medicaid than the SSI requirements. (This includes persons who qualify for benefits under section 1619(a) of the Act or who meet the requirements for SSI status under section 1619(b)(1) of the Act and who met the State's more restrictive requirements for Medicaid in the month before the month they qualified for SSI under section 1619(a) or met the requirements under section 1619(b)(1) of the Act. Medicaid eligibility for these individuals continues as long as they continue to meet the 1619(a) eligibility standard or the requirements of section 1619(b) of the Act.)

- Aged
- Blind
- Disabled

The more restrictive categorical eligibility criteria are described below:

*(Financial criteria are described in ATTACHMENT 2.6-A).*

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*Agency that determines eligibility for coverage.*

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<td>OCT 01 1991</td>
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<th>TN No.</th>
<th>Attachment 2.2-A, pg 5, Item 96</th>
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HCFA ID: 7983E
A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

14. Qualified severely impaired blind and disabled individuals under age 65, who--
   a. For the month preceding the first month of eligibility under the requirements of section 1905(q)(2) of the Act, received SSI, a State supplemental payment under section 1616 of the Act or under section 212 of P.L. 93-66 or benefits under section 1619(a) of the Act and were eligible for Medicaid; or
   b. For the month of June 1987, were considered to be receiving SSI under section 1619(b) of the Act and were eligible for Medicaid. These individuals must--
      (1) Continue to meet the criteria for blindness or have the disabling physical or mental impairment under which the individual was found to be disabled;
      (2) Except for earnings, continue to meet all nondisability-related requirements for eligibility for SSI benefits;
      (3) Have unearned income in amounts that would not cause them to be ineligible for a payment under section 1611(b) of the Act;

*Agency that determines eligibility for coverage.

TN No. 91-34 Approval Date JAN 14 1992 Effective Date OCT 01 1991
Supersedes
TN No. 87-10 Attachment 2.2-A, pg 6, Item 10.9, HCFA ID: 7983E

STATE Texas
DATE REC'D DEC 1 1991
DATE APPV'D JAN 14 1992
DATE EFF OCT 01 1991
HCFA 179 91-34
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<td>A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)</td>
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<td>(4) Be seriously inhibited by the lack of Medicaid coverage in their ability to continue to work or obtain employment; and</td>
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<td>(5) Have earnings that are not sufficient to provide for himself or herself a reasonable equivalent of the Medicaid, SSI (including any Federally administered SSP), or public funded attendant care services that would be available if he or she did have such earnings.</td>
</tr>
<tr>
<td></td>
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<td>XXX Not applicable with respect to individuals receiving only SSP because the State either does not make SSP payments or does not provide Medicaid to SSP-only recipients.</td>
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*Agency that determines eligibility for coverage.*

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HCFA ID: 7983E
A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

The State applies more restrictive eligibility requirements for Medicaid than under SSI and under 42 CFR 435.121. Individuals who qualify for benefits under section 1619(a) of the Act or individuals described above who meet the eligibility requirements for SSI benefits under section 1619(b)(1) of the Act and who met the State's more restrictive requirements in the month before the month they qualified for SSI under section 1619(a) or met the requirements of section 1619(b)(1) of the Act are covered. Eligibility for these individuals continues as long as they continue to qualify for benefits under section 1619(a) of the Act or meet the SSI requirements under section 1619(b)(1) of the Act.

*Agency that determines eligibility for coverage.

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<tr>
<td>A.</td>
<td>1619(b)(3) of the Act</td>
<td>The State applies more restrictive eligibility requirements for Medicaid than under SSI and under 42 CFR 435.121. Individuals who qualify for benefits under section 1619(a) of the Act or individuals described above who meet the eligibility requirements for SSI benefits under section 1619(b)(1) of the Act and who met the State's more restrictive requirements in the month before the month they qualified for SSI under section 1619(a) or met the requirements of section 1619(b)(1) of the Act are covered. Eligibility for these individuals continues as long as they continue to qualify for benefits under section 1619(a) of the Act or meet the SSI requirements under section 1619(b)(1) of the Act.</td>
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TN No. 91-34
Supersedes TN No. 87-10 Attachment 2.2-A, pg. 6.a.
2nd FL following 10.e

HCFA ID: 7983E

STATE: TEXAS
DATE REC'D: DEC 11 1991
DATE APPVD: JAN 4 1992
DATE EFF: OCT 1 1991
HCFA ID: 91-34
A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

15. Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, blind or disabled individuals who--

a. Are at least 18 years of age;

b. Lose SSI eligibility because they become entitled to OASDI child's benefits under section 202(d) of the Act or an increase in those benefits based on their disability. Medicaid eligibility for these individuals continues for as long as they would be eligible for SSI, absent their OASDI eligibility.

c. The State applies more restrictive eligibility requirements than those under SSI, and part or all of the amount of the OASDI benefit that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.

d. The State applies more restrictive requirements than those under SSI, and none of the OASDI benefit is deducted in determining the amount of countable income for categorically needy eligibility.

16. Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, individuals who are ineligible for SSI or optional State supplements (if the agency provides Medicaid under §435.230), because of requirements that do not apply under title XIX of the Act.

17. Individuals receiving mandatory State supplements.

*Agency that determines eligibility for coverage.
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<tr>
<td>TDHS</td>
<td>42 CFR 435.131</td>
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18. Individuals who in December 1973 were eligible for Medicaid as an essential spouse and who have continued, as spouse, to live with and be essential to the well-being of a recipient of cash assistance. The recipient with whom the essential spouse is living continues to meet the December 1973 eligibility requirements of the State's approved plan for OAA, AB, APTD, or AABD and the spouse continues to meet the December 1973 requirements for having his or her needs included in computing the cash payment.

In December 1973, Medicaid coverage of the essential spouse was limited to the following group(s):

- Aged
- Blind
- Disabled

Not applicable. In December 1973, the essential spouse was not eligible for Medicaid.

*Agency that determines eligibility for coverage.

Supersedes

TN No. 91-34 Attachment 2.2-A, pg 6b, item 14 HCFA ID: 7983E

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<td>HCFA ID</td>
<td>91-34</td>
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</table>
A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

19. Institutionalized individuals who were eligible for Medicaid in December 1973 as inpatients of title XIX medical institutions or residents of title XIX intermediate care facilities, if, for each consecutive month after December 1973, they--
   a. Continue to meet the December 1973 Medicaid State plan eligibility requirements; and
   b. Remain institutionalized; and
   c. Continue to need institutional care.

20. Blind and disabled individuals who--
   a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria; and
   b. Were eligible for Medicaid in December 1973 as blind or disabled; and
   c. For each consecutive month after December 1973 continue to meet December 1973 eligibility criteria.

*Agency that determines eligibility for coverage.

TN No. 91-34  Approval Date   JAN 14 1992  Effective Date   OCT 01 1991
Supersedes
TN No. 87-10, Attachment 2.2-A, pg 6c, item 15 & 16  HCFA ID: 7983E
### A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

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<td>TDHS</td>
<td>42 CFR 435.134</td>
<td>21. Individuals who would be SSI/SSP eligible except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972.</td>
</tr>
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</table>

- Includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in this State's August 1972 plan).

- Includes persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care facility (this group was included in this State's August 1972 plan).

- Not applicable with respect to intermediate care facilities; the State did or does not cover this service.

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*Agency that determines eligibility for coverage.*

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Superseded by TN No. 87-10

HCFA ID: 7983E
A. Mandatory Coverage - Categorically Needy and Other
   Required Special Groups (Continued)

TDHS 42 CFR 435.135  22. Individuals who --
   a. Are receiving OASDI and were receiving SSI/SSP
      but became ineligible for SSI/SSP after April
      1977; and
   b. Would still be eligible for SSI or SSP if
      cost-of-living increases in OASDI paid under
      section 215(i) of the Act received after the
      last month for which the individual was
      eligible for and received SSI/SSP and OASDI,
      concurrently, were deducted from income.

   // Not applicable with respect to individuals
   receiving only SSP because the State either
   does not make such payments or does not
   provide Medicaid to SSP-only recipients.

   // Not applicable because the State applies
   more restrictive eligibility requirements
   than those under SSI.

   // The State applies more restrictive
   eligibility requirements than those under
   SSI and the amount of increase that caused
   SSI/SSP ineligibility and subsequent
   increases are deducted when determining the
   amount of countable income for categorically
   needy eligibility.

*Agency that determines eligibility for coverage.
A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

TDHS 1634 of the Act

23. Disabled widows and widowers who would be eligible for SSI or SSP except for the increase in their OASDI benefits as a result of the elimination of the reduction factor required by section 134 of Pub. L. 98-21 and who are deemed, for purposes of title XIX, to be SSI beneficiaries or SSP beneficiaries for individuals who would be eligible for SSP only, under section 1634(b) of the Act.

Not applicable with respect to individuals receiving only SSP because the State either does not make these payments or does not provide Medicaid to SSP-only recipients.

The State applies more restrictive eligibility standards than those under SSI and considers these individuals to have income equaling the SSI Federal benefit rate, or the SSP benefit rate for individuals who would be eligible for SSP only, when determining countable income for Medicaid categorically needy eligibility.

*Agency that determines eligibility for coverage.

TN No. 91-34 Approval Date JAN 14 1992 Effective Date OCT 01 1991
Supersedes TN No. 88-15, Attachment 2.2-A, pg 8, item 19
91-12, Attachment 2.2-A, pg 9, top half

HCFA ID: 7983E
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<td>TDHS</td>
<td>1634(d) of the Act</td>
<td>A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)</td>
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<tr>
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<td>24. Disabled widows, disabled widowers, and disabled unmarried divorced spouses who had been married to the insured individual for a period of at least ten years before the divorce became effective, who have attained the age of 50, who are receiving title II payments, and who because of the receipt of title II income lost eligibility for SSI or SSP which they received in the month prior to the month in which they began to receive title II payments, who would be eligible for SSI or SSP if the amount of the title II benefit were not counted as income, and who are not entitled to Medicare Part A.</td>
</tr>
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</table>

The State applies more restrictive eligibility requirements for its blind or disabled than those of the SSI program.

In determining eligibility as categorically needy, the State disregards the amount of the title II benefits identified in §1634(d)(1)(A) in determining the income of the individual, but does not disregard any more of this income than would reduce the individual's income to the SSI income standard.

In determining eligibility as categorically needy, the State disregards only part of the amount of the benefits identified in §1634(d)(1)(A) in determining the income of the individual, which amount would not reduce the individual's income below the SSI income standard. The amount of these benefits to disregarded is specified in Supplement 4 to Attachment 2.6-A.

In determining eligibility as categorically needy, the State chooses not to deduct any of the benefit identified in §1634(d)(1)(A) in determining the income of the individual.

*Agency that determines eligibility for coverage.
Agency Citation(s) Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

1902(a)(10)(E)(i), 1905(p) and 1860D-14(a)(3)(D) of the Act

25. Qualified Medicare Beneficiaries --
   a. Who are entitled to hospital insurance benefits under Medicare Part A, (but not pursuant to an enrollment under section 1818A of the Act);
   b. Whose income does not exceed 100 percent of the Federal poverty level; and
   c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the Consumer Price Index (CPI).

   (Medical assistance for this group is limited to Medicare cost-sharing as defined in item 3.2 of this plan.)

26. Qualified Disabled and Working Individuals --
   a. Who are entitled to hospital insurance benefits under Medicare Part A under section 1818A of the Act;
   b. Whose income does not exceed 200 percent of the Federal poverty level; and
   c. Whose resources do not exceed twice the maximum standard under SSI.

TN No: 16-47 Approval Date 3-21-11 Effective Date 9-1-10
Supersedes TN No. 93-05
A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

   d. Who are not otherwise eligible for medical assistance under Title XIX of the Act.

   (Medical assistance for this group is limited to Medicare Part A premiums under section 1818A of the Act.)

27. Specified Low-Income Medicare Beneficiaries --

   a. Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under section 1818A of the Act);

   b. Whose income is greater than 100 percent but less than 120 percent of the Federal poverty level; and

   c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the Consumer Price Index (CPI).

   (Medical assistance for this group is limited to Medicare Part B premiums under section 1839 of the Act.)

28. Qualifying Individuals --

   a. Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under section 1818A of the Act);
A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

b. Whose income is at least 120 percent but less than 135 percent of the Federal poverty level;

c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the Consumer Price Index (CPI).

(Medical assistance for this group is limited to Medicare Part B premiums under section 1839 of the Act.)

b. The state applies more restrictive eligibility standards than those under SSI.

Individuals whose eligibility for SSI benefits are based solely on disability who are not payable for any months solely by reason of clause (i) or (v) of Section 1611(e)(3)(A) and who continue to meet the more restrictive requirements for Medicaid eligibility under the State plan, are eligible for Medicaid as categorically needy.

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<td>Social Security Administration</td>
<td>1634(e) of the Act</td>
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TN No: 16-47  Approval Date 3-21-11  Effective Date 4-1-10

Supersedes TN No. 95-04

STATE Texas
DATE REC'D 6-25-10
DATE APPV'D 3-21-11
DATE EFF 4-1-10
HCFA 179 10-47

SUPERSEDES: TN- 95-04
B. Optional Groups Other Than the Medically Needy

1. Individuals described below who meet the income and resource requirements of AFDC, SSI, or an optional State supplement as specified in 42 CFR 435.230, but who do not receive cash assistance.

The plan covers all individuals as described above.

The plan covers only the following group or groups of individuals:

- Aged
- Blind
- Disabled
- Caretaker relatives
- Pregnant women

2. Individuals who would be eligible for AFDC, SSI or an optional State supplement as specified in 42 CFR 435.230, if they were not in a medical institution.

STATE: Texas

DATE REC'D: 12-11-91
DATE APPV'D: 1-14-92
DATE EFF: 10-1-91

*Agency that determines eligibility for coverage.
### Optional Groups Other Than the Medically Needy

**Continued**

The State deems as eligible those individuals who became otherwise ineligible for Medicaid while enrolled in an HMO qualified under Title XIII of the Public Health Service Act, or a managed care organization (MCO), or primary care case management (PCCM) program, but who have been enrolled in the entity for less than the minimum enrollment period listed below. Coverage under this section is limited to MCO or PCCM services and family planning services described in section 1905(a)(4)(C) of the Act.

<table>
<thead>
<tr>
<th>Agency*</th>
<th>Citation(s)</th>
<th>Groups Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>42 CFR 435.212 &amp; 1902(e)(2) of the Act, P.L. 99-272 (section 9517) P.L. 101-508 (section 4732)</td>
<td>[ ] 3.</td>
<td>The State deems as eligible those individuals who became otherwise ineligible for Medicaid while enrolled in an HMO qualified under Title XIII of the Public Health Service Act, or a managed care organization (MCO), or primary care case management (PCCM) program, but who have been enrolled in the entity for less than the minimum enrollment period listed below. Coverage under this section is limited to MCO or PCCM services and family planning services described in section 1905(a)(4)(C) of the Act.</td>
</tr>
</tbody>
</table>

X The State elects not to guarantee eligibility.

_ The State elects to guarantee eligibility. The minimum enrollment period is ___ months (not to exceed six).

The State measures the minimum enrollment period from:

[ ] The date beginning the period of enrollment in the MCO or PCCM, without any intervening disenrollment, regardless of Medicaid eligibility.

[ ] The date beginning the period of enrollment in the MCO or PCCM as a Medicaid patient (including periods when payment is made under this section), without any intervening disenrollment.

[ ] The date beginning the last period of enrollment in the MCO or PCCM as a Medicaid patient (not including periods when payment is made under this section) without any intervening disenrollment or periods of enrollment as a privately paying patient. (A new minimum enrollment period begins each time the individual becomes Medicaid eligible other than under this section).

*Agency that determines eligibility for coverage.

<table>
<thead>
<tr>
<th>TN #</th>
<th>Effective Date</th>
<th>Approval Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>03-16</td>
<td>8-13-03</td>
<td>10-17-03</td>
</tr>
</tbody>
</table>

Supersedes TN # 00-19

---

**Supersedes:** TN- 00-19
B. Optional Groups Other Than Medically Needy (continued)

The Medicaid Agency may elect to restrict the disenrollment of Medicaid enrollees of MCOs, PIHPs, PAHPs, and PCCMs in accordance with the regulations at 42 CFR 438.56. This requirement applies unless a recipient can demonstrate good cause for disenrolling or if he/she moves out of the entity's service area or becomes ineligible.

---

Disenrollment rights are restricted for a period of ____ months (not to exceed 12 months).

During the first three months of each enrollment period the recipient may disenroll without cause. The State will provide notification, at least once per year, to recipients enrolled with such organization of their right to and restrictions of terminating such enrollment.

---

X No restrictions upon disenrollment rights.

In the case of individuals who have become ineligible for Medicaid for the brief period described in section 1903(m)(2)(H) and who were enrolled with an MCO, PIHP, PAHP, or PCCM when they became ineligible, the Medicaid agency may elect to reenroll those individuals in the same entity if that entity still has a contract.

---

X The agency elects to reenroll the above individuals who are eligible in a month but in the succeeding two months become eligible, into the same entity in which they were enrolled at the time eligibility was lost.

---

The agency elects not to reenroll above individuals into the same entity in which they were previously enrolled.

---

* Agency that determines eligibility for coverage.

---

STATE ___TEXAS____
DATE REC'D 9-24-03
DATE APPV'D 10-17-03
DATE EFF 8-13-03
HCFA 179 03-16

---

TN # 03-16
Supersedes TN # 06-19
Effective Date 8-13-03
Approval Date 10-17-03

SUPERSEDES: TN_ 06-19_
## B. Optional Groups Other Than the Medically Needy

(Continued)

<table>
<thead>
<tr>
<th>Agency*</th>
<th>Citation(s)</th>
<th>Groups Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>TDHS</td>
<td>42 CFR 435.217 XXX 4.</td>
<td>A group or groups of individuals who would be eligible for Medicaid under the plan if they were in a NF or an ICF/MR, who but for the provision of home and community-based services under a waiver granted under 42 CFR Part 441, Subpart G would require institutionalization, and who will receive home and community-based services under the waiver. The group or groups covered are listed in the waiver request. This option is effective on the effective date of the State's section 1915(c) waiver under which this group(s) is covered. In the event an existing 1915(c) waiver is amended to cover this group(s), this option is effective on the effective date of the amendment.</td>
</tr>
</tbody>
</table>

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*Agency that determines eligibility for coverage.

**TCFA ID:**

- **HCFA ID:** 79832
- **State/Territory:** Texas
- **Agency Citation(s):** (MB)
- **Revision:** HCFA-PM-91-10
- **Date:** DECEMBER 1991
- **Attachment:** 2.2-A
- **Page:** 11

**Date Rec'd:** FEB 18 1992

**Date App'd:** MAR 13 1992

**Date Eff.:** OCT 01 1991

**HCFA 179:** 92-04

**Supersedes:** TN No. 91-24

**Effective Date:** MAR 13 1992

**Effective Date:** OCT 01 1991
### B. Optional Groups Other Than the Medically Needy (Continued)

<table>
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<tbody>
<tr>
<td>1902(a)(10) (A)(ii)(VII) of the Act</td>
</tr>
<tr>
<td>5. Individuals who would be eligible for Medicaid under the plan if they were in a medical institution, who are terminally ill, and who receive hospice care in accordance with a voluntary election described in section 1905(o) of the Act.</td>
</tr>
<tr>
<td>The State covers all individuals as described above.</td>
</tr>
<tr>
<td>The State covers only the following group or groups of individuals:</td>
</tr>
<tr>
<td>- Aged</td>
</tr>
<tr>
<td>- Blind</td>
</tr>
<tr>
<td>- Disabled</td>
</tr>
<tr>
<td>- Individuals under the age of--</td>
</tr>
<tr>
<td>- 21</td>
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<tr>
<td>- 20</td>
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<tr>
<td>- 19</td>
</tr>
<tr>
<td>- 18</td>
</tr>
<tr>
<td>- Caretaker relatives</td>
</tr>
<tr>
<td>- Pregnant women</td>
</tr>
</tbody>
</table>

*Agency that determines eligibility for coverage.*

<table>
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<th>TN No.</th>
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<th>Effective Date</th>
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<td>91-34</td>
<td>JAN 1 1992</td>
<td>OCT 1 1991</td>
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**Supersedes**

<table>
<thead>
<tr>
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<th>HCFA ID: 7983E</th>
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<tbody>
<tr>
<td>84-23</td>
<td>2.2-A, p5 1, item 5</td>
<td></td>
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**State:**

<table>
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<th>Date</th>
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<td>Texas</td>
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<td></td>
<td>JAN 1 1992</td>
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<td></td>
<td>OCT 1 1991</td>
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<td></td>
<td>91-34</td>
</tr>
<tr>
<td>Agency*</td>
<td>Citation(s)</td>
</tr>
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<td>---------</td>
<td>-------------</td>
</tr>
</tbody>
</table>

### B. Optional Groups Other Than the Medically Needy

(Continued)

6. Individuals who would be eligible for AFDC if their work-related child care costs were paid from earnings rather than by a State agency as a service expenditure. The State's AFDC plan deducts work-related child care costs from income to determine the amount of AFDC.

- The State covers all individuals as described above.

7. All individuals who are not described in section 1902(a)(10)(A)(i) of the Act, who meet the income and resource requirements of the AFDC State plan, and who are under the age of 21 as indicated below.

<table>
<thead>
<tr>
<th>Age</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>21</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td></td>
</tr>
</tbody>
</table>

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Deleted from State's Letter Dated 10-4-2016 under Transmittal Number TX 16-0024, with Effective Date of 10-1-2016. This action was approved on 12-21-2016.
B. Optional Groups Other Than the Medically Needy (Continued)

TDHS 42 CFR 435.222

b. Reasonable classifications of individuals described in (a) above, as follows:

   (1) Individuals for whom public agencies are assuming full or partial financial responsibility and who are:

      (a) In foster homes (and are under the age of ___).

      (b) In private institutions (and are under the age of ___).

      (c) In addition to the group under b.(1)(a) and (b), individuals placed in foster homes or private institutions by private, nonprofit agencies (and are under the age of ___).

   (2) Individuals in adoptions subsidized in full or part by a public agency (who are under the age of ___).

   (3) Individuals in NFs (who are under the age of ___). NF services are provided under this plan.

   (4) In addition to the group under (b)(3), individuals in ICFs/MR (who are under the age of ___).
Agency*: TDHS

**Citation(s):** XXX

**Groups Covered**

B. Optional Groups Other Than the Medically Needy (Continued)

(5) Individuals receiving active treatment as inpatients in psychiatric facilities or programs (who are under the age of ). Inpatient psychiatric services for individuals under age 21 are provided under this plan.

(6) Other defined groups (and ages), as specified in Supplement 1 of ATTACHMENT 2.2-A.
B. Optional Groups Other Than the Medically Needy
(Continued)

8. A child for whom there is in effect a State adoption assistance agreement (other than under title IV-E of the Act), who, as determined by the State adoption agency, cannot be placed for adoption without medical assistance because the child has special needs for medical or rehabilitative care, and who before execution of the agreement –

a. Was eligible for Medicaid under the State's approved Medicaid plan; or

b. Would have been eligible for Medicaid if the standards and methodologies of the title IV-E foster care program were applied rather than the AFDC standards and methodologies.

The Agency does not consider income or resources when determining eligibility for this population.

The State covers individuals under the age of –

- ☒ 21
- □ 20
- □ 19
- □ 18

The Agency does not consider income or resources when determining eligibility for this population.

SUPERSEDES: TN-94-36

* Agency that determines eligibility for coverage

TN No. 10-03 Approval Date 7-9-10 Effective Date 10-1-10

Supersedes TN No. 94-36

Deleted from State's Letter Dated 10-4-2016 under Transmittal Number TX 16-0024, with Effective Date of 10-1-2016. This action was approved on 12-21-2016.
9. Individuals described below who would be eligible for AFDC if coverage under the State's AFDC plan were as broad as allowed under title IV-A:

- Individuals under the age of: 
  - 21
  - 20
  - 19
  - 18
- Caretaker relatives
- Pregnant women

Deleted from State's Letter Dated 10-4-2016 under Transmittal Number TX 16-0024, with Effective Date of 10-1-2016. This action was approved on 12-21-2016.
B. Optional Groups Other Than the Medically Needy
(Continued)

10. States using SSI criteria with agreements under sections 1616 and 1634 of the Act.

The following groups of individuals who receive only a State supplementary payment (but no SSI payment) under an approved optional State supplementary payment program that meets the following conditions. The supplement is--

a. Based on need and paid in cash on a regular basis.

b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement.

c. Available to all individuals in the State.

d. Paid to one or more of the classifications of individuals listed below, who would be eligible for SSI except for the level of their income.

   (1) All aged individuals.
   (2) All blind individuals.
   (3) All disabled individuals.

HCFA ID: 7983E
B. Optional Groups Other Than the Medically Needy

(Continued)

42 CFR 435.230

(4) Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.

(5) Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.

(6) Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.

(7) Individuals receiving a Federally administered optional State supplement that meets the conditions specified in 42 CFR 435.230.

(8) Individuals receiving a State administered optional State supplement that meets the conditions specified in 42 CFR 435.230.

(9) Individuals in additional classifications approved by the Secretary as follows:
B. **Optional Groups Other Than the Medically Needy**
(Continued)

The supplement varies in income standard by political subdivisions according to cost-of-living differences.

- Yes.
- No.

The standards for optional State supplementary payments are listed in Supplement 6 of ATTACHMENT 2.6-A.

**Institutionalized Supplemental Security Income cash recipients who receive the $30 federal benefit rate also receive a $15 per month state supplementation check. Refer to SUPPLEMENT 1 TO ATTACHMENT 2.2-A, PAGE 1a.**

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*Agency that determined eligibility for coverage*

TN No. **03-10**  
Approval Date **12-4-03**  
Effective Date **9-1-03**

Supersedes

TN No. **91-34**

HCFA ID: 7983E
State: Texas

### Groups Covered

#### B. Optional Groups Other Than the Medically Needy (Continued)

<table>
<thead>
<tr>
<th>Agency* Citation(s)</th>
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<tbody>
<tr>
<td>42 CFR 435.230</td>
<td></td>
</tr>
<tr>
<td>435.121</td>
<td></td>
</tr>
<tr>
<td>1902(a)(10)</td>
<td></td>
</tr>
<tr>
<td>(A)(ii)(XI)</td>
<td></td>
</tr>
</tbody>
</table>

---

Section 1902(f) States and SSI criteria States without agreements under section 1615 or 1634 of the Act.

The following groups of individuals who receive a State supplementary payment under an approved optional State supplementary payment program that meets the following conditions. The supplement is--

a. Based on need and paid in cash on a regular basis.

b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement.

c. Available to all individuals in each classification and available on a Statewide basis.

d. Paid to one or more of the classifications of individuals listed below:

   - (1) All aged individuals.
   - (2) All blind individuals.
   - (3) All disabled individuals.

---

**Supersedes:** 91-34

**Approval Date:** MAR 13 1992

**Effective Date:** JAN 01 1992

**TN No.:** 92-05

**HCFA ID:** 7983E
<table>
<thead>
<tr>
<th>Agency</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td><strong>B. Optional Groups Other Than the Medically Needy</strong> (Continued)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(4) Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(5) Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(6) Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(7) Individuals receiving federally administered optional State supplement that meets the conditions specified in 42 CFR 435.230.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(8) Individuals receiving a State administered optional State supplement that meets the conditions specified in 42 CFR 435.230.</td>
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<tr>
<td></td>
<td></td>
<td>(9) Individuals in additional classifications approved by the Secretary as follows:</td>
</tr>
</tbody>
</table>
### B. Optional Groups Other Than the Medically Needy (Continued)

The supplement varies in income standard by political subdivisions according to cost-of-living differences.

- Yes
- No

The standards for optional State supplementary payments are listed in Supplement 6 of ATTACHMENT 2.6-A.
### B. Optional Groups Other Than the Medically Needy (Continued)

<table>
<thead>
<tr>
<th>Agency*</th>
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</tr>
</thead>
<tbody>
<tr>
<td>TDHS</td>
<td>42 CFR 435.231</td>
<td>XXX12. Individuals who are in institutions for at least 30 consecutive days and who are eligible under a special income level. Eligibility begins on the first day of the 30-day period. These individuals meet the income standards specified in Supplement 1 to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td>TDHS</td>
<td>1902(a)(10)(A) (ii) and 1905(a) of the Act</td>
<td>XXXThe State covers only the following group or groups of individuals:</td>
</tr>
</tbody>
</table>

- **Aged**
- **Blind**
- **Disabled**
- Individuals under the age of--
  - 21
  - 20
  - 19
  - 18
- Caretaker relatives
- Pregnant women

---

**Supersedes**: TN No. 97-10, Attachment 2.2-A, pg 17, item 11

**Effective Date**: OCT 01 1991

**HCFA ID**: 7983E
B. Optional Groups Other Than the Medically Needy (Continued)

13. Certain disabled children age 18 or under who are living at home, who would be eligible for Medicaid under the plan if they were in an institution, and for whom the State has made a determination as required under section 1902(e)(3)(B) of the Act.

Supplement 3 to ATTACHMENT 2.2-A describes the method that is used to determine the cost effectiveness of caring for this group of disabled children at home.

14. The following individuals who are not mandatory categorically needy whose income does not exceed the income level (established at an amount above the mandatory level and not more than 185 percent of the Federal poverty income level) specified in Supplement 1 to ATTACHMENT 2.6-A for a family of the same size, including the woman and unborn child or infant and who meet the resource standards specified in Supplement 2 to ATTACHMENT 2.6-A:

   a. Women during pregnancy (and during the 60-day period beginning on the last day of pregnancy); and
   
   b. Infants under one year of age.
State: Texas

<table>
<thead>
<tr>
<th>Agency*</th>
<th>Citation(s)</th>
<th>Groups Covered</th>
</tr>
</thead>
</table>

*(RESERVED FOR FUTURE USE)*

* Agency that determines eligibility for coverage.

TN NO. 91-34

Approval Date: JAN 14 1992 Effective Date: OCT 01 1991

Supersedes TN NO. 91-34
B. Optional Groups Other Than the Medically Needy
(Continued)

1902(a)
16. Individuals--

(a) (ii) and (X)

and 1902(m)

(l) and (3)
of the Act

a. Who are 65 years of age or older or are disabled, as determined under section 1614(a)(3) of the Act. Both aged and disabled individuals are covered under this eligibility group.

b. Whose income does not exceed the income level (established at an amount up to 100 percent of the Federal income poverty level) specified in Supplement 1 to ATTACHMENT 2.6-A for a family of the same size; and

c. Whose resources do not exceed the maximum amount allowed under SSI; under the State's more restrictive financial criteria; or under the State's medically needy program as specified in ATTACHMENT 2.8-A.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Texas

COVERAGE AND CONDITIONS OF ELIGIBILITY

B. Optional Groups Other Than the Medically Needy
(Continued)

TDHS 1902(a)(47) and 1920 of the Act

XXX 17. Pregnant women who are determined by a "qualified provider" (as defined in §1920(b)(2) of the Act) based on preliminary information, to meet the highest applicable income criteria specified in this plan under ATTACHMENT 2.6-A and are therefore determined to be presumptively eligible during a presumptive eligibility period in accordance with §1920 of the Act.
B. Optional Groups Other Than the Medically Needy (Continued)

18. Individuals required to enroll in cost-effective employer-based group health plans remain eligible for a minimum enrollment period of \(0\) months.

19. Individuals entitled to elect COBRA continuation coverage and whose income as determined under Section 1612 of the Act for purposes of the SSI program, is no more than 100 percent of the Federal poverty level, whose resources are no more than twice the SSI resource limit for an individual, and for whom the State determines that the cost of COBRA premiums is likely to be less than the Medicaid expenditures for an equivalent set of services. See Supplement 11 to Attachment 2.6-A.
B. Optional Groups Other Than the Medically Needy
(Continued)

P.L. No. 106-169

X 20. Individuals who were in foster care when they left the Texas Department of Protective and Regulatory Services conservatorship on their 18th birthday or later, until they reach age 21. To be eligible for Medical Assistance, the following requirements must be met:

1. Age. Individuals must be age 18 through the month of their 21st birthday.

2. Resources. Resource limits and types of countable and exempt resources for youth transitioning out of foster care are the same as those for the Children and Pregnant Women (CPW) programs, with the following exceptions:

   A) The resource limit is $10,000.

   B) Any financial benefit used for the purpose of educational or vocational training, such as scholarships, student loans, or grants is excluded as a resource.

   C) Any financial benefit used for the purpose of housing is excluded as a resource.

   D) Any grants or subsidies obtained as a result of the Foster Care Independence Act of 1999 are excluded as a resource.

Deleted from State's Letter Dated 10-4-2016 under Transmittal Number TX 16-0024, with Effective Date of 10-1-2016. This action was approved on 12-21-2016.
### Groups Covered

**B. Optional Groups Other Than the Medically Needy**

(Continued)

<table>
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</thead>
<tbody>
<tr>
<td>ATTACHMENT 2.2-A</td>
<td>Page 23b(1)</td>
</tr>
</tbody>
</table>

(3) Income. Income eligibility is determined using the TANF eligibility requirements with the following exceptions:

- **(A)** The income limit is 400% of the federal poverty level adjusted annually to federal requirements.
- **(B)** Any financial benefit used for the purpose of educational or vocational training, such as scholarships, student loans, or grants is excluded from income.
- **(C)** Any financial benefit used for the purpose of housing is excluded from income.
- **(D)** Any grants or subsidies obtained as a result of the Foster Care Independence Act of 1999 are excluded from income.

Deleted from State's Letter Dated 10-4-2016 under Transmittal Number TX 16-0024, with Effective Date of 10-1-2016. This action was approved on 12-21-2016.
Groups Covered

B. Optional Coverage Other Than the Medically Needy (Continued)

XXX 21. Women who:

a. have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program established under Title XV of the Public Health Service Act in accordance with the requirements of section 1504 of that ACT and need treatment for breast or cervical cancer, including a precancerous condition of the breast or cervix;

b. are not otherwise covered under creditable coverage, as defined in section (2701 9c) of the Public Health Service Act;

c. are not eligible for Medicaid under any mandatory categorically needy eligibility group; and

d. have not attained age 65.
B. Optional Coverage Other Than the Medically Needy (Continued)

1920B of the Act

XXX 22. Women who are determined by a "qualified entity" (as defined in 1920B (b)) based on preliminary information, to be a woman described in 1902 (aa) of the Act, relating to certain breast and cervical cancer patients.

The presumptive period begins on the day that the determination is made. The period ends on the date that the State makes a determination with respect to the woman's eligibility for Medicaid or, if the woman does not apply for Medicaid (or a Medicaid application was not made on her behalf) by the last day of the month following the month in which the determination of presumptive eligibility was made, the presumptive period ends on that last day.

Deleted from State's Letter Dated 10-4-2016 under Transmittal Number TX 16-0024, with Effective Date of 10-1-2016. This action was approved on 12-21-2016.
### Groups Covered

<table>
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<th>[ ] 24.</th>
<th>[ ] 25.</th>
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</thead>
<tbody>
<tr>
<td>1902(a)(10)(A) (ii)(XIII) of the Act</td>
<td><strong>BBA Work Incentives Eligibility Group</strong> - Individuals with a disability whose net family income is below 250 percent of the Federal Poverty Level for a family of the size involved and who, except for earned income, meet all criteria for receiving benefits under the SSI program. See page 12c of Attachment 2.6-A.</td>
<td><strong>TWWIIA Basic Insurance Group</strong> - Individuals with a disability at least 16 but less than 65 years of age whose income and resources do not exceed a standard established by the State. See page 12d of Attachment 2.6-A.</td>
<td><strong>TWWIIA Medical Improvement Group</strong> - Employed individuals at least 16 but less than 65 years of age with a medically improved disability whose income and resources do not exceed a standard established by the State. See page 12h of Attachment 2.6-A.</td>
</tr>
</tbody>
</table>

**NOTE:** If the State elects to cover this group, it MUST also cover the Basic Insurance Group described in No. 24 above.

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**TN No. 01-01**

Supercedes **Approval Date 12-30-06**

Effective Date **9-1-06**
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State: TEXAS

Citation
Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

1902(a)(10)(A) (ii)(XIX) of the Act
26. Family Opportunity Act – Children who have not attained 19 years of age, who would be considered disabled under Section 1614(a)(3)(C) of the Act, and whose family income meets the standard described on Page 12d of Attachment 2.6-A.

- Beginning with the effective date of its plan amendment, the State covers all children eligible under this group, as described below.

In the case of the second, third, and fourth quarters of fiscal year 2007, the State covers children who were born on or after January 1, 2001, or who were born on or after the following earlier date: NA.

In the case of each quarter of fiscal year 2008, the State covers children who were born on or after October 1, 1995, or who were born on or after the following earlier date: NA.

In the case of each quarter of fiscal year 2009 and each quarter of any fiscal year thereafter, the State covers children who were born after October 1, 1989. NA
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State: TEXAS

Citation

Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

1902(a)(10)(A)
(ii)(XIX) of the Act

Income Standards

☐ The agency uses the family income standard of 300% of federal poverty level;

☒ The agency uses the family income standard of less than 300% of the federal poverty level.

Specify the income standard: 150%

☐ The agency uses a family income standard higher than 300% of the federal poverty level, (no federal financial participation is provided for benefits to families above 300% FPL).

Specify the income standard: ___

Resource Standards

Under this provision agencies may not impose resource standards or asset tests in determining eligibility.

State: Texas

DATE REC'D: 2-26-10
DATE APP'V'D: 5-27-10
DATE EFF: 1-1-11
HCFA 179: 10-02

TN No. 10-02 Approval Date 5-27-10 Effective Date 1-1-11
Supersedes TN No. SUPERSEDES: NONE - NEW PAGE
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
MEDICAL ASSISTANCE PROGRAM

State: _____ TEXAS _____

**Citation**

<table>
<thead>
<tr>
<th>Groups Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>B. Optional Groups Other Than the Medically Needy (Continued)</td>
</tr>
</tbody>
</table>

**1902(a)(10)(A) (ii)(XIX) of the Act**

**Income Methodologies**

- In determining whether a family meets the income standard described above, the agency uses the following methodologies.

- The income methodologies of the SSI program.

- The agency uses methodologies for treatment of income that are more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 to Attachment 2.6-A.

- The agency uses more liberal income methodologies than the SSI program. More liberal income methodologies are described in Supplement 8a to Attachment 2.6-A.

The agency defines family unit as the following members living in the household:

- applicant child with a disability,

- natural, adoptive, or step parent (step parent must be the current spouse of the natural or adoptive parent), and

- natural, adoptive, or step siblings (under age 18 or under age 22 regularly attending school, college or training in preparation for a paying job).

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**TN No. 10-02**

**Supersedes TN No.**  
**Supercedes: NONE - NEW PAGE**

**State of Texas**  
**Attachment 2.2-A**  
**Page 23h**
Optional Groups other than the Medically Needy

In addition to providing State plan HCBS to individuals described in 1915(i)(1), the state may also cover the optional categorically needy eligibility group of individuals described in 1902(a)(10)(A)(ii)(XXII) who are eligible for HCBS under the needs-based criteria established under 1915(i)(1)(A) and have income that does not exceed 150% of the FPL, or who are eligible for HCBS under a waiver approved for the state under Section 1915(c), (d) or (e) or Section 1115 (even if they are not receiving such services), and who do not have income that exceeds 300% of the supplemental security income benefit rate. See 42 CFR § 435.219. (Select one):

☐ No. Does not apply. State does not cover optional categorically needy groups.

☐ Yes. State covers the following optional categorically needy groups.
(Select all that apply):

(a) ☐ Individuals not otherwise eligible for Medicaid who meet the needs-based criteria of the 1915(i) benefit, have income that does not exceed 150% of the federal poverty level, and will receive 1915(i) services. There is no resource test for this group. Methodology used:
(Select one):

☐ SSI. The state uses the following less restrictive 1902(r)(2) income disregards for this group. (Describe, if any):

☐ OTHER (describe):

(b) ☐ Individuals who are eligible for home and community-based services under a waiver approved for the State under section 1915(c), (d) or (e) (even if they are not receiving such services), and who do not have income that exceeds 300% of the supplemental security income benefit rate.
Income limit: (Select one):

☐ 300% of the SSI/FBR
☐ Less than 300% of the SSI/FBR (Specify): ____%
Specify the applicable 1915(c), (d), or (e) waiver or waivers for which these individuals would be eligible: *(Specify waiver name(s) and number(s)):

(e) □ Individuals eligible for 1915(c), (d) or (e) -like services under an approved 1115 waiver. The income and resource standards and methodologies are the same as the applicable approved 1115 waiver.
   Specify the 1115 waiver demonstration or demonstrations for which these individuals would be eligible. *(Specify demonstration name(s) and number(s)):

PRA Disclosure Statement
According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to average 114 hours per response, including the time to review instructions, search existing data resources, and gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, and Baltimore, Maryland 21244-1850.
C. Optional Coverage of the Medically Needy

42 CFR 435.301  This plan includes the medically needy.

//  No.

/X/  Yes. This plan covers:

1. Pregnant women who, except for income and/or resources, would be eligible as categorically needy under title XIX of the Act.

1902(e) of the Act 2. Women who, while pregnant, were eligible for and have applied for Medicaid and receive Medicaid as medically needy under the approved State plan on the date the pregnancy ends. These women continue to be eligible, as though they were pregnant, for all pregnancy-related and postpartum services under the plan for a 60-day period, beginning with the date the pregnancy ends, and any remaining days in the month in which the 60th day falls.

1902(a)(10) (C)(ii)(I) of the Act 3. Individuals under age 18 who, but for income and/or resources, would be eligible under section 1902(a)(10)(A)(i) of the Act.
C. Optional Coverage of the Medically Needy (Continued)

4. [Reserved.]

5. ☑ a. Financially eligible individuals who are not described in section C.3. above and who are under the age of—

☐ 21
☐ 20
☒ 19

☐ 18 or under age 19 who are full-time students in a secondary school or in the equivalent level of vocational or technical training.

☒ b. Reasonable classifications of financially eligible individuals under the ages of 21, 20, 19, or 18 as specified below:

☐ (1) Individuals for whom public agencies are assuming full or partial financial responsibility and who are:

☐ (a) In foster homes (and are under the age of ___).

☐ (b) In private institutions (and are under the age of ___).
C. Optional Coverage of Medically Needy (Continued)

   (c) In addition to the group under b.(1)(a) and (b), individuals placed in foster homes or private institutions by private, nonprofit agencies (and are under the age of ___ ___).

   (2) Individuals in adoptions subsidized in full or part by a public agency (who are under the age of _____).

   (3) Individuals in NFs (who are under the age of ____) NF services are provided under this plan.

   (4) In addition to the group under (b)(3), individuals in ICFs/MR (who are under the age of _____).

   (5) Individuals receiving active treatment as inpatients in psychiatric facilities or programs (who are under the age of ___ ). Inpatient psychiatric services for individuals under age 21 are provided under this plan.

   (6) Other defined groups (and ages), as specified in Supplement 1 of ATTACHMENT 2.2-A.
## C. Optional Coverage for the Medically Needy (Continued)

<table>
<thead>
<tr>
<th>Agency</th>
<th>Citation(s)</th>
<th>Groups Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>IV-A</td>
<td>42CFR 435.310</td>
<td>6. Caretaker Relatives</td>
</tr>
<tr>
<td></td>
<td>42CFR 435.326</td>
<td>10. Individuals who would be ineligible if they were not enrolled in an HMO. Categorically needy individuals are covered under 42 CFR 435.212 and the same rules apply to medically needy individuals.</td>
</tr>
<tr>
<td></td>
<td>42CFR 435.340</td>
<td>11. Blind and disabled individuals who: a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria; b. Were eligible as medically needy in December 1973 as blind or disabled; and c. For each consecutive month after December 1973 continue to meet the December 1973 eligibility criteria.</td>
</tr>
</tbody>
</table>
C. Optional Coverage of Medically Needy
   (Continued)

1906 of the Act

12. Individuals required to enroll in cost effective employer-based group health plans remain eligible for a minimum enrollment period of ___0___ months.
**STATE:** Texas

<table>
<thead>
<tr>
<th>Agency*</th>
<th>Citation</th>
<th>Groups Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Section 4723 of F.L. 101-508 and Section 1903(f)(2)(B) of the Act</td>
<td>The State agency allows medically needy individuals and families to pay an amount to the State, which when combined with incurred medical costs in prior months, is sufficient when excluded from the family's income, to reduce such family's income below the applicable income limitation described in Section 1903(f)(1) of the Act.</td>
</tr>
</tbody>
</table>

**STATE:** Texas  
**DATE REC'D:** 12-28-90  
**DATE APP'D:** 2-5-91  
**DATE EFF:** 11-5-90  
**HCFA 179:** 90-49

* Agency that determines eligibility for coverage

**TN NO.:** 90-49  
**Effective Date:** 11/5/90  
**Approval Date:** 2/5/91
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Texas

REASONABLE CLASSIFICATIONS OF INDIVIDUALS UNDER THE AGE OF 21, 20, 19, AND 18

A. Individuals under 21 years of age for whom the Texas Department of Family and Protective Services (TDFPS) assumes financial responsibility, in whole or in part, and who are being cared for in:

1. Family foster homes which are licensed and monitored by TDFPS;
2. Family foster homes which are verified and monitored by licensed, public or private child-placing agencies;
3. Private 24-hour care facilities licensed by TDFPS; or
4. In a supervised setting designed for independent living for individuals 18 and older who are in extended foster care.

B. Children in the community who are under the age 18 (or under age 19 if expected to graduate by their 19th birthday and who live with relative(s)) within the Aid for Families with Dependent Children (AFDC) required degree of relationship.

C. Children under the age of 18 placed by the county or district court in the managing conservatorship of TDFPS as the result of a finding of abuse or neglect by TDFPS.

D. Children under the age of 21 who have been committed to the custody of the Texas Juvenile Justice Department.

E. Children ages 10 through 17 who are under the continuing jurisdiction of the juvenile court and who are placed in a setting such as a group home, a residential treatment facility, or a foster home which will permit children to receive Medicaid services.

F. Former foster care youth under the age of 21 who had been placed inside or outside of Texas under the Interstate Compact on the Placement of Children.

Deleted from State's Letter Dated 10-4-2016 under Transmittal Number TX 16-0024, with Effective Date of 10-1-2016. This action was approved on 12-21-2016.

State: Texas
Date Received: 12-20-13
Date Approved: 5-9-14
Date Effective: 12-31-13
Transmittal Number: 13-51
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Texas

REASONABLE CLASSIFICATIONS OF INDIVIDUALS RECEIVING STATE SUPPLEMENTATION

Institutionalized Supplemental Security Income cash recipients who receive the $30 Federal benefit rate also receive a state supplementation check of not less than $15 per month.

Deleted from State's Letter Dated 10-4-2016 under Transmittal Number TX 16-0024, with Effective Date of 10-1-2016. This action was approved on 12-21-2016.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Texas

Method for Determining Cost Effectiveness of Caring for Certain Disabled Children At Home
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Texas

ELIGIBILITY CONDITIONS AND REQUIREMENTS

<table>
<thead>
<tr>
<th>Citation(s)</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>42 CFR Part 435, Subpart G</td>
<td>1. Is financially eligible (using the methods and standards described in Parts B and C of this Attachment) to receive services.</td>
</tr>
<tr>
<td>(i)</td>
<td>a. For the categorically needy:</td>
</tr>
<tr>
<td>1902(1) of the Act</td>
<td>Except as specified under items A.2.a.(ii) and (iii) below, for AFDC-related individuals, meets the non-financial eligibility conditions of the AFDC program.</td>
</tr>
<tr>
<td>1902(m) of the Act</td>
<td>(ii) For SSI-related individuals, meets the non-financial criteria of the SSI program or more restrictive SSI-related categorically needy criteria.</td>
</tr>
<tr>
<td>(iv)</td>
<td>For financially eligible aged and disabled individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act, meets the non-financial criteria of section 1902(m) of the Act.</td>
</tr>
</tbody>
</table>

**Approval Date**: APR 29 1992
**Effective Date**: APR 01 1992

**Supersedes**: 98-10
**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**
**MEDICAL ASSISTANCE PROGRAM**

State: Texas

<table>
<thead>
<tr>
<th>Citation</th>
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</tr>
</thead>
<tbody>
<tr>
<td>1905(p) of the Act</td>
<td>b. For the medically needy, meets the non-financial eligibility conditions of 42 CFR Part 435.</td>
</tr>
<tr>
<td>1905(s) of the Act</td>
<td>c. For financially eligible qualified Medicare beneficiaries covered under Section 1902(a)(10)(E)(i) of the Act, meets the non-financial criteria of Section 1905(p) of the Act.</td>
</tr>
<tr>
<td>42 CFR §435.406</td>
<td>d. For financially eligible qualified disabled and working individuals covered under Section 1902(a)(10)(E)(ii) of the Act, meets the non-financial criteria of Section 1905(s).</td>
</tr>
<tr>
<td>3. Is residing in the United States and –</td>
<td></td>
</tr>
<tr>
<td>a.</td>
<td>a. Is a citizen or national of the United States;</td>
</tr>
<tr>
<td>b.</td>
<td>b. Is a qualified alien (QA) as defined in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) as amended, and the QA's eligibility is required by section 402(b) of PRWORA as amended, and is not prohibited by section 403 of PRWORA as amended;</td>
</tr>
<tr>
<td>c.</td>
<td>c. Is a qualified alien subject to the 5-year bar as described in section 403 of PRWORA, so that eligibility is limited to treatment of an emergency medical condition as defined in section 401 of PRWORA;</td>
</tr>
<tr>
<td>d.</td>
<td>d. Is a non-qualified alien, so that eligibility is limited to treatment of an emergency medical condition as defined in section 401 of PRWORA;</td>
</tr>
<tr>
<td>e.</td>
<td>e. Is a QA whose eligibility is authorized under section 402(b) of PRWORA as amended, and is not prohibited by section 403 of PRWORA as amended.</td>
</tr>
</tbody>
</table>

☐ State covers all authorized QAs
☒ State does not cover authorized QAs.

**SUPERSEDES: TN. 91-34**

TN 10-08 Approval Date 2-11-11 Effective Date 5-1-10

Supersedes TN 91-34
f. State elects CHIPRA option to provide full Medicaid coverage to children as specified below who are aliens lawfully residing in the United States; which consist of the following:

(1) A qualified alien as defined in section 431 of PRWORA (8 USC § 1641);

(2) An alien in nonimmigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission;

(3) An alien who has been paroled into the United States pursuant to section 212(d)(5) of the Immigration and Nationality Act (INA) (8 USC §1182(d)(5)) for less than one year, except for an alien paroled for prosecution, for deferred inspection or pending removal proceedings;

(4) An alien who belongs to one of the following classes:
   (i) Aliens currently in temporary resident status pursuant to section 210 or 245A of the Immigration and Nationality Act (INA) (8 USC §1160 or 1255a, respectively);
   (ii) Aliens currently under Temporary Protected Status (TPS) pursuant to section 244 of the INA (1254a), and pending applicants for TPS who have been granted employment authorization;
   (iii) Aliens who have been granted employment authorization under 8 CFR 274a12(c)(9), (10), (16), (18), (22), or (24);
   (iv) Family Unity beneficiaries pursuant to section 301 of Public Law 101-649 as amended;
   (v) Aliens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President;
   (vi) Aliens currently in deferred action status; or
   (vii) Aliens whose visa petition has been approved and who have a pending application for adjustment of status;
### Citation Condition or Requirement

<table>
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</thead>
<tbody>
<tr>
<td>(5)</td>
<td>A pending applicant for asylum under section 208(a) of the INA (8 USC §1158) or for withholding of removal under section 241(b)(3) of the INA (8 USC §1231) or under the Convention Against Torture who has been granted employment authorization, and such an applicant under the age of 14 who has had an application pending for at least 180 days;</td>
</tr>
<tr>
<td>(6)</td>
<td>An alien who has been granted withholding of removal under the Convention Against Torture;</td>
</tr>
<tr>
<td>(7)</td>
<td>A child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA (8 USC §1101(a)(27)(J));</td>
</tr>
<tr>
<td>(8)</td>
<td>An alien who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 USC §1806(e); or</td>
</tr>
<tr>
<td>(9)</td>
<td>An alien who is lawfully present in American Samoa under the immigration laws of American Samoa.</td>
</tr>
</tbody>
</table>

- ✅ Elected for pregnant women.
- ✗ Elected for children under age 19.

State also covers children up to age 21 who are the optional group of children described in Attachment 2.2-A, page 23b of this state plan (former foster care), as well as those foster care-related children up to age 21 who are described in Supplement 1 to Attachment 2.2-A to this state plan.

**g. ✗ The State provides assurance that for an individual whom it enrolls in Medicaid under the CHIPRA section 214 option, it has verified, at the time of the individual’s initial eligibility determination and at the time of the eligibility redetermination, that the individual continues to be lawfully residing in the United States. The State must first attempt to verify this status using information provided at the time of initial application. If the State cannot do so from the information readily available, it must require the individual to provide documentation or further evidence to verify satisfactory immigration status in the same manner as it would for anyone else claiming satisfactory immigration status under section 1137(d) of the Act.**
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>42 CFR §435.403; 1902(b) of the Act</td>
<td>4. Is a resident of the State, regardless if whether or not the individual maintains the residence permanently or maintains it at a fixed address.</td>
</tr>
</tbody>
</table>

- [x] State has an interstate residency agreement with the following states:
  - On file in the Texas Health and Human Services Commission, Office of General Counsel.

- [ ] State has open agreement(s).

- [ ] Not applicable; no residency requirement.

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**Deleted from State’s Letter Dated 10-4-2016 under Transmittal Number TX 16-0024, with Effective Date of 10-1-2016. This action was approved on 12-21-2016.**
<table>
<thead>
<tr>
<th>Citation</th>
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</thead>
<tbody>
<tr>
<td>42 CFR 435.1008 a.</td>
<td>Is not an inmate of a public institution. Public institutions do not include medical institutions, <em>nursing facilities and intermediate care facilities</em> for the mentally retarded.</td>
</tr>
<tr>
<td>42 CFR 435.1008 b.</td>
<td>Is not a patient under age 65 in an institution for mental diseases except as an inpatient under age 22 receiving active treatment in an accredited psychiatric facility or program.</td>
</tr>
<tr>
<td>42 CFR 433.145 1905(a) of the Act</td>
<td>Not applicable with respect to individuals under age 22 in psychiatric facilities or programs. Such services are not provided under the plan.</td>
</tr>
<tr>
<td>42 CFR 433.145 1912 of the Act</td>
<td>Is required, as a condition of eligibility, to assign his or her own rights, or the rights of any other person who is eligible for Medicaid and on whose behalf the individual has legal authority to execute an assignment, to medical support and payments for medical care from any third party. (Medical support is defined as support specified as being for medical care by a court or administrative order.)</td>
</tr>
</tbody>
</table>
An applicant or recipient must also cooperate in establishing the paternity of any eligible child and in obtaining medical support and payments for himself or herself and any other person who is eligible for Medicaid and on whose behalf the individual can make an assignment; except that individuals described in §1902(l)(1)(A) of the Social Security Act (pregnant women and women in the post-partum period) are exempt from these requirements involving paternity and obtaining support. Any individual may be exempt from the cooperation requirements by demonstrating good cause for refusing to cooperate.

An applicant or recipient must also cooperate in identifying any third party who may be liable to pay for care that is covered under the State plan and providing information to assist in pursuing these third parties. Any individual may be exempt from the cooperation requirements by demonstrating good cause for refusing to cooperate.

Assignment of rights is automatic because of State law. Only as relates to Third Party Liability.

42 CFR 435.910 (7) Is required, as a condition of eligibility, to furnish his/her social security account number (or numbers, if he/she has more than one number), except for aliens seeking medical assistance for the treatment of an emergency medical condition under section 1903(v)(2) of the Social Security Act (section 1137(f)).
<table>
<thead>
<tr>
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<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(c)(2)</td>
<td>8. Is not required to apply for AFDC benefits under title IV-A as a condition of applying for, or receiving, Medicaid if the individual is a pregnant woman, infant, or child that the State elects to cover under sections 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Act.</td>
</tr>
<tr>
<td>1902(e)(10)(A)</td>
<td>9. Is not required, as an individual child or pregnant woman, to meet requirements under section 402(a)(43) of the Act to be in certain living arrangements. (Prior to terminating AFDC individuals who do not meet such requirements under a State's AFDC plan, the agency determines if they are otherwise eligible under the State's Medicaid plan.)</td>
</tr>
</tbody>
</table>

Deleted from State's Letter Dated 10-4-2016 under Transmittal Number TX 16-0024, with Effective Date of 10-1-2016. This action was approved on 12-21-2016.
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1906 of the Act</td>
<td>10. Is required to apply for enrollment in an employer-based cost-effective group health plan, if such plan is available to the individual. Enrollment is a condition of eligibility except for the individual who is unable to enroll on his/her own behalf (failure of a parent to enroll a child does not affect a child's eligibility).</td>
</tr>
</tbody>
</table>
## B. Posteligibility Treatment of Institutionalized Individuals' Incomes

1. The following items are not considered in the posteligibility process:

<table>
<thead>
<tr>
<th>Citation</th>
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</tr>
</thead>
<tbody>
<tr>
<td>1902(o) of the Act</td>
<td>a. SSI and SSP benefits paid under §1611(e)(1)(E) and (G) of the Act to individuals who receive care in a hospital, nursing home, SNF, or ICF.</td>
</tr>
<tr>
<td>1902(r)(1) of the Act</td>
<td>c. German Reparations Payments (reparation payments made the Federal Republic of Germany).</td>
</tr>
<tr>
<td>1. (a) of P.L. 103-286</td>
<td>e. Netherlands Reparation Payments based on Nazi, but not Japanese, persecution (during World War II).</td>
</tr>
<tr>
<td>10405 of P.L. 101-239</td>
<td>f. Payments from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In re Agent orange product liability litigation, M.D.L. No.381 (E.D.N.Y.)</td>
</tr>
<tr>
<td>6(h)(2) of P.L. 101-426</td>
<td>g. Radiation Exposure Compensation.</td>
</tr>
<tr>
<td>12005 of P.L. 103-66</td>
<td>h. VA pensions limited to $90 per month under 38 U.S.C. 5503.</td>
</tr>
</tbody>
</table>
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State: TEXAS

Citation | Condition or Requirement
--- | ---

2. The following monthly amounts for personal needs are deducted from total monthly income in the application of an institutionalized individual’s or couple’s income to the cost of institutionalized care:

Personal Needs Allowance (PNA) of not less than $30 for Individuals and $60 for Couples for all Institutionalized Persons.

a. Aged Blind, Disabled:

Individuals: \( \$60.00 \)

Couples: \( \$120.00 \)

For the following persons with greater needs:

Supplement 12 to Attachment 2.6-A describes the greater need of an institutionalized individual with a court ordered guardianship/fiduciary fee when calculating the cost of institutionalized care.

b. AFDC related:

Children: \( \$45.00 \)

Adults: \( \$45.00 \)

For the following persons with greater need:

Supplement 12 to Attachment 2.6-A described the greater need; described the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met;

c. Individuals under age 21 covered in the plan as specified in Item B.7 of Attachment 2.2-A.

Supersedes TN: 06-19
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State: TEXAS

Citation | Condition or Requirement
---|---
1924 of the Act | B. Posteligibility Treatment of Institutionalized Individuals' Incomes, Cont.

For the following persons with greater need:

Supplement 12 to Attachment 2.6-A describes the greater need; describes the basis for formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met.

1924 of the Act

3. In addition to the amounts under item 2, the following monthly amounts are deducted from the remaining income of an institutionalized individual with a community spouse:

   a. The monthly income allowance for the community spouse, calculated using the formula in §1924(d)(3)(C), is the amount by which the maintenance needs standard exceeds the community spouse's income. The maintenance needs standard cannot exceed the maximum prescribed in §1924(d)(3)(C). The maintenance needs standard consists of a poverty level component plus an excess shelter allowance.

   □ The poverty level component is calculated using the applicable percentage (set out in §1924(d)(3)(B) of the Act) of the official poverty level.

   □ The poverty level component is calculated using a percentage greater than the applicable percentage, equal to ____% of the official poverty level (still subject to maximum maintenance needs standard).

   ☑ The maintenance needs standard for all community spouses is set at the maximum permitted by §1924(d)(3)(C).

Except that, when applicable, the State will set the community spouse's monthly income allowance at the amount by which exceptional maintenance needs, established at a fair hearing, exceed the community spouse's income, or at the amount of any court-ordered support.

TN No. 09-32 Approval Date 6-7-10 Effective Date 9-1-09

Supersedes TN No. 98-02

SUPERScedes: TN- 98-02
B. Posteligibility Treatment of Institutionalized Individuals' Incomes, Cont.

In determining any excess shelter allowance, utility expenses are calculated using:

☐ the standard utility allowance under §5(e) of the Food Stamp Act of 1977; or

☐ the actual unreimbursable amount of the community spouse's utility expenses less any portion of such amount included in condominium or cooperative charges.

b. The monthly income allowance for other dependent family members living with the community spouse is:

☒ one-third of the amount by which the poverty level component (calculated under §1924(d)(3)(A)(i) of the Act, using the applicable percentage specified in §1924 (d)(3)(B) ) exceeds the dependent family member's monthly income.

☐ a greater amount calculated as follows:

The following definition is used in lieu of the definition provided by the Secretary to determine the dependency of family members under §1924 (d)(1):

c. Amounts for health care expenses described below that are incurred by and for the institutionalized individual and are not subject to payments by a third party:

(i) Medicaid, Medicare, and other health insurance premiums, deductibles, or coinsurance charges, or copayments.

(ii) Necessary medical or remedial care recognized under State law but not covered under the State plan. (Reasonable limits on amounts are described in Supplement 3 to ATTACHMENT 2.6-A).
State: TEXAS

<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>435.725</td>
<td>B. Posteligibility Treatment of Institutionalized Individuals' Incomes, Cont.</td>
</tr>
<tr>
<td>435.733</td>
<td>4. In addition to any amount deductible under the items above, the following monthly amounts are deducted from the remaining monthly income of an institutionalized individual or an institutionalized couple:</td>
</tr>
<tr>
<td>435.832</td>
<td>a. An amount for the maintenance of each member of a family living in the institutionalized individual's home with no community spouse living in the home. The amount must be based on a reasonable assessment of need but must not exceed the higher of the:</td>
</tr>
<tr>
<td></td>
<td>• AFDC level; or</td>
</tr>
<tr>
<td></td>
<td>• Medically needy level:</td>
</tr>
<tr>
<td></td>
<td>☑ AFDC levels in Supplement 1</td>
</tr>
<tr>
<td></td>
<td>☐ Medically needy level in Supplement 1</td>
</tr>
<tr>
<td></td>
<td>☐ Other: $______</td>
</tr>
<tr>
<td></td>
<td>b. Amounts for health care expenses described below that have not been deducted under 3c above (i.e., for an institutionalized individual with a community spouse), are incurred by and for the institutionalized individual or institutionalized couple, and are not subject to the payment by a third party:</td>
</tr>
<tr>
<td></td>
<td>(i) Medicaid, Medicare, and other health insurance premiums, deductibles, or coinsurance charges, or copayments.</td>
</tr>
<tr>
<td></td>
<td>(ii) Necessary medical or remedial care recognized under State law but not covered under the State plan. (Reasonable limits on amount are described in Supplement 3 to Attachment 2.6-A)</td>
</tr>
<tr>
<td>435.725</td>
<td>5. At the option of the State, as specified below, the following is deducted from any remaining monthly income of an institutionalized individual or an institutionalized couple:</td>
</tr>
<tr>
<td>435.733</td>
<td>A monthly amount for the maintenance of the home of the individual or couple for not longer than 6 months if a physician has certified that the individual, or one member of the institutionalized couple, is likely to return to the home within that period:</td>
</tr>
<tr>
<td>435.832</td>
<td>☑ Yes (the applicable amount if shown on page 5a).</td>
</tr>
</tbody>
</table>

TN No. 09-32 Approval Date 6-7-10 Effective Date 9-1-09
Supersedes TN No. 98-02
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State: TEXAS

<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>B.</td>
<td>Posteligibility Treatment of Institutionalized Individuals' Incomes, Cont.</td>
</tr>
</tbody>
</table>

☐ Amount for maintenance of home is: $_____.

☒ Amount for maintenance of home is the actual maintenance costs not to exceed $*_____.

☐ Amount for maintenance of home is deductible when countable income is determined under §1924(d)(1) of the Act only if the individual's home and the community spouse's home are different.

Amount for maintenance of home is not deductible when countable income is determined under §1924 (d)(1) of the Act.

* the SSI income limit (excluding the $20.00 disregard)
### ELIGIBILITY CONDITIONS AND REQUIREMENTS

<table>
<thead>
<tr>
<th>Citation(s)</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>42 CFR 435.711, 435.721, 435.831</td>
<td>C. Financial Eligibility</td>
</tr>
</tbody>
</table>

For individuals who are **AFDC** or **SSI** recipients, the income and resource levels and methods for determining countable income and resources of the **AFDC** and **SSI** program apply, unless the plan provides for more restrictive levels and methods than **SSI** for **SSI** recipients under section 1902(f) of the Act, or more liberal methods under section 1902(r)(2) of the Act, as specified below.

For individuals who are not **AFDC** or **SSI** recipients in a non-section 1902(f) State and those who are deemed to be cash assistance recipients, the financial eligibility requirements specified in this section C apply.

STATE: TEXAS

<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>X Supplement 2 to ATTACHMENT 2.6-A specifies the resource levels for mandatory and optional categorically needy poverty level related groups, and for medically needy groups.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Supplement 7 to ATTACHMENT 2.6-A specifies the income levels for categorically needy aged, blind and disabled persons who are covered under requirements more restrictive than SSI.</td>
</tr>
<tr>
<td></td>
<td>Supplement 4 to ATTACHMENT 2.6-A specifies the methods for determining resource eligibility used by States that have more restrictive method than SSI, permitted under section 1902(f) of the Act.</td>
</tr>
<tr>
<td></td>
<td>Supplement 5 to ATTACHMENT 2.6-A specifies the methods for determining resource eligibility used by States that have more restrictive methods than SSI, permitted under section 1902(f) of the Act.</td>
</tr>
<tr>
<td>X Supplement 6a to ATTACHMENT 2.6-A specifies the methods for determining income eligibility used by States that are more liberal than the methods of the cash assistance programs, permitted under section 1902(r)(2) of the Act.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Supplement 8b to ATTACHMENT 2.6-A specifies the methods for determining resource eligibility used by States that are more liberal than the methods of the cash assistance programs, permitted under section 1902(r)(2) of the Act.</td>
</tr>
<tr>
<td></td>
<td>Supplement 14 to ATTACHMENT 2.6-A specifies income levels used by States for determining eligibility of Tuberculosis-infected individuals whose eligibility is determined under §1902(a)(1) of the Act.</td>
</tr>
</tbody>
</table>

Superseded Approval Date 06/18/97 Effective Date 04/01/97
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Texas

ELIGIBILITY CONDITIONS AND REQUIREMENTS

<table>
<thead>
<tr>
<th>Citation(s)</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(r)(2)</td>
<td>1. Methods of Determining Income</td>
</tr>
<tr>
<td>of the Act</td>
<td>a. AFDC-related individuals (except for poverty level related pregnant women, infants, and children).</td>
</tr>
<tr>
<td></td>
<td>(1) In determining countable income for AFDC-related individuals, the following methods are used:</td>
</tr>
<tr>
<td></td>
<td>(a) The methods under the State's approved AFDC plan only; or</td>
</tr>
<tr>
<td></td>
<td>(b) The methods under the State's approved AFDC plan and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td>1902(e)(6)</td>
<td>2. In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.</td>
</tr>
<tr>
<td>the Act</td>
<td>3. Agency continues to treat women eligible under the provisions of sections 1902(a)(10) of the Act as eligible, without regard to any changes in income of the family of which she is a member, for the 60-day period after her pregnancy ends and any remaining days in the month in which the 60th day falls.</td>
</tr>
</tbody>
</table>
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Texas

ELIGIBILITY CONDITIONS AND REQUIREMENTS

<table>
<thead>
<tr>
<th>Citation(s)</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>42 CFR 435.721, 435.831, and 1902(m)(1)(B)(m)(4) and 1902(r)(2) of the Act</td>
<td>b. Aged individuals. In determining countable income for aged individuals, including aged individuals with incomes up to the Federal poverty level described in section 1902(m)(1) of the Act, the following methods are used:</td>
</tr>
<tr>
<td></td>
<td>XXX The methods of the SSI program only.</td>
</tr>
<tr>
<td></td>
<td>The methods of the SSI program and/or any more liberal methods described in Supplement</td>
</tr>
<tr>
<td></td>
<td>8a to ATTACHMENT 2.6-A.</td>
</tr>
</tbody>
</table>

Effective Date: APR 01 1992
For individuals other than optional State supplement recipients, more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in Supplement 4 to ATTACHMENT 2.6-A; and any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.

For institutional couples, the methods specified under section 1611(e)(5) of the Act.

For optional State supplement recipients under §435.230, income methods more liberal than SSI, as specified in Supplement 4 to ATTACHMENT 2.6-A.

For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements—

SSI methods only.

SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A.

Methods more restrictive and/or more liberal than SSI. More restrictive methods are described in Supplement 4 to ATTACHMENT 2.6-A and more liberal methods are described in Supplement 8a to ATTACHMENT 2.6-A.

In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses.
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>42 CFR 435.721 and 435.831, 1902(m)(1)(B), (m)(4), and 1902(r)(2) of the Act</td>
<td>c. Blind individuals. In determining countable income for blind individuals, the following methods are used:</td>
</tr>
<tr>
<td></td>
<td>XXX The methods of the SSI program only.</td>
</tr>
<tr>
<td></td>
<td>— SSI methods and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td></td>
<td>— For individuals other than optional State supplement recipients, more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in Supplement 4 to ATTACHMENT 2.6-A, and any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td></td>
<td>XXX For institutional couples, the methods specified under section 1611(e)(5) of the Act.</td>
</tr>
<tr>
<td></td>
<td>— For optional State supplement recipients under §435.230, income methods more liberal than SSI, as specified in Supplement 4 to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td></td>
<td>— For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements—</td>
</tr>
<tr>
<td></td>
<td>— SSI methods only.</td>
</tr>
<tr>
<td></td>
<td>— SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td></td>
<td>— Methods more restrictive and/or more liberal than SSI. More restrictive methods are described in Supplement 4 to ATTACHMENT 2.6-A and more liberal methods are described in Supplement 8a to ATTACHMENT 2.6-A.</td>
</tr>
</tbody>
</table>
In determining relative responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.

In determining countable income of disabled individuals, including individuals with incomes up to the Federal poverty level described in section 1902(m) of the Act the following methods are used:

- The methods of the SSI program.
- SSI methods and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.
- For institutional couples: the methods specified under section 1611(e)(5) of the Act.
- For optional State supplement recipients under §435.230: income methods more liberal than SSI, as specified in Supplement 4 to ATTACHMENT 2.6-A.
- For individuals other than optional State supplement recipients (except aged and disabled individuals described in section 1903(m)(1) of the Act): more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in Supplement 4 to ATTACHMENT 2.6-A; and any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.
For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements—

SSI methods only.

SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A.

Methods more restrictive and/or more liberal than SSI, except for aged and disabled individuals described in section 1902(m)(1) of the Act. More restrictive methods are described in Supplement 4 to ATTACHMENT 2.6-A and more liberal methods are specified in Supplement 8a to ATTACHMENT 2.6-A.

In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Texas

ELIGIBILITY CONDITIONS AND REQUIREMENTS

<table>
<thead>
<tr>
<th>Citation(s)</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(1)(3)(E) and 1902(r)(2) of the Act</td>
<td>e. Poverty level pregnant women, infants, and children. For pregnant women and infants or children covered under the provisions of sections 1902(a)(10)(A)(i)(IV), (VI), and (VII), and 1902(a)(10)(A)(ii)(IX) of the Act--</td>
</tr>
<tr>
<td></td>
<td>(1) The following methods are used in determining countable income:</td>
</tr>
<tr>
<td></td>
<td>XXX The methods of the State's approved AFDC plan.</td>
</tr>
<tr>
<td></td>
<td>The methods of the approved title IV-E plan.</td>
</tr>
<tr>
<td></td>
<td>The methods of the approved AFDC State plan and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td></td>
<td>The methods of the approved title IV-E plan and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.</td>
</tr>
</tbody>
</table>

Deleted from State's Letter Dated 10-4-2016 under Transmittal Number TX 16-0024, with Effective Date of 10-1-2016. This action was approved on 12-21-2016.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Texas

ELIGIBILITY CONDITIONS AND REQUIREMENTS

<table>
<thead>
<tr>
<th>Citation(s)</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(e)(6) of the Act</td>
<td>(2) In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.</td>
</tr>
<tr>
<td>1905(p)(1), 1902(m)(4), and 1902(r)(2) of the Act</td>
<td>(3) The agency continues to treat women eligible under the provisions of sections 1902(a)(10) of the Act as eligible, without regard to any changes in income of the family of which she is a member, for the 60-day period after her pregnancy ends and any remaining days in the month in which the 60th day falls.</td>
</tr>
<tr>
<td></td>
<td>f. Qualified Medicare beneficiaries. In determining countable income for qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act, the following methods are used:</td>
</tr>
</tbody>
</table>

- XXX The methods of the SSI program only. |
- ___ SSI methods and/or any more liberal methods than SSI described in Supplement Sa to ATTACHMENT 2.6-A. |
- XXX For institutional couples, the methods specified under section 1611(e)(5) of the Act. |
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>If an individual receives a title II benefit, any amounts attributable to the most recent increase in the monthly insurance benefit as a result of a title II COLA is not counted as income during a &quot;transition period&quot; beginning with January, when the title II benefit for December is received, and ending with the last day of the month following the month of publication of the revised annual Federal poverty level.</td>
</tr>
<tr>
<td></td>
<td>For individuals with title II income, the revised poverty levels are not effective until the first day of the month following the end of the transition period.</td>
</tr>
<tr>
<td></td>
<td>For individuals not receiving title II income, the revised poverty levels are effective no later than the date of publication.</td>
</tr>
<tr>
<td>1905(s) of the Act</td>
<td>g. (1) <strong>Qualified disabled and working individuals.</strong></td>
</tr>
<tr>
<td></td>
<td>In determining countable income for qualified disabled and working individuals covered under 1902(a)(10)(E)(ii) of the Act, the methods of the SSI program are used.</td>
</tr>
<tr>
<td>1905(p) of the Act</td>
<td>(2) <strong>Specified low-income Medicare beneficiaries.</strong></td>
</tr>
<tr>
<td></td>
<td>In determining countable income for specified low-income Medicare beneficiaries covered under 1902(a)(10)(E)(iii) of the Act, the same method as in f. is used.</td>
</tr>
</tbody>
</table>

**Supersedes**

MAY 03 1993

Effective Date JAN 01 1993

<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
</table>
| 1902(u) of the Act | (h) **COBRA Continuation Beneficiaries**

In determining countable income for COBRA continuation beneficiaries, the following disregards are applied:

- The disregards of the SSI program;
- The agency uses methodologies for treatment of income more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 to Attachment 2.6-A.

**NOTE:** For COBRA continuation beneficiaries specified at 1902(u)(4), costs incurred from medical care or for any other type of remedial care shall not be taken into account in determining income, except as provided in section 1612(b)(4)(B)(ii).
In determining countable income and resources for (ii)(XIII) of the working individuals with disabilities under the BBA, as described in No. 23 on page 23e of Attachment 2.2-A, the following methodologies are applied:

- [ ] The methodologies of the SSI program.
- [ ] The agency uses methodologies for treatment of income and resources more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 (income) and/or Supplement 5 (resources) to Attachment 2.6-A.
- [X] The agency uses more liberal income and/or resource methodologies than the SSI program. More liberal income methodologies are described in Supplement 8a to Attachment 2.6-A. More liberal resource methodologies are described in Supplement 8b to Attachment 2.6-A.
- [X] The agency requires individuals to pay premiums or other cost-sharing charges. The premiums or other cost-sharing charges, and how they are applied, are described below:

<table>
<thead>
<tr>
<th>Approval Date</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>12-20-06</td>
<td>9-1-06</td>
</tr>
</tbody>
</table>

Supersedes TN No. 06-01

STATE: TEXAS
DATE REC'D: 9-21-06
DATE APP'D: 12-26-06
DATE EFF: 9-1-06
HCFA 170: 06-01
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Texas

Citations

Conditions or Requirements

Payment of Premiums or Other Cost-Sharing Charges

For individuals eligible under the BBA eligibility group:

- The agency requires individuals to pay premiums or other cost-sharing charges on a sliding scale based on income. The premiums or other cost-sharing charges, and how they are applied, are described below:

As a condition of establishing initial MBI eligibility and to remain eligible, a person is required to pay monthly premiums based on the amount of the person's countable earned and countable unearned income.

The monthly premium amount is:

- the amount of a person's countable unearned income for the month that exceeds the Federal Benefit Rate for SSI for an individual; plus
- a flat fee amount, not to exceed $50, based on the amount of the person's countable earned income for the month whenever it exceeds 150% of the Federal Poverty Limit (FPL). The monthly earned income premium amounts follow:

<table>
<thead>
<tr>
<th>Monthly Countable Earned Income</th>
<th>Premiums</th>
</tr>
</thead>
<tbody>
<tr>
<td>Above 150% FPL up to and including 185% FPL</td>
<td>$20</td>
</tr>
<tr>
<td>Above 185% FPL up to and including 200% FPL</td>
<td>$25</td>
</tr>
<tr>
<td>Above 200% FPL up to and including 250% FPL</td>
<td>$30</td>
</tr>
<tr>
<td>Above 250% FPL</td>
<td>$40</td>
</tr>
</tbody>
</table>

The upper limit for the total monthly premium per person is $500. If the unearned income premium amount plus the earned income premium amount equals or exceeds $500, then the total monthly premium remains at $500.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Texas

Citations

Conditions or Requirements

Persons residing in a federally-declared disaster area are exempt from being required to pay monthly premiums and other cost sharing charges for the MBI program. A person can only be exempt from payment for up to three months and once per disaster.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State: TEXAS

Citation | Groups Covered
---------|------------------
1902(cc) and 1903(a) of the Act | Interaction with Employer Sponsored Family Coverage

For individuals eligible under the FOA eligibility group described in No. 26 on page 23f of Attachment 2.2-A:

The agency requires parents to enroll in available group health plans through their employers if the plan qualifies under Section 2791(a) of the Public Health Service Act and the employer contributes at least 50 percent of the total cost of annual premiums for such coverage.

If such coverage is obtained, the agency (subject to the payment of premiums described in Attachment 2.6-A, pages 12e and 12f) reduces any premium imposed by the State by an amount that reasonably reflects the premium contribution made by the parent for private coverage on behalf of a child with a disability; and treats such coverage as a third party liability.

The agency provides for payment of all or some portion of the annual premium for the employer-provided private family coverage that the parent is required to pay. Any payments made by the State are considered, for purposes of section 1903(a), to be payments for medical assistance.

The agency pays 100 percent of the premiums for employer-sponsored family coverage for families enrolled in the state's Medicaid premium assistance program under Section 1906 of the Act.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State: TEXAS

Citation Groups Covered

1902(a)(10)(A) (ii)(XIX), 1916(i) and 1902(cc)(2)(A)(ii)(I) of the Act

Payment of Premiums MCD

For individuals eligible under the FOA eligibility group described in No. 26 on page 23f of Attachment 2.2-A:

☐ The agency does not require the payment of premiums for Medicaid coverage.

☒ The agency requires payment of premiums on a sliding scale based on income. The premiums and how they are applied are described below:

The state requires monthly premiums for the FOA program, which increase based on family income. The state reduces the monthly premium amounts for certain families enrolled in employer-sponsored family coverage and waives monthly premiums for undue hardship as described below.

Full Monthly Premiums

The state charges full monthly premiums for families who are not enrolled in employer-sponsored family coverage. The full monthly premium amounts follow:

<table>
<thead>
<tr>
<th>Family Income</th>
<th>Persons in Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>At or below 150% FPL</td>
<td>None, None</td>
</tr>
<tr>
<td>151-200% FPL</td>
<td>$90, $115</td>
</tr>
<tr>
<td>201-300% FPL</td>
<td>$180, $230</td>
</tr>
</tbody>
</table>

Note: Monthly premium amounts are per family.

State of Texas

TN No. 10-02 Approval Date 5-27-10 Effective Date 1-1-11

Supersedes TN No. SUPERSEDES: NONE - NEW PAGE
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State: TEXAS

Citation Groups Covered

1902(a)(10)(A) Reduced Monthly Premiums
(ii)(XIX), 1916(i) and The state charges reduced monthly premiums for families
1902(cc)(2)(A)(ii)(l) enrolled in employer-sponsored family coverage who receive
of the Act premium assistance from the state under Section 1906 of

<table>
<thead>
<tr>
<th>Family Income</th>
<th>Persons in Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>At or below 150% FPL</td>
<td>None</td>
</tr>
<tr>
<td>151-200% FPL</td>
<td>$25</td>
</tr>
<tr>
<td>201-300% FPL</td>
<td>$50</td>
</tr>
</tbody>
</table>

Note: Monthly premium amounts are per family.

NOTE: Amounts paid for premiums for Medicaid, required
family coverage, and other cost-sharing may not exceed 5%
of a family’s income for families with income up to and
including 200% FPL and 7.5% of a family’s income for
families above 200% and up to 300% FPL.

The annual aggregate cost-sharing limits per family follow:

<table>
<thead>
<tr>
<th>Family Income</th>
<th>Annual Cost-Sharing Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>At or below 200% FPL</td>
<td>5% of gross annual income</td>
</tr>
<tr>
<td>201-300% FPL</td>
<td>7.5% of gross annual income</td>
</tr>
</tbody>
</table>

The annual aggregate cost-sharing limits described above
apply to monthly premiums for the FOA program and cost
sharing for employer-sponsored family coverage. For
families without employer-sponsored family coverage, the
state determines when FOA premium payments reach the
cost-sharing limits. Families with employer-sponsored family
coverage must track their cost-sharing expenditures and
report to the state when they reach their annual cost-sharing
limits. Families are not required to pay monthly premiums for
the FOA program once they reach their annual cost-sharing
limits.

Supersedes TN No. SUPERSEDES: NONE - NEW PAGE
# STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

### MEDICAL ASSISTANCE PROGRAM

**State:** TEXAS

<table>
<thead>
<tr>
<th>Citation</th>
<th>Groups Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(a)(10)(A) (ii)(XIX), 1916(i) and 1902(cc)(2)(A)(ii)(l) of the Act</td>
<td>Payment of Premiums (Continued)</td>
</tr>
</tbody>
</table>

**NOTE:** A State may not require prepayment of premiums and may not terminate eligibility of a child for medical assistance on the basis of failure to pay a premium until the failure to pay continues for at least 60 days from the date on which the premium was past due.

The state does not require prepayment of premiums to establish initial eligibility for the FOA program. However, families must pay monthly premiums to remain eligible for the FOA program. The state terminates FOA eligibility for failure to pay premiums the first month beginning after 60 days from the date on which premiums are past due.

**NOTE:** The State may waive payment of any such premium in any case where the State determines that requiring payment would create an undue hardship.

### Waivers for Undue Hardship

The state waives monthly premiums for the FOA program for:

- Native Americans and Alaskan Natives.
- Families enrolled in employer-sponsored family coverage who are not receiving premium assistance from the state under Section 1906 of the Act.

The state also waives premiums for 3 months for:

- Families residing in a federally-declared disaster area. A family can only receive one waiver per disaster.
- Loss of income due to layoff or business closing, involuntary reduction in work hours, or change in marital status. A family can only receive one waiver for loss of income per 12 months.

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**STATE**

**TEXAS**

**DATE REC'D:** 2-26-10  
**DATE APP'MD:** 5-27-10  
**DATE EFF:** 1-1-11  
**HCPA 179:** 10-02

**TN No.:** 10-02  
**Approval Date:** 5-27-10  
**Effective Date:** 1-1-11  
**Supersedes TN No.:** SUPERSEDES: NONE - NEW PAGE
2. Medicaid Qualifying Trusts

In the case of a Medicaid qualifying trust described in section 1902(k)(2) of the Act, the amount from the trust that is deemed available to the individual who established the trust (or whose spouse established the trust) is the maximum amount that the trustee(s) is permitted under the trust to distribute to the individual. This amount is deemed available to the individual, whether or not the distribution is actually made. This provision does not apply to any trust or initial trust decree established before April 7, 1986, solely for the benefit of a mentally retarded individual who resides in an intermediate care facility for the mentally retarded.

[ ] The agency does not count the funds in a trust as described above in any instance where the State determines that it would work an undue hardship. Supplement 10 of ATTACHMENT 2.6-A specifies what constitutes an undue hardship.

3. Medically needy income levels (MNILs) are based on family size.

Supplement 1 to ATTACHMENT 2.6-A specifies the MNILs for all covered medically needy groups. If the agency chooses more restrictive levels under section 1902(f) of the Act, Supplement 1 so indicates.
### Handling of Excess Income - Spend-down for the Medically Needy in All States and the Categorically Needy in 1902(f) States Only

**a. Medically Needy**

1. Income in excess of the MNIL is considered as available for payment of medical care and services. The Medicaid agency measures available income for periods of either **one** or **six** months (not to exceed 6 months) to determine the amount of excess countable income applicable to the cost of medical care and services.

2. If countable income exceeds the MNIL standard, the agency deducts the following incurred expenses in the following order:

   - **(a)** Health insurance premiums, deductibles and coinsurance charges.
   - **(b)** Expenses for necessary medical and remedial care not included in the plan.
   - **(c)** Expenses for necessary medical and remedial care included in the plan.

   Reasonable limits on amounts of expenses deducted from income under **(2)(a) and (b)** above are listed below.

   The only expenses not allowed are those paid before a potentially eligible month. Unpaid expenses are allowed if still considered a debt by the provider. A potentially eligible month includes: three month prior periods and the earliest possible month of regular coverage under **1902(a)(17) of the Act**.

   Incurred expenses that are subject to payment by a third party are not deducted unless the expenses are subject to payment by a third party that is a publicly funded program (other than Medicaid) of a State or local government.
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1903(f)(2) of the Act</td>
<td>(3) If countable income exceeds the MNIL standard, the agency deducts spenddown payments made to the State by the individual.</td>
</tr>
<tr>
<td>Citation</td>
<td>Condition or Requirement</td>
</tr>
<tr>
<td>----------</td>
<td>--------------------------</td>
</tr>
<tr>
<td><strong>b. Categorically Needy - Section 1902(f) States</strong></td>
<td></td>
</tr>
<tr>
<td>42 CFR 435.732</td>
<td>The agency applies the following policy under the provisions of section 1902(f) of the Act. The following amounts are deducted from income to determine the individual’s countable income:</td>
</tr>
<tr>
<td>(1)</td>
<td>Any SSI benefit received.</td>
</tr>
<tr>
<td>(2)</td>
<td>Any State supplement received that is within the scope of an agreement described in sections 1616 or 1634 of the Act, or a State supplement within the scope of section 1902(a)(10)(A)(ii)(XI) of the Act.</td>
</tr>
<tr>
<td>(3)</td>
<td>Increases in OASDI that are deducted under §§435.134 and 435.135 for individuals specified in that section, in the manner elected by the State under that section.</td>
</tr>
<tr>
<td>(4)</td>
<td>Other deductions from income described in this plan at Attachment 2.6-A, Supplement 4.</td>
</tr>
<tr>
<td>(5)</td>
<td>Incurred expenses for necessary medical and remedial services recognized under State law.</td>
</tr>
<tr>
<td>1902(a)(17) of the Act, P.L. 100-203</td>
<td>Incurred expenses that are subject to payment by a third party are not deducted unless the expenses are subject to payment by a third party that is a publicly funded program (other than Medicaid) of a State or local government.</td>
</tr>
</tbody>
</table>
Citation | Condition or Requirement
---|---
4.b. **Categorically Needy - Section 1902(f) States**
Continued
1903(f)(2) of the Act | (6) Spenddown payments made to the State by the individual.

**NOTE:** FFP will be reduced to the extent a State is paid a spenddown payment by the individual.
5. Methods for Determining Resources
   
a. AFDC-related individuals (except for poverty level related pregnant women, infants, and children).

   (1) In determining countable resources for AFDC-related individuals, the following methods are used:

      (a) The methods under the State's approved AFDC plan; and

      (b) The methods under the State's approved AFDC plan and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A.

   (2) In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.
### 5. Methods for Determining Resources

<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B) and (C), and 1902(r) of the Act</td>
<td>b. <strong>Aged individuals.</strong> For aged individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act, the agency used the following methods for treatment of resources:</td>
</tr>
<tr>
<td>YYYY</td>
<td>The methods of the SSI program.</td>
</tr>
<tr>
<td></td>
<td>SSI methods and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td></td>
<td>Methods that are more restrictive (except for individuals described in section 1902(m)(1) of the Act) and/or more liberal than those of the SSI program. Supplement 5 to ATTACHMENT 2.6-A describes the more restrictive methods and Supplement 8b to ATTACHMENT 2.6-A specifies the more liberal methods.</td>
</tr>
</tbody>
</table>
In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses.

1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B), and 1902(r) of the Act

c. Blind individuals. For blind individuals the agency uses the following methods for treatment of resources:

XXX The methods of the SSI program.

SSI methods and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A.

Methods that are more restrictive and/or more liberal than those of the SSI program. Supplement 5 to ATTACHMENT 2.6-A describe the more restrictive methods and Supplement 8b to ATTACHMENT 2.6-A specify the more liberal methods.

In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.
d. Disabled individuals, including individuals covered under section 1902(a)(10)(A)(i)(X) of the Act. The agency uses the following methods for the treatment of resources:

- XXX The methods of the SSI program.

- SSI methods and/or any more liberal methods described in Supplement Bb to ATTACHMENT 2.6-A.

- Methods that are more restrictive (except for individuals described in section 1902(m)(1) of the Act) and/or more liberal that those under the SSI program. More restrictive methods are described in Supplement 5 to ATTACHMENT 2.6-A and more liberal methods are specified in Supplement Bb to ATTACHMENT 2.6-A.

In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.


The agency uses the following methods in the treatment of resources.

- The methods of the SSI program only.

- The methods of the SSI program and/or any more liberal methods described in Supplement Bb or Supplement Bb to ATTACHMENT 2.6-A.
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(l)(3) and 1902(r)(2) of the Act</td>
<td>Methods that are more liberal than those of SSI. The more liberal methods are specified in Supplement 5a or Supplement Bb to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td>XXX</td>
<td>Not applicable. The agency does not consider resources in determining eligibility.</td>
</tr>
<tr>
<td>1902(l)(3)(C) of the Act</td>
<td>Methods more liberal than those in the State's approved AFDC plan, in accordance with section 1902(l)(3)(C) of the Act, as specified in Supplement 5a of ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td>1902(r)(2) of the Act</td>
<td>Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as described in Supplement 5a or Supplement Bb to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td>f. Poverty level infants covered under section 1902(a)(10)(A)(i)(IV) of the Act.</td>
<td>The agency uses the following methods for the treatment of resources:</td>
</tr>
<tr>
<td>XXX</td>
<td>Not applicable. The agency does not consider resources in determining eligibility.</td>
</tr>
</tbody>
</table>

Deleted from State's Letter Dated 10-4-2016 under Transmittal Number TX 16-0024, with Effective Date of 10-1-2016. This action was approved on 12-21-2016.
# STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: **Texas**

## ELIGIBILITY CONDITIONS AND REQUIREMENTS

### Citation(s)

<table>
<thead>
<tr>
<th>Citation(s)</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(1)(3) and 1902(r)(2) of the Act</td>
<td>g. 1. Poverty level children covered under section 1902(a)(10)(A)(i)(VI) of the Act. The agency uses the following methods for the treatment of resources: The methods of the State's approved AFDC plan. XXX Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), in accordance with section 1902(1)(3)(C) of the Act, as specified in Supplement 5a of ATTACHMENT 2.6-A. Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as described in Supplement 8b to ATTACHMENT 2.6-A. Not applicable. The agency does not consider resources in determining eligibility. In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.</td>
</tr>
<tr>
<td>1902(1)(3)(C) of the Act</td>
<td></td>
</tr>
</tbody>
</table>
| 1902(r)(2) of the Act | }
# STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

## State: Texas

### ELIGIBILITY CONDITIONS AND REQUIREMENTS

<table>
<thead>
<tr>
<th>Citation(s)</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(1)(3) and 1902(r)(2) of the Act</td>
<td>g. 2. Poverty level children under section 1902(a)(10)(A)(i)(VII) The agency uses the following methods for the treatment of resources:</td>
</tr>
<tr>
<td>1902(1)(3)(C) of the Act</td>
<td>Methods more liberal than those in the State's approved AFDC plan (but not more restrictive) as specified in Supplement 5a of ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td>1902(r)(2) of the Act</td>
<td>Methods more liberal than those in the State's approved AFDC plan (but not more restrictive), as described in Supplement 8a to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td>1902(r)(2) of the Act</td>
<td>Not applicable. The agency does not consider resources in determining eligibility.</td>
</tr>
</tbody>
</table>

In determining relative responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.

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<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
</table>
| 1905(p)(1) (C) and (D) and 1902(r)(2) of the Act | 5. h. For Qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(ii) of the Act the agency uses the following methods for treatment of resources:  
 XXX The methods of the SSI program only.  
 XXX The methods of the SSI program and/or more liberal methods as described in Supplement 8b to ATTACHMENT 2.6-A. |
| 1905(s) of the Act | i. For qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, the agency uses SSI program methods for the treatment of resources. |
| 1902(u) of the Act | j. For COBRA continuation beneficiaries, the agency uses the following methods for treatment of resources:  
 XXX The methods of the SSI program only.  
 XXX More restrictive methods applied under section 1902(f) of the Act as described in Supplement 5 to Attachment 2.6-A. |

**TN No.:** 92-12  
**Supersedes Approval Date:** APR 29 1992  
**Effective Date:** JAN 01 1992  
**HCFA ID:** 7985E
6. Resource Standard - Categorically Needy

a. 1902(f) States (except as specified under items 6.c. and d. below) for aged, blind and disabled individuals:

- Same as SSI resource standards.

- More restrictive.

The resource standards for other individuals are the same as those in the related cash assistance program.

b. Non-1902(f) States (except as specified under items 6.c. and d. below)

The resource standards are the same as those in the related cash assistance program.

Supplement 8 to ATTACHMENT 2.6-A specifies for 1902(f) States the categorically needy resource levels for all covered categorically needy groups.
**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

State: Texas

**ELIGIBILITY CONDITIONS AND REQUIREMENTS**

<table>
<thead>
<tr>
<th>Citation(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(1)(3)(A), (B) and (C) of the Act</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>c. For pregnant women covered under the provisions of section 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Act, the agency applies a resource standard.</td>
</tr>
</tbody>
</table>

| XXX Yes. Supplement 2 to ATTACHMENT 2.6-A specifies the standard which is no more restrictive than the standard under the SSI program. |

| XXX No. The agency does not apply a resource standard to these individuals. |

For infants covered under the provisions of section 1902(a)(10)(A)(i)(IV) and 1902(a)(10)(A)(ii)(IX) of the Act, the agency applies a resource standard.

| XXX Yes. Supplement 2 to ATTACHMENT 2.6-A specifies the standard which is no more restrictive than the standard applied in the State's approved AFDC plan. |

| XXX No. The agency does not apply a resource standard to these individuals. |

| d. For children covered under the provisions of section 1902(a)(10)(A)(i)(VI) of the Act, the agency applies a resource standard. |

| XXX Yes. Supplement 2 to ATTACHMENT 2.6-A specifies the standard which is no more restrictive than the standard applied in the State's approved AFDC plan. |

| XXX No. The agency does not apply a resource standard to these individuals. |

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<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>e. For children covered under the provisions of section 1902(a)(10)(A)(i)(VII) of the Act, the agency applies a resource standard.</td>
<td>Yes. Supplement 2 to ATTACHMENT 2.6-A specifies the standard which is no more restrictive than the standard applied in the State's approved AFDC plan.</td>
</tr>
<tr>
<td>No. The agency does not apply a resource standard to these individuals.</td>
<td></td>
</tr>
<tr>
<td>f. For aged and disabled individuals described in section 1902(a)(1) of the Act who are covered under section 1902(a)(10)(A)(i)(II)(X) of the Act, the resource standard is:</td>
<td>Same as SSI resource standards.</td>
</tr>
<tr>
<td>Same as the medically needy resource standards, which are higher than the SSI resource standards (if the State covers the medically needy).</td>
<td>Supplement 2 to ATTACHMENT 2.6-A specifies the resource levels for these individuals.</td>
</tr>
</tbody>
</table>
7. Resource Standard - Medically Needy

a. Resource standards are based on family size.

1902(a)(10)(C)(i) of the Act

b. A single standard is employed in determining resource eligibility for all groups.

c. In 1902(f) States, the resource standards are more restrictive than in 7.b. above for--

   _ Aged
   ___ Blind
   ___ Disabled

Supplement 2 to Attachment 2.6-A specifies the resource standards for all covered medically needy groups. If the agency chooses more restrictive levels under 7.c., Supplement 2 to Attachment 2.6-A so indicates.

8. Resource Standard - Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries and Qualifying Individuals

For Qualified Medicare Beneficiaries covered under section 1902(a)(10)(E)(i) of the Act, Specified Low-Income Medicare Beneficiaries covered under section 1902(a)(10)(E)(iii) of the Act, and Qualifying Individuals covered under 1902(a)(10)(E)(iv) of the Act, the resource standard is three times the SSI resource limit, adjusted annually by the increase in the Consumer Price Index (CPI).
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(u) of the Act</td>
<td>10. For COBRA continuation beneficiaries, the resource standard is:</td>
</tr>
</tbody>
</table>

- Twice the SSI resource standard for an individual.
- More restrictive standard as applied under section 1902(f) of the Act as described in Supplement 8 to Attachment 2.6-A.
10. Excess Resources

a. Categorically Needy, Qualified Medicare Beneficiaries, Qualified Disabled and Working Individuals, and Specified Low-Income Medicare Beneficiaries

Any excess resources make the individual ineligible.

b. Categorically Needy Only

XXX This State has a section 1634 agreement with SSI. Receipt of SSI is provided for individuals while disposing of excess resources.

c. Medically Needy

Any excess resources make the individual ineligible.
11. Effective Date of Eligibility

a. Groups Other Than Qualified Medicare Beneficiaries

(1) For the prospective period.

Coverage is available for the full month if the following individuals are eligible at any time during the month.

XXX Aged, blind, disabled.
_____ AFDC-related.

Coverage is available only for the period during the month for which the following individuals meet the eligibility requirements.

XXX Aged, blind, disabled.
_____ AFDC-related.

(2) For the retroactive period.

Coverage is available for three months before the date of application if the following individuals would have been eligible had they applied:

XXX Aged, blind, disabled.
XXX AFDC-related.

Coverage is available beginning the first day of the third month before the date of application if the following individuals would have been eligible at any time during that month, had they applied.

_____ Aged, blind, disabled.
_____ AFDC-related.
### Eligibility Conditions and Requirements

<table>
<thead>
<tr>
<th>Citation(s)</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1920(b)(1) of the Act</td>
<td>XXX(3) For a presumptive eligibility period for pregnant women only. Coverage is available for ambulatory prenatal care for the period that begins on the day a qualified provider determines that a woman meets any of the income eligibility levels specified in ATTACHMENT 2.6-A of this approved plan. If the woman files an application for Medicaid by the last day of the month following the month in which the qualified provider made the determination of presumptive eligibility, the period ends on the day that the State agency makes the determination of eligibility based on that application. If the woman does not file an application for Medicaid by the last day of the month following the month in which the qualified provider made the determination, the period ends on that last day.</td>
</tr>
</tbody>
</table>
| 1902(e)(8) and 1905(a) of the Act | XXX b. For qualified Medicare beneficiaries defined in section 1905(p)(1) of the Act coverage is available beginning with the first day of the month after the month in which the individual is first determined to be a qualified Medicare beneficiary under section 1905(p)(1). The eligibility determination is valid for: 

- 12 months
- 6 months
- months (no less than 6 months and no more than 12 months) |
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Texas

ELIGIBILITY CONDITIONS AND REQUIREMENTS

<table>
<thead>
<tr>
<th>Citation(s)</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>42 CFR 435.914 and</td>
<td>XXX c. For certified SSI clients, coverage begins the month prior to the first SSI payment month and would be available for the two preceding months if the individuals would have been eligible had they applied under 435.914</td>
</tr>
<tr>
<td>Sec. 204 of P.L. 104-193</td>
<td></td>
</tr>
</tbody>
</table>

STATE: TX
DATE REC'D: 9-29-97
DATE APV'D: 12-8-97
DATE EFF: 7-1-97
HCCA: 97-14

TN No. 97-14
Supersedes Approval Date 12-8-97 Effective Date 7-1-97

TN No. New
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(a)(18) and 1902(f)</td>
<td>12. Pre-OBRA 93 Transfer of Resources – Categorically and Medically Needy, Qualified Medicare Beneficiaries, and Qualified Disabled and Working Individuals</td>
</tr>
<tr>
<td>of the Act</td>
<td>The agency complies with the provisions of section 1917 of the Act with respect to the transfer of resources.</td>
</tr>
<tr>
<td></td>
<td>Disposal of resources at less than fair market value affects eligibility for certain services as detailed in Supplement 9 to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td>1917(c)</td>
<td>13. Transfer of Assets – All eligibility groups</td>
</tr>
<tr>
<td></td>
<td>The agency complies with the provisions of section 1917(c) of the Act, as enacted by OBRA 93, with regard to the transfer of assets.</td>
</tr>
<tr>
<td></td>
<td>Disposal of assets at less than fair market value affects eligibility for certain services as detailed in Supplement 9(a) to ATTACHMENT 2.6-A, except in instances where the agency determines that the transfer rules would work an undue hardship.</td>
</tr>
<tr>
<td>1917(d)</td>
<td>14. Treatment of Trusts – All eligibility groups</td>
</tr>
<tr>
<td></td>
<td>The agency complies with the provisions of section 1917(d) of the Act, as amended by OBRA 93, with regard to trusts.</td>
</tr>
<tr>
<td></td>
<td>The agency uses more restrictive methodologies under section 1902(f) of the Act, and applies those methodologies in dealing with trusts;</td>
</tr>
<tr>
<td></td>
<td>X The agency meets the requirements in section 1917(d)(f)(B) of the Act for use of Miller trusts.</td>
</tr>
<tr>
<td></td>
<td>The agency does not count the funds in a trust in any instance where the agency determines that the transfer would work an undue hardship, as described in Supplement 10 to ATTACHMENT 2.6-A.</td>
</tr>
</tbody>
</table>
15. The agency complies with the provisions of §1924 with respect to income and resource eligibility and post eligibility determinations for individuals who are expected to be institutionalized for at least 30 consecutive days and who have a spouse living in the community.

When applying the formula used to determine the amount of resources in initial eligibility determinations, the State standard for community spouses is:

- the maximum standard permitted by law;
- the minimum standard permitted by law; or
- a standard that is an amount between the minimum and the maximum: $___.

SUPERSEDES: TN- 98-02
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Texas

INCOME ELIGIBILITY LEVELS

A. MANDATORY CATEGORICALLY NEEDY

1. AFDC-Related Groups Other Than Poverty Level Pregnant Women and Infants:

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Need Standard Payment Standard</th>
<th>Maximum Payment Amounts</th>
</tr>
</thead>
</table>

2. Pregnant Women and Infants under Section 1902(a)(10)(i)(IV) of the Act:

   Effective 9/1/2004 based on the following percentage of the official Federal poverty income level – (as revised annually in the Federal Register)

   | 133 percent | 185 Percent (no more than 185 percent) for all ages |

   (specify) for all ages

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Income Level</th>
</tr>
</thead>
</table>

Deleted from State's Letter Dated 10-4-2016 under Transmittal Number TX 16-0024, with Effective Date of 10-1-2016. This action was approved on 12-21-2016.

STATE: Texas

DATE REC'D: 9-29-04
DATE APPV'D: 12-21-04
DATE EFF: 9-1-04
HCFA 179: 04-23

HCFA ID: 7985E
Deleted from SPA 16-0024 (Effective Date: 10/01/2016)
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Texas

INCOME ELIGIBILITY LEVELS

A. MANDATORY CATEGORICALLY NEEDY (Continued)

3. For children under Section 1902(a)(10)(i)(VI) of the Act (children who have attained age 1 but have not attained age 6), the income eligibility level is 133 percent of the Federal poverty level (as revised annually in the Federal Register) for the size family involved.

4. For children under Section 1902(a)(10)(i)(VII) of the Act (children who were born after September 30, 1983 and have attained age 6 but have not attained age 19), the income eligibility level is 100 percent of the Federal poverty level (as revised annually in the Federal Register) for the size family involved.

Deleted from State's Letter Dated 10-4-2016 under Transmittal Number TX 16-0024, with Effective Date of 10-1-2016. This action was approved on 12-21-2016.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Texas

INCOME ELIGIBILITY LEVELS (Continued)

B. OPTIONAL CATEGORICALLY NEEDY GROUPS WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

1. Pregnant Women and Infants

The levels for determining income eligibility for optional groups of pregnant women and infants under the provisions of sections 1902(a)(1)(A)(ii)(IX) and 1902(l)(2) of the act are as follows:

Based on 185 percent of the official Federal poverty income level (no less than 133 percent and no more than 185 percent) for infants and pregnant women, as revised annually in the Federal Register.

<table>
<thead>
<tr>
<th>Family size</th>
<th>Income Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$</td>
</tr>
<tr>
<td>2</td>
<td>$</td>
</tr>
<tr>
<td>3</td>
<td>$</td>
</tr>
<tr>
<td>4</td>
<td>$</td>
</tr>
<tr>
<td>5</td>
<td>$</td>
</tr>
</tbody>
</table>

Per each additional member

$
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Texas

OPTIONAL CATEGORICALLY NEEDY GROUPS WITH INCOMES RELATED TO THE SUPPLEMENTAL SECURITY INCOME (SSI) FEDERAL BENEFIT RATE

In accordance with 42 CFR 435.231, the State allows eligibility for individuals in institutions who are eligible under a special income level as follows:

<table>
<thead>
<tr>
<th>Type of Medical Institution</th>
<th>Income Eligibility Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>XX Nursing Facilities</td>
<td>300% of FBR</td>
</tr>
<tr>
<td>XX ICF/MR Facilities</td>
<td>300% of FBR</td>
</tr>
<tr>
<td>XX Acute Care Hospitals</td>
<td>Any amount under FBR</td>
</tr>
<tr>
<td>N/A* Inpatient Psychiatric Facilities for Under Age 21</td>
<td>300% of FBR</td>
</tr>
<tr>
<td>XX Institutions for Mental Diseases for Individuals 65 &amp; Over</td>
<td>300% of FBR</td>
</tr>
</tbody>
</table>

* Only through OBRA '89 EPSDT mandate

TN No. 94-30 Supersedes Approval Date: AUG 24 1995 Effective Date: NOV 16 1994

TN No. 94-25
Page 4 (TN 91-04) was deleted by TN 91-05
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Texas

INCOME ELIGIBILITY LEVELS (Continued)

3. Aged and Disabled Individuals

The levels for determining income eligibility for groups of aged and disabled individuals under the provisions of section 1902(m)(f) of the Act are as follows:

Based on _____ percent of the official Federal income poverty line.

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Income Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$__________</td>
</tr>
<tr>
<td>2</td>
<td>$__________</td>
</tr>
<tr>
<td>3</td>
<td>$__________</td>
</tr>
<tr>
<td>4</td>
<td>$__________</td>
</tr>
<tr>
<td>5</td>
<td>$__________</td>
</tr>
</tbody>
</table>

TN No. 91-34
Supersedes Approval Date JAN 14 1992 Effective Date JUL 01 1991
TN No. 91-10 Suppl. 1 to Attachment 2.6-A, pg 3
HCFA ID: 7985E

STATE Texas
DATE REC'D DEC 11 1991
DATE APP'ED JAN 14 1992
DATE EFF OCT 01 1991
HCFA 179 91-34
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Texas

INCOME ELIGIBILITY LEVELS (Continued)

C. QUALIFIED MEDICARE BENEFICIARIES WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

The levels for determining income eligibility for groups of qualified Medicare beneficiaries under the provisions of section 1905(p) (2) (A) of the Act are as follows:

a. Based on the following percent of the official Federal income poverty level:

Eff. Jan. 1, 1989: ☑ 85 percent ☐ ___ percent (no more than 100)
Eff. Jan. 1, 1990: ☑ 90 percent ☐ ___ percent (no more than 100)
Eff. Jan. 1, 1991: 100 percent
Eff. Jan. 1, 1992: 100 percent

b. Levels:

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Income Levels</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$ 568.00</td>
</tr>
<tr>
<td>2</td>
<td>$ 766.00</td>
</tr>
</tbody>
</table>

CA. QUALIFIED DISABLED WORKING INDIVIDUALS WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

The levels for determining income eligibility for groups of qualified disabled working individuals under the provisions of section 1905(s) of the Act are as follows:

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Income Levels</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$ 1,136.00</td>
</tr>
<tr>
<td>2</td>
<td>$ 1,532.00</td>
</tr>
</tbody>
</table>

TN. No. 98-15  Supersedes Approval Date 5/26/92 Effective Date 4/1/92
TN. No. 98-07  

HCFA ID: 7985E
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Texas

INCOME ELIGIBILITY LEVELS (Continued)

C. QUALIFIED MEDICARE BENEFICIARIES WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

2. SECTION 1902(f) STATES WHICH AS OF JANUARY 1, 1989 USED INCOME STANDARDS MORE RESTRICTIVE THAN SSI

a. Based on the following percent of the official Federal income poverty level:

<table>
<thead>
<tr>
<th>Eff. Jan. 1, 1989</th>
<th>80 percent</th>
<th>______ percent (no more than 100)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eff. Jan. 1, 1990</td>
<td>85 percent</td>
<td>______ percent (no more than 100)</td>
</tr>
<tr>
<td>Eff. Jan. 1, 1991</td>
<td>95 percent</td>
<td>______ percent (no more than 100)</td>
</tr>
<tr>
<td>Eff. Jan. 1, 1992</td>
<td>100 percent</td>
<td></td>
</tr>
</tbody>
</table>

b. Levels:

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Income Levels</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$_________</td>
</tr>
<tr>
<td>2</td>
<td>$_________</td>
</tr>
</tbody>
</table>

TN No. 91-34
Supersedes 91-34
Approval Date JAN 14 1992  Effective Date OCT 01 1991
HCFA ID: 7985E
D. MEDICALLY NEEDY

XXX Applicable to all groups. ___ Applicable to all groups except those specified below. Excepted group income levels are also listed on an attached page 3.

<table>
<thead>
<tr>
<th>(1)</th>
<th>(2)</th>
<th>(3)</th>
<th>(4)</th>
<th>(5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Size</td>
<td>Net income level protected for maintenance for one month</td>
<td>Amount by which Column (2) exceeds limits specified in 42 CFR</td>
<td>Net income level for persons living in rural areas for ___ months</td>
<td>Amount by which Column (4) exceeds limits specified in 42 CFR</td>
</tr>
<tr>
<td>urban only</td>
<td>435.1007½</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>$104.00</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>2</td>
<td>$216.00</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>3</td>
<td>$275.00</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>4</td>
<td>$308.00</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

For each additional person, add: $ $ $ $ .

1/ The agency has methods for excluding from its claim for FFP payments made on behalf of individuals whose income exceeds these limits.
### D. MEDICALLY NEEDY

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Net income level protected for maintenance for one month:</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>$357.00</td>
</tr>
<tr>
<td>6</td>
<td>$392.00</td>
</tr>
<tr>
<td>7</td>
<td>$440.00</td>
</tr>
<tr>
<td>8</td>
<td>$475.00</td>
</tr>
<tr>
<td>9</td>
<td>$532.00</td>
</tr>
<tr>
<td>10</td>
<td>$467.00</td>
</tr>
</tbody>
</table>

For each additional person, add: $532.00

---

1/ The agency has methods for excluding from its claim for FFP payments made on behalf of individuals whose income exceeds these limits.

---

**State:** Texas

---

**INCOME LEVELS (Continued)**

| Amount by which Column (2) exceeds limits specified in 42 CFR 435.1007/ |
|---|---|---|
| 5 | $ | $ |
| 6 | $ | $ |
| 7 | $ | $ |
| 8 | $ | $ |
| 9 | $ | $ |
| 10 | $ | $ |

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**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

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**Approval Date:** JUL 28 1994

**Effective Date:** APR 01 1994

---

**TN No.:** 94-22

---

**HCFA IPY:** 94-22
State Texas

D. Medically Needy (Continued)

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Income Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>$624.00</td>
</tr>
<tr>
<td>12</td>
<td>$659.00</td>
</tr>
<tr>
<td>13</td>
<td>$716.00</td>
</tr>
<tr>
<td>14</td>
<td>$751.00</td>
</tr>
<tr>
<td>15</td>
<td>$808.00</td>
</tr>
</tbody>
</table>

Per each additional Member $57.00

SUPERSEDES: TN
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Texas

RESOURCE LEVELS

A. CATEGORICALLY NEEDY GROUPS WITH INCOMES RELATED TO FEDERAL POVERTY LEVEL

1. Pregnant Women

a. Mandatory Groups

☐ Same as SSI resources levels.

XX Less restrictive than SSI resource levels and is as follows:

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Resource Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>

b. Optional Groups

☐ Same as SSI resources levels.

☐ Less restrictive than SSI resource levels and is as follows:

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Resource Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>

Supersedes: TN No. 91-34

Approval Date: JAN 14 1992

Effective Date: DEC 1 1991

HCFA ID: 7985E

Deleted from State's Letter Dated 10-4-2016 under Transmittal Number TX 16-0024, with Effective Date of 10-1-2016. This action was approved on 12-21-2016.
2. Infants
   a. Mandatory Group of Infants

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Resource Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2000</td>
</tr>
<tr>
<td>2</td>
<td>2000</td>
</tr>
<tr>
<td>3</td>
<td>2000</td>
</tr>
<tr>
<td>4</td>
<td>2000</td>
</tr>
<tr>
<td>5</td>
<td>2000</td>
</tr>
<tr>
<td>6</td>
<td>2000</td>
</tr>
<tr>
<td>7</td>
<td>2000</td>
</tr>
<tr>
<td>8</td>
<td>2000</td>
</tr>
<tr>
<td>9</td>
<td>2000</td>
</tr>
<tr>
<td>10</td>
<td>2000</td>
</tr>
</tbody>
</table>

Deleted from State's Letter Dated 10-4-2016 under Transmittal Number TX 16-0024, with Effective Date of 10-1-2016. This action was approved on 12-21-2016.
b. Optional Group of Infants

☐ Same as resource levels in the State’s approved AFDC plan.

☐ Less restrictive than the AFDC levels and are as follows:

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Resource Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
</tr>
</tbody>
</table>

TN No. 91-34

Supersedes Approval Date JAN 14 1992 Effective Date OCT 01 1991

HCFA ID: 7985E

Deleted from State's Letter Dated 10-4-2016 under Transmittal Number TX 16-0024, with Effective Date of 10-1-2016. This action was approved on 12-21-2016.
3. Children

a. Mandatory Group of Children under Section 1902(a)(10)(i)(VI) of the Act. (Children who have attained age 1 but have not attained age 6.)

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Resource Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2000.00</td>
</tr>
<tr>
<td>2</td>
<td>2000.00</td>
</tr>
<tr>
<td>3</td>
<td>2000.00</td>
</tr>
<tr>
<td>4</td>
<td>2000.00</td>
</tr>
<tr>
<td>5</td>
<td>2000.00</td>
</tr>
<tr>
<td>6</td>
<td>2000.00</td>
</tr>
<tr>
<td>7</td>
<td>2000.00</td>
</tr>
<tr>
<td>8</td>
<td>2000.00</td>
</tr>
<tr>
<td>9</td>
<td>2000.00</td>
</tr>
<tr>
<td>10</td>
<td>2000.00</td>
</tr>
</tbody>
</table>

Same as resource levels in the State's approved AFDC plan.

XXX Less restrictive than the AFDC levels and are as follows:

Deleted from State's Letter Dated 10-4-2016 under Transmittal Number TX 16-0024, with Effective Date of 10-1-2016. This action was approved on 12-21-2016.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Texas

b. Mandatory Group of Children under Section 1902(a)(10)(i)(VII) of the Act. (Children born after September 30, 1983 who have attained age 6 but have not attained age 19.)

- Same as resource levels in the State's approved AFDC plan.

- Less restrictive than the AFDC levels and are as follows:

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Resource Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2,000</td>
</tr>
<tr>
<td>2</td>
<td>2,000</td>
</tr>
<tr>
<td>3</td>
<td>2,000</td>
</tr>
<tr>
<td>4</td>
<td>2,000</td>
</tr>
<tr>
<td>5</td>
<td>2,000</td>
</tr>
<tr>
<td>6</td>
<td>2,000</td>
</tr>
<tr>
<td>7</td>
<td>2,000</td>
</tr>
<tr>
<td>8</td>
<td>2,000</td>
</tr>
<tr>
<td>9</td>
<td>2,000</td>
</tr>
<tr>
<td>10</td>
<td>2,000</td>
</tr>
</tbody>
</table>

Deleted from State’s Letter Dated 10-4-2016 under Transmittal Number TX 16-0024, with Effective Date of 10-1-2016. This action was approved on 12-21-2016.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Texas

4. Aged and Disabled Individuals

☐ Same as SSI resource levels.

☐ More restrictive than SSI levels and are as follows:

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Resource Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

☐ Same as medically needy resource levels (applicable only if State has a medically needy program)

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**TN No.** 91-34
**Supersedes** App 2 to Attachment 2.6-A,
**Approval Date** JAN 1 4 1992
**Effective Date** JUL 01 1991
**HCFA ID:** 7985E

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[State of Texas Certification]

STATE: TEXAS
DATE REC'D: DEC 11 1991
DATE APP'ED: JAN 1 4 1992
DATE E'F: OCT 01 1991
HCFA 179

---

**Page 2, Item 3**
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Texas

RESOURCE LEVELS (Continued)

B. MEDICALLY NEEDY

Applicable to all groups -

Except those specified below under the provisions of section 1902(f) of the Act.

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Resource Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2000</td>
</tr>
<tr>
<td>2</td>
<td>2000</td>
</tr>
<tr>
<td>3</td>
<td>2000</td>
</tr>
<tr>
<td>4</td>
<td>2000</td>
</tr>
<tr>
<td>5</td>
<td>2000</td>
</tr>
<tr>
<td>6</td>
<td>2000</td>
</tr>
<tr>
<td>7</td>
<td>2000</td>
</tr>
<tr>
<td>8</td>
<td>2000</td>
</tr>
<tr>
<td>9</td>
<td>2000</td>
</tr>
<tr>
<td>10</td>
<td>2000</td>
</tr>
</tbody>
</table>

For each additional person N/A

TN No. 03-12 Supersedes TN No. 91-34

Approval Date 12-4-03 Effective Date 9-1-03

HCFA ID: 7985E
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State:______ TExAs______

REASONABLE LIMITS ON AMOUNTS FOR NECESSARY MEDICAL
OR REMEDIAL CARE NOT COVERED UNDER MEDICAID

In determining the amount of monthly income an institutionalized client must pay toward
the cost of his care, Texas uses the following limits:

- Covered services beyond the amount, duration, and scope of the Medicaid State
  Plan that are medically necessary are limited to the Medicaid State Plan rates;

- Services available from Medicaid providers, but recipient elects a non-Medicaid
  provider is zero;

- A deduction for incurred medically necessary non-covered medical or remedial
  care expenses will be allowed when the bill is incurred during a period which is
  no more than three months prior to the month of current application;

- A deduction for incurred medical expenses for dental services is based on the
  American Dental Association, West South Central Region, Survey of Fees at the
  90th percentile. If an item is not listed on the Survey of Fees, the item is cleared
  through a Texas Health and Human Services dental consultant;

- A deduction for incurred medical expenses for durable medical equipment is
  based on the Medicare fee schedule for durable medical equipment. If an item is
  not listed on the schedule, the item is cleared through a Medicare contact at the
  CMS Regional Office; and

- Expenses incurred as the result of imposition of a transfer of assets penalty
  period is limited to zero.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Texas

METHODS FOR TREATMENT OF INCOME THAT DIFFER FROM THOSE OF THE SSI PROGRAM

(Section 1902(f) more restrictive methods and criteria and State supplement criteria in SSI criteria States without section 1634 agreements and in section 1902(f) States. Use to reflect more liberal methods only if you limit to State supplement recipients. DO NOT USE this supplement to reflect more liberal policies that you elect under the authority of section 1902(r)(2) of the Act. Use Supplement Sa for section 1902(r)(2) methods.)

Supersedes TN No. 91-10, Attachment 2.6-A

HCFA ID: 7985E
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Texas

MORE RESTRICTIVE METHODS OF TREATING RESOURCES
THAN THOSE OF THE SSI PROGRAM - Section 1902(f) States only

TN No. 91-34
Supersedes Approval Date JAN 14 1992 Effective Date OCT 01 1991
TN No. 87-10 Supp 5 to Attachment 2.6-A

HCFA ID: 7985E

STATE: TEXAS
DATE REC'D: DEC 11 1991
DATE APP'D: JAN 14 1992
DATE EFF: OCT 01 1991
HCFA 179: 91-34
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

METHODS FOR TREATMENT OF RESOURCES FOR INDIVIDUALS WITH INCOMES RELATED TO FEDERAL POVERTY LEVELS

(Do not complete if you are electing more liberal methods under the authority of section 1902(r)(2) of the Act instead of the authority specific to Federal poverty levels. Use Supplement 8b for section 1902(r)(2) methods.)

The methodologies for treatment of resources for poverty level children are those required by the Food Stamp Act of 1977 (as amended), with the following exceptions:

1. only the resource limit ($2000) for families with no members age 60 or older is applied; and

2. the value of the family's primary vehicle is exempt.

Current Food Stamp policy is found in Section A-500 of the Income Assistance Services handbook.
State: **Texas**

Standards for Optional State Supplementary Payments

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<td>$60*</td>
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*Maintenance of Effort: The optional state supplementation check is not less than $15 for individuals and $30.00 for couples per month making the total PNA not less than $45 for individuals and $90 for couples.*

Effective January 01, 2006 the Personal Needs Allowance for SSI Individuals is a cumulative $60.00 for an individual and $120.00 for a couple.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Texas

INCOME LEVELS FOR 1902(f) STATES - CATEGORICALLY NEEDY WHO ARE COVERED UNDER REQUIREMENTS MORE RESTRICTIVE THAN SSI

TN No. 91-34
Supersedes TN No. 85-1

Approval Date JAN 14 1992
Effective Date OCT 01 1991

HCFA ID: 7985E
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Texas

RESOURCE STANDARDS FOR 1902(f) STATES - CATEGORICALLY NEEDY

TN No. 97-34
Supersedes TN No. 85-1

Approval Date JAN 14 1992
Effective Date OCT 01 1991

NCFA ID: 7985E
More Liberal Methods of Treating Income
Under Section 1902(r)(2) of the Act*

Section 1902(f) State  XX  Non-Section 1902(f) State

When applying the AFDC 185% gross income test described in 45 CFR 233.20(a)(3)(xiii) in AFDC-related categorically needy cases, all income in excess of 185% of the state's need standard will be excluded.

This is more liberal policy in that it exempts the applicant from the gross income test and requires only that the applicant's net income (after applying allowable deductions) be compared to the AFDC recognizable needs when determining if the applicant is income-eligible.

*More liberal methods may not result in exceeding gross income limitations under section 1903(f).

Deleted from State's Letter Dated 10-4-2016 under Transmittal Number TX 16-0024, with Effective Date of 10-1-2016. This action was approved on 12-21-2016.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Texas

MORE LIBERAL METHODS OF TREATING INCOME UNDER SECTION 1902(f)(2) OF THE ACT

[ ] Section 1902(f) State
[X] Non-Section 1902(f) State

The following income regulations apply to the Medicaid Buy In individuals as defined by Section 1902 (a)(10)(A)(ii)(XIII) of the Social Security Act.

1. Net family earned income must be less than 250% of the federal poverty level.

   Net earned income means earned income for SSI purposes minus all Applicable exclusions and exemptions, as explained in 20 CFR §416.1110 – §416.1112.

2. The following unearned income rules apply to the Medicaid Buy In individuals:

   Unearned income is entirely excluded under this section, but is considered in determination of a person's monthly premium amount.
State Plan Under Title XIX of the Social Security Act

State: Texas

LESS RESTRICTIVE METHODS OF TREATING INCOME UNDER SECTION 1902(r)(2) OF THE ACT

For all eligibility groups not subject to the limitations on payment explained in section 1903 (f) of the Act*:

XX The agency uses less restrictive income and/or resource methodologies than those in effect as of July 16, 1996, as follows:

Wages paid by the Census Bureau for temporary employment related to census activities are excluded for the following eligibility groups:


XX Poverty level pregnant women and infants (133 –185% FPL) under 1902(a)(10)(A)(i)(IV).

XX Poverty level children under age 6 (133% FPL) under 1902(a)(10)(A)(i)(VI).

XX Poverty level children under age 19 (100% FPL) under 1902(a)(10)(A)(i)(VII).

Optional categorically needy groups under 1902(a)(10)(A)(ii) as listed below.


XX All aged, blind or disabled groups in 209(b) states under 1902(f).

XX QMBs, SLMBs and QIs under 1905(p).

*Less restrictive methods may not result in exceeding gross income limitations under section 1903(f)
MORE LIBERAL METHODS OF TREATING INCOME UNDER SECTION 1902(r)(2) OF THE ACT

[X] Non-Section 1902(f) State

Allow the exclusion of payments made from or interest earned on Texas Save and Match Programs under Texas Education Code, chapter 54, subchapters G, H, and I, and on any qualified tuition program of any state that meets the requirements of the Internal Revenue Service Code of 1986, section 529, for a fund, plan, or tuition program established before the 21st birthday of the beneficiary of the fund, plan, or tuition program by a member of the minor’s family. A member of the minor’s family means the minor’s parent, step-parent, spouse, grandparent, brother, sister, uncle or aunt, whether of whole or half blood or by adoption. Any withdrawal from a fund, plan, or tuition program for purposes other than paying educational expenses of the beneficiary or cancellation of a fund, plan, or tuition program negates the exclusion of payments made from or interest earned on a fund, plan, or tuition program.

This liberal income policy applies to the following groups:

- Individuals who would be eligible for cash assistance if they were not in medical institutions under 1902(a)(10)(A)(ii)(IV) and 42 CFR 435.211;
- Working individuals with disabilities who buy into Medicaid (Medicaid Buy-In program) under 1902(a)(10)(A)(ii)(XIII);
- Children with disabilities in the Medicaid Buy-In for Children under 1902(cc);
- Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries, Qualifying Individuals, and Qualified Disabled and Working Individuals under 1902(a)(10)(E), 1905(p), and 1905(s).

*Less restrictive methods may not result in exceeding gross income limitations under section 1903(f)
MORE LIBERAL METHODS OF TREATING INCOME UNDER SECTION
1902(r)(2) OF THE ACT

[X] Non-Section 1902(f) State

Allow the exclusion of payments made from or interest earned on Texas Save and Match Programs under Texas Education Code, chapter 54, subchapters G, H, and I, and on any qualified tuition program of any state that meets the requirements of the Internal Revenue Service Code of 1986, section 529, for a fund, plan, or tuition program established by a member of the minor’s family.

This liberal income policy applies to the following groups:

- Qualified children and pregnant women under 1902(a)(10)(A)(i)(III);
- Poverty level pregnant women and infants (133-185% FPL) under 1902(a)(10)(A)(i)(IV);
- Poverty level children under age 6 (133% FPL) under 1902(a)(10)(A)(i)(VI);
- Poverty level children under age 19 (100% FPL) under 1902(a)(10)(A)(i)(VII);
- Medically Needy under 1902(a)(10)(C)(i)(III);

*Less restrictive methods may not result in exceeding gross income limitations under section 1903(f)
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Texas

MORE LIBERAL METHODS OF TREATING RESOURCES
UNDER SECTION 1902(r)(2) OF THE ACT

Section 1902(f) State XXX Non-Section 1902(f) State

The more liberal resource policy cited below applies to the following groups of individuals specified in the Social Security Act:

1. 1902(a)(10)(A)(ii)(IV) – individuals who would be eligible for SSI if not in an institution.
2. 1902(a)(10)(A)(ii)(V) – individuals in institutions who are eligible under a special income limit (300% of SSI federal benefit rate).

For client in the above listed groups, the value of home property, including life estates and remainder interest, is exempt if the client places the property for sale. The exemption continues until the proceeds of the sale are available to the client.

A revocable annuity is a countable resource.

An irrevocable annuity is a countable resource unless it meets the following four requirements:

1. issued by a Texas licensed insurance company;
2. the State of Texas is the residual beneficiary (does not apply to annuities purchased by or for a community spouse);
3. the payout is equal monthly principal installments, and the interest portion increases at least annually; and
4. repays the principal investment, plus interest within the annuitant’s life expectancy (actuarially sound).

When the irrevocable annuity meets the above four criteria:

1. it is not counted as a resource; and
2. payments are counted as unearned income.

Approval Date 3-8-05
Effective Date 10-1-09

HCFA ID: 7985E
MORE LIBERAL METHODS OF TREATING RESOURCES
UNDER SECTION 1902 (r)(2) OF THE ACT

The following resource income regulations apply to the Medicaid Buy In individuals as defined by Section 1902 (a)(10)(A)(ii)(XIII) of the Social Security Act.

1902 (r) (2) of the Act

(1) Exempted Resources are an individual's available resources up to and including $3,000 plus resources up to the limit allowed by SSI, shall be disregarded in determining eligibility for MBI.

(2) Countable resources are resources that are used to calculate SSI resources.

(3) A resource disregard shall be given to a Medicaid Buy In individual who holds monies in any Independence Account. These accounts will be held separate from non-exempt resources. The resource disregard shall equal the total of all monies held in such accounts.

(4) The resource disregard shall equal the total of all monies held in such accounts.

(5) An Independence Account (IA) is a segregated account in a financial institution that shall be used to save for future health care and/or work-related expenses to increase an individual's independence and employment potential.

(6) Only a person's own earned income shall be deposited into an IA and amounts deposited cannot exceed 50% of the person's gross earnings. If an individual deposits more than 50% of their gross earning into an IA in a Qualifying Quarter, the account loses its IA designation and the funds in the account become a countable resource for the 12-month period beginning with the first month after the SSA Qualifying Quarter.

(7) Only health care or work-related expenses may be paid from an IA. If in any SSA Qualifying Quarter, funds in a IA are used for any other purpose, the account loses its IA designation and the funds in the account become a countable resource for the 12-month period beginning with the first month after the SSA Qualifying Quarter.

(8) An individual, who wishes to participate in the Medicaid Buy In program and wishes to establish an IA, must seek approval from the State that the account qualifies as an IA before the resource disregard is applied.

(9) Retirement related tax-sheltered accounts, such as Individual Retirement Accounts (IRAs), 401(k) plans, tax-sheltered annuities (TSAs) and Keogh plans are not designated as IAs.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State: TEXAS

LESS RESTRICTIVE METHODS OF TREATING INCOME UNDER SECTION
1902(r)(2) OF THE ACT


If applicable, all SSI income exclusions and disregards will be applied to the family income.

In kind support and maintenance income will be disregarded.

An income disregard of $85 will be applied to total gross (earned and unearned) family income and then half of the remaining income will be disregarded.

*Less restrictive methods may not result in exceeding gross income limitations under section 1903(f)
[X] Non-Section 1902(f) State

Allow the exclusion of funds held in Texas Save and Match Programs under Texas Education Code, chapter 54, subchapters G, H, and I, and on any qualified tuition program of any state that meets the requirements of the Internal Revenue Service Code of 1986, section 529, for a fund, plan, or tuition program established before the 21st birthday of the beneficiary of the fund, plan, or tuition program by a member of the minor’s family. A member of the minor’s family means the minor’s parent, step-parent, spouse, grandparent, brother, sister, uncle or aunt, whether of whole or half blood or by adoption. Any withdrawal from a fund, plan, or tuition program for purposes other than paying educational expenses of the beneficiary or cancellation of a fund, plan, or tuition program negates the exclusion of resources held in a fund, plan, or tuition program.

This liberal resource policy applies to the following groups:

- Individuals who would be eligible for cash assistance if they were not in medical institutions under 1902(a)(10)(A)(ii)(IV) and 42 CFR 435.211;
- Individuals receiving home and community-based services under 42 CFR 435.217;
- Individuals in institutions who are eligible under a special income level under 42 CFR 435.236;
- Working individuals with disabilities who buy into Medicaid (Medicaid Buy-In program) under §1902(a)(10)(A)(ii)(XIII);
- Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries, Qualifying Individuals, and Qualified Disabled and Working Individuals under 1902(a)(10)(E), 1905(p), and 1905(s).
[X] Non-Section 1902(f) State

Allow the exclusion of funds held in Texas Save and Match Programs under Texas Education Code, chapter 54, subchapters G, H, and I, and on any qualified tuition program of any state that meets the requirements of the Internal Revenue Service Code of 1986, section 529, for a fund, plan, or tuition program established by a member of the minor’s family.

This liberal resource policy applies to the following groups:

- Qualified children and pregnant women under 1902(a)(10)(A)(i)(III);
- Poverty level infants (133-185% FPL) under 1902(a)(10)(A)(i)(IV);
- Poverty level children under age 6 (133% FPL) under 1902(a)(10)(A)(i)(VI);
- Poverty level children under age 19 (100% FPL) under 1902(a)(10)(A)(i)(VII);
- Medically Needy under 1902(a)(10)(C)(i)(III);
MORE LIBERAL METHODS OF TREATING RESOURCES UNDER SECTION 1902(r)(2) OF THE ACT

☑ Non-Section 1902(f) State

Allow an exclusion of resources for a School Based Savings Program up to the applicable amount permissible by State Law held in certificates of deposit, savings accounts, or Series 1 savings bonds. A student or student and an adult in the student’s family jointly must establish an account or purchase a bond under the program. The amount in an account or cash value of a bond can be no more than the cost of undergraduate resident tuition and required fees for one academic year consisting of 30 semester credit hours charged by the general academic teaching institution with the highest such tuition and fee costs for the most recent academic year in accordance with State law.

This liberal resource policy applies to the following groups:

- Medically Needy coverage for pregnant women and individuals under 18 years of age under 42 CFR §435.301;
- Individuals who would be eligible for cash assistance if they were not in a medical institution under 1902(a)(10)(A)(ii)(IV) and 42 CFR 453.211;
- Individuals in institutions who are eligible under a special income level under 42 CFR 435.236;
- Working individuals with disabilities who buy into Medicaid (Medicaid Buy-In program) under 1902(a)(10)(A)(ii)(XIII);
- Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries,
- Qualifying Individuals, and Qualified Disabled and Working Individuals under 1902(a)(10)(e), 1905(p), and 1905(s).
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Texas

STATE LONG-TERM CARE INSURANCE PARTNERSHIP

1902(r)(2) The following more liberal methodology applies to individuals who are eligible for medical assistance under one of the following eligibility groups:

Individuals eligible under Section 1902(a)(10)(A)(ii)(V) (300% of SSI benefit standard).

An individual who is a beneficiary under a long-term care insurance policy that meets the requirements of a “qualified State long-term care insurance partnership” policy (partnership policy) as set forth below, is given a resource disregard as described in this amendment. The amount of the disregard is equal to the amount of the insurance benefit payments made to or on behalf of the individual. The term “long-term care insurance policy” includes a certificate issued under a group insurance contract.

\_X\_
The State Medicaid Agency (Agency) stipulates that the following requirements will be satisfied in order for a long-term care policy to qualify for a disregard. Where appropriate, the Agency relies on attestations by the State Insurance Commissioner (Commissioner) or other State official charged with regulation and oversight of insurance policies sold in the state, regarding information within the expertise of the State’s Insurance Department.

- The policy is a qualified long-term care insurance policy as defined in section 7702B(b) of the Internal Revenue Code of 1986.
- The policy meets the requirements of the long-term care insurance model regulation and long-term care insurance model Act promulgated by the National Association of Insurance Commissioners (as adopted as of October 2000) as those requirements are set forth in section 1917(b)(5)(A) of the Social Security Act.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Texas

STATE LONG-TERM CARE INSURANCE PARTNERSHIP

- The policy was issued no earlier than the effective date of this State plan amendment.

- The insured individual was a resident of a Partnership State when coverage first became effective under the policy. If the policy is later exchanged for a different long-term care policy, the individual was a resident of a Partnership State when coverage under the earliest policy became effective.

- The policy meets the inflation protection requirements set forth in section 1917(b)(1)(C)(iii)(IV) of the Social Security Act.

- The Commissioner requires the issuer of the policy to make regular reports to the Secretary that include notification regarding when benefits provided under the policy have been paid and the amount of such benefits paid, notification regarding when the policy otherwise terminates, and such other information as the Secretary determines may be appropriate to the administration of such partnerships.

- The State does not impose any requirement affecting the terms or benefits of a partnership policy that the state does not also impose on non-partnership policies.

- The State Insurance Department assures that any individual who sells a partnership policy receives training, and demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care.

- The Agency provides information and technical assistance to the Insurance Department regarding the training described above.

STATE TEXAS
DATE REC'T 1-10-08
DATE APPROVD 3-17-08
DATE EFF 3-1-08
HCFA 179 08-03

TN No. 08-03
Supersedes Approval Date 3-17-08 Effective Date 3-1-08
TN No. SUPERSEDES: NONE - NEW PAGE
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Texas

TRANSFER OF RESOURCES

1902(f) and 1917 of Title XIX of the Act

The agency provides for the denial of nursing facility services by reason of disposal of resources for less than fair market value.

EFFECTIVE JULY 1, 1988

1. Public Law 100-360 restricts the transfer-of-resources policy to clients eligible under institutional criteria for any uncompensated transfer occurring on or after July 1, 1988. Such transfer may result in the client's ineligibility for nursing facility care or home/community-based waiver services for the lesser of:

- 30 months from the month of transfer, or
- The number of months the uncompensated value would have paid for institutional care at the average cost of a private-pay patient.

i. Transfer of an individual's home does not affect his eligibility when the title is transferred to his

a. spouse, who lives in the home;
b. minor or disabled child (as defined in title XVI of the Social Security Act);
c. sibling, who has equity interest in the home and has lived there for at least one year before the individual's institutionalization; or

Superseded Approval Date JAN 20 1994 Effective Date OCT 1 1993
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Texas

ii. Resources, including the individual's home, may be transferred without affecting eligibility when:

a. the resources are transferred to the individual's spouse (who lives in the community), or his disabled child, or to another person for the sole benefit of the spouse or child;

b. satisfactory evidence exists that the individual intended to dispose of the resource at fair market value;

c. satisfactory evidence exists that the transfer was exclusively for some purpose other than to qualify for Medicaid; or

d. denial of eligibility would cause undue hardship.

An individual may claim undue hardship when denial of Medicaid would result in discharge to the community and inability to obtain necessary medical services. Undue hardship relates to hardship to the individual, not the relatives or responsible parties of the individual.

Undue hardship may exist when any one of the

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: __________________________ Texas

following three conditions exists:

1. location of the receiver of the resource is unknown to the individual, or other family members, or other interested parties, and the individual has no place to return in the community and receive the care required to meet his needs;

2. the individual can show that physical harm may come as a result of pursuing the return of the resource, and the individual has no place to return in the community and receive the care required to meet his needs; or

3. the receiver of the resource is unwilling to cooperate with the individual and the department, resulting in the individual's needs not being met, and the individual has no place to return in the community and receive the care required to meet his needs.

Date: JAN 20 1994

Effective Date: OCT 1 1993

TN No. 93-43

Supersedes TN No. 90-16
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State:

1902(f) States

[ ] Under the provisions of section 1902(f) of the Social Security Act, the following transfer of resource criteria more restrictive than those established under section 1919(c) of the Act, apply:

1917(c)*

Other than those procedures specified elsewhere in the supplement, the procedures for implementing denial of eligibility by reason of disposal of resources for less than fair market value are as follows:

1. If the uncompensated value of the transfer is $12,000 or less:

2. If the uncompensated value of the transfer is more than $12,000:

3. If the agency sets a period of ineligibility of less than 24 months and applies it to all transfers of resources (regardless of uncompensated value):

TN No. 93-43 Supersedes Approval Date JAN 20 1994 Effective Date OCT 1 1993

TN No. 92-16

* Correction made in HCFM Realms Office
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Texas

4. Other procedures:
AFDC-related coverage groups
In applicants transferred a countable resource within the last five years for less than the resource’s fair market value to qualify for assistance, or to increase their AFDC grant, the length of denial is equal to the time the applicant’s needs would have been met by the resource.

Aged, Blind, Disabled
Categorically Needy
The only exceptions allowed are when the individual can provide evidence that the property was transferred exclusively for some purpose other than to become eligible for Medicaid, or undue hardship is found to exist.

iii. When an irrevocable annuity does not pay out the principal plus interest within the annuitant’s life expectancy, the annuity is considered a transfer of asset.

Approval Date 3-8-05
Effective Date 10-1-04
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Texas

TRANSFER OF ASSETS

1917(c) The agency provides for the denial of certain Medicaid services by reason of disposal of assets for less than fair market value.

1. Institutionalized individuals may be denied certain Medicaid services upon disposing of assets for less than fair market value on or after the look-back date.

The agency withholds payment to institutionalized individuals for the following services:

- Payments based on a level of care in a nursing facility;
- Payments based on a nursing facility level of care in a medical institution;
- Home and community-based services under a 1915 waiver.

2. Non-institutionalized individuals:

The agency applies these provisions to the following non-institutionalized eligibility groups. These groups can be no more restrictive than those set forth in section 1905(a) of the Social Security Act:

The agency withholds payment to non-institutionalized individuals for the following services:

- Home health services (section 1905(a)(7));
- Home and community care for functionally disabled and elderly adults (section 1905(a)(22));
- Personal care services furnished to individuals who are not inpatients in certain medical institutions, as recognized under agency law and specified in section 1905(a)(24).

The following other long-term care services for which medical assistance is otherwise under the agency plan:
3. **Penalty Date**--The beginning date of each penalty period imposed for an uncompensated transfer of assets is:

- the first day of the month in which the asset was transferred;
- the first day of the month following the month of transfer.

4. **Penalty Period - Institutionalized Individuals**--In determining the penalty for an institutionalized individual, the agency uses:

- the average monthly cost to a private patient of nursing facility services in the agency;  
  State:  
- the average monthly cost to a private patient of nursing facility services in the community in which the individual is institutionalized.

5. **Penalty Period - Non-institutionalized Individuals**--The agency imposes a penalty period determined by using the same method as is used for an institutionalized individual, including the use of the average monthly cost of nursing facility services; imposes a shorter penalty period than would be imposed for institutionalized individuals, as outlined below:
TRANSFER OF ASSETS

6. Penalty period for amounts of transfer less than cost of nursing facility care--
   a. Where the amount of the transfer is less than the monthly cost of nursing facility care, the agency:
      __ does not impose a penalty;
      ___ imposes a penalty for less than a full month, based on the proportion of the agency's private nursing facility rate that was transferred.
   b. Where an individual makes a series of transfers, each less than the private nursing facility rate for a month, the agency:
      __ does not impose a penalty;
      ___ imposes a series of penalties, each for less than a full month.

7. Transfers made so that penalty periods would overlap--
The agency:
      __ totals the value of all assets transferred to produce a single penalty period;
      ___ calculates the individual penalty periods and imposes them sequentially.

8. Transfers made so that penalty periods would not overlap--
The agency:
      __ assigns each transfer its own penalty period;
      ___ uses the method outlined below:
9. Penalty periods - transfer by a spouse that results in a penalty period for the individual--

(a) The agency apportions any existing penalty period between the spouses using the method outlined below, provided the spouse is eligible for Medicaid. A penalty can be assessed against the spouse, and some portion of the penalty against the individual remains. According to State Medicaid Manual, Part 3, Item 3258.5, Transfer by a Spouse that Results in a Penalty Period for the Individual, Section J.

(b) If one spouse is no longer subject to a penalty, the remaining penalty period must be served by the remaining spouse.

10. Treatment of income as an asset--

When income has been transferred as a lump sum, the agency will calculate the penalty period on the lump sum value.

The agency will impose partial month penalty periods.

When a stream of income or the right to a stream of income has been transferred, the agency will impose a penalty period for each income payment.

For transfers of individual income payments, the agency will impose partial month penalty periods.

For transfers of the right to an income stream, the agency will use the actuarial value of all payments transferred.

The agency uses an alternate method to calculate penalty periods, as described below:

For transferred monthly income amounts less than the private pay rate, no penalty is imposed. For transferred monthly income amounts equal to or above the private pay rate, a month-to-month penalty is assessed.
TRANSFER OF ASSETS

11. Imposition of a penalty would work an undue hardship. The agency does not apply the transfer of assets provisions in any case in which the agency determines that such an application would work an undue hardship. The agency will use the following procedures in making undue hardship determinations:

TDHS procedures provide for and include:

- Notice to recipients that an undue hardship exception exists;
- A timely process for determining whether an undue hardship waiver will be granted; and
- A process under which an adverse determination can be appealed.

The following criteria will be used to determine whether the agency will not count assets transferred because the penalty would work an undue hardship:

Undue hardship may exist when any one of the following three conditions exists:

1. Location of the receiver of the asset is unknown to the client, or other family members, or other interested parties, and the client has no place to return in the community and receive the care required to meet his needs;

2. Client can show that physical harm may come as a result of pursuing the return of the asset, and the client has no place to return in the community and receive the care required to meet his needs; or

3. Receiver of the asset is unwilling to cooperate (such as an exploitation or potential fraud case) with the client and TDHS, resulting in the client's needs not being met, and the client has no place to return in the community and receive the care required to meet his needs.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Texas

TRANSFER OF ASSETS

1917(c) FOR TRANSFERS OF ASSETS FOR LESS THAN FAIR MARKET VALUE MADE ON OR AFTER FEBRUARY 8, 2006, the agency provides for the denial of certain Medicaid services.

1. Institutionalized individuals are denied coverage of certain Medicaid services upon disposing of assets for less than fair market value on or after the look-back date.

The agency does not provide medical assistance coverage for institutionalized individuals for the following services:

- Nursing facility services;
- Nursing facility level of care provided in a medical institution;
- Home and community-based services under a 1915(c) or (d) waiver.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Texas

TRANSFER OF ASSETS

2. Non-institutionalized individuals:

The agency applies these provisions to the following non-institutionalized eligibility groups. These groups can be no more restrictive than those set forth in section 1905(a) of the Social Security Act:

The agency withholds payment to non-institutionalized individuals for the following services:

- Home health services (section 1905(a)(7));
- Home and community care for functionally disabled elderly adults (section 1905(a)(22));
- Personal care services furnished to individuals who are not inpatients in certain medical institutions, as recognized under agency law and specified in section 1905(a)(24).

The following other long-term care services for which payment for medical assistance is otherwise made under the agency plan:

STATE: Texas
DATE REC'D: 03-31-06
DATE APP'V'D: 11-28-06
DATE EFF: 02-08-06
HCFA 179: 06-20
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Texas

TRANSFER OF ASSETS

3. Penalty Date--The beginning date of each penalty period imposed for an uncompensated transfer of assets is the later of:
   • the first day of a month during or after which assets
     have been transferred for less than fair market value;
   _X_ The State uses the first day of the month in which the assets were transferred
   ____ The State uses the first day of the month after the month in which the assets were transferred
   or
   • the date on which the individual is eligible for medical assistance under the State plan and is receiving institutional level care services described in paragraphs 1 and 2 that, were it not for the imposition of the penalty period, would be covered by Medicaid;

AND

which does not occur during any other period of ineligibility for services by reason of a transfer of assets penalty.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State: Texas  

TRANSFER OF ASSETS

4. **Penalty Period - Institutionalized Individuals**--  
In determining the penalty for an institutionalized individual, the agency uses:

- the average monthly cost to a private patient of nursing facility services in the State at the time of application;
- the average monthly cost to a private patient of nursing facility services in the community in which the individual is institutionalized at the time of application.

5. **Penalty Period - Non-institutionalized Individuals**--  
The agency imposes a penalty period determined by using the same method as is used for an institutionalized individual, including the use of the average monthly cost of nursing facility services; imposes a shorter penalty period than would be imposed for institutionalized individuals, as outlined below:

6. **Penalty period for amounts of transfer less than cost of nursing facility care**--

- Where the amount of the transfer is less than the monthly cost of nursing facility care, the agency imposes a penalty for less than a full month, based on the option selected in item 4.
- The state adds together all transfers for less than fair market value made during the look-back period in more than one month and calculates a single period of ineligibility, that begins on the earliest date that would otherwise apply if the transfer had been made in a single lump sum.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Texas

TRANSFER OF ASSETS

7. Penalty periods - transfer by a spouse that results in a penalty period for the individual—

(a) The agency apportions any existing penalty period between the spouses using the method outlined below, provided the spouse is eligible for Medicaid. A penalty can be assessed against the spouse, and some portion of the penalty against the individual remains.

(b) If one spouse is no longer subject to a penalty, the remaining penalty period must be served by the remaining spouse.

8. Treatment of a transfer of income—

When income has been transferred as a lump sum, the agency will calculate the penalty period on the lump sum value.

When a stream of income or the right to a stream of income has been transferred, the agency will impose a penalty period for each income payment.

X For transfers of individual income payments, the agency will impose partial month penalty periods using the methodology selected in 6. above.

X For transfers of the right to an income stream, the agency will base the penalty period on the combined actuarial value of all payments transferred.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Texas

TRANSFER OF ASSETS

9. **Imposition of a penalty would work an undue hardship**—

The agency does not impose a penalty for transferring assets for less than fair market value in any case in which the agency determines that such imposition would work an undue hardship. The agency will use the following criteria in making undue hardship determinations:

Application of a transfer of assets penalty would deprive the individual:

(a) Of medical care such that the individual's health or life would be endangered; or

(b) Of food, clothing, shelter, or other necessities of life.

10. **Procedures for Undue Hardship Waivers**

The agency has established a process under which hardship waivers may be requested that provides for:

(a) Notice to a recipient subject to a penalty that an undue hardship exception exists;

(b) A timely process for determining whether an undue hardship waiver will be granted; and

(c) A process, which is described in the notice, under which an adverse determination can be appealed.

These procedures shall permit the facility in which the institutionalized individual is residing to file an undue hardship waiver application on behalf of the individual with the consent of the individual or the individual's personal representative.
11. **Bed Hold Waivers For Hardship Applicants**

The agency provides that while an application for an undue hardship waiver is pending in the case of an individual who is a resident of a nursing facility:

_____ Payments to the nursing facility to hold the bed for the individual will be made for a period not to exceed ____ days (may not be greater than 30).
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Texas

The agency does not apply the trust provisions in any case in which the agency determines that such application would work an undue hardship.

The following criteria will be used to determine whether the agency will not count assets transferred because doing so would work an undue hardship:

See SUPPLEMENT 9(a) to ATTACHMENT 2.6-A, page 5.

Under the agency's undue hardship provisions, the agency exempts the funds in an irrevocable burial trust.

The maximum value of the exemption for an irrevocable burial trust is $ N/A.
Citation of the Act

1902(u) of the Act

Condition or Requirement

COST EFFECTIVENESS METHODOLOGY FOR COBRA CONTINUATION BENEFICIARIES

Premium payments are made by the agency only if such payments are likely to be cost-effective. The agency specifies the guidelines used in determining cost effectiveness by selecting one of the following methods:

- The methodology as described in SMM section 3598.
- Another cost-effective methodology as described below.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State: TEXAS

VARIATIONS FROM THE BASIC PERSONAL NEEDS ALLOWANCE

As earnings increase the following individuals have greater need due to work related expenses:

The method used to calculate the amount of Personal Needs Allowance that can be retained by persons living in ICF/MR facilities with earnings is as follows:

- If an individual earns $30 or less:
  
  In addition to the basic Personal Needs Allowance of $60, individuals with earnings up to $30 keep an additional amount up to the $30 earned.

- If an individual's net monthly earnings exceed $30 but do not exceed $120:
  
  In addition to the basic Personal Needs Allowance of $60, individuals with earnings above $30 but less than $120 keep an additional amount which includes the first $30 earned, plus one half of whatever amount exceeds that up to $120.

- If an individual's net monthly earnings exceed $120:
  
  In addition to the basic Personal Needs Allowance of $60, individuals with earnings above $120 keep an additional amount which includes the first $30 earned, plus one half of whatever amount exceeds that up to $120, plus 30% of the amount greater than $120.

All institutionalized individuals may receive a deduction from the cost of care in an institution for court ordered guardianship/fiduciary fees. The deduction is limited to guardianship-related costs and fees, subject to the limitations of the Texas Probate Code.

SUPERSEDES: TN- 99-04
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Texas

Section 1924 Provisions

A. Income and resource eligibility policies used to determine eligibility for institutionalized individuals who have spouses living in the community are consistent with Section 1924.

B. In the determination of resource eligibility, the State resource standard is ___*__.

C. The definition of undue hardship for purposes of determining if institutionalized spouses receive Medicaid in spite of having excess countable resources is described below:

Undue hardship is defined as financial duress caused by insufficient funds to meet living expenses. Cases of undue hardship will be reviewed every six months to monitor changes in circumstances.

* the federally-mandated minimum, as adjusted by annual Consumer Price Index increases.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Texas

ELIGIBILITY UNDER SECTION 1931 OF THE ACT

The State covers low-income families and children under section 1931 of the Act.

The following groups were included in the AFDC State Plan effective July 16, 1996:

____ Pregnant women with no other eligible children.

X AFDC children age 18 who are full-time students in a secondary school or in the equivalent level of vocational or technical training.

___ In determining eligibility for Medicaid, the agency uses the AFDC standards and methodologies in effect as of July 16, 1996 without modification.

X In determining eligibility for Medicaid, the agency uses the AFDC standards and methodologies in effect as of July 16, 1996 with the following modifications.

____ The agency applies lower standards which are no lower than the AFDC standard in effect on May 1, 1988, as follows:

____ The agency applies higher income standards than those in effect as of July 16, 1996, increased by no more than the percentage increases in the CPI-U since July 16, 1996, as follows:

____ The agency applies higher resource standards than those in effect as of July 16, 1996, increased by no more than the percentage increases in the CPI-U since July 16, 1996, as follows:
The agency uses less restrictive income and/or resource methodologies than those in effect as of July 16, 1996, as follows:

- allows for exclusion of a child's income from earnings/resources as long as the child is:
  - enrolled and attending school, GED classes, or home-schooled, regardless of the number of hours, and
  - employed less that 30 hours per week.

- excludes an additional $1,000 from a household's resources, resulting in allowing a resource limit of $2,000. Also, excludes an additional $2,000 from resources of households with an aged or disabled member, resulting in allowing a resource limit of $3,000 for these households.

- allows a fair market value (FMV) exemption for a household's vehicles. The amount of the exemption is the current food stamp FMV exemption as published in the Food and Consumer Service, U.S. Department of Agriculture regulations.

- all wages paid by the Census Bureau for temporary employment related to census activities are excluded.

The agency terminates medical assistance (except for certain pregnant women and children) for individuals who fail to meet TANF work requirements.

The agency continues to apply the following waivers of provisions of Part A of Title IV in effect as of July 16, 1996, or submitted prior to August 22, 1996 and approved by the Secretary on or before July 1, 1997.

- Allows removal of the 100-hour rule for meeting the Medicaid deprivation eligibility criteria for two parent families.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State: TEXAS

ELIGIBILITY UNDER SECTION 1925 OF THE ACT
TRANSITIONAL MEDICAL ASSISTANCE

The State covers low-income families and children for Transitional Medical Assistance (TMA) under section 1925 of the Social Security Act (the Act). This coverage is provided for families who no longer qualify under section 1931 of the Act due to increased earned income, or working hours, from the caretaker relative's employment, or due to the loss of a time-limited earned income disregard. (42 CFR 435.112, 1902(a)(52), 1902(e)(1), and 1925 of the Act)

The amount, duration, and scope of services for this coverage are specified in Section 3.5 of this State plan.

For Medicaid eligibility to be extended through TMA, families must have been Medicaid eligible under section 1931 (months of retroactive eligibility may be used to meet this requirement):

- During at least 3 of the 6 months immediately preceding the month in which the family became ineligible under section 1931.
- For fewer than 3 of the 6 previous months immediately preceding the month in which the family became ineligible under section 1931. Specify:

The State extends Medicaid eligibility under TMA for an initial period of:

- 6 months. For TMA eligibility to continue into a second 6-month extension period, the family must meet the reporting, technical, and income eligibility requirements specified at section 1925(b) of the Act.
- 12 months. Section 1925(b) does not apply for a second 6-month extension period.

The State collects and reports participation information to the Department of Health and Human Services as required by section 1925(g) of the Act, in accordance with the format, timing, and frequency specified by the Secretary and makes such information publicly available.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Texas

ASSET VERIFICATION SYSTEM

1940(a) of the Act

1. The agency will provide for the verification of assets for purposes of determining or redetermining Medicaid eligibility for aged, blind and disabled Medicaid applicants and recipients using an Asset Verification System (AVS) that meets the following minimum requirements:

A. The request and response system must be electronic:
   (1) Verification requirements inquiries must be sent electronically via the internet or similar means from the agency to the financial institution (FI).
   (2) The system cannot be based on mailing paper-based requests.
   (3) The system must have the capability to accept responses electronically.

B. The system must be secure based on recognized industry standards of security, as defined by the U.S. Commerce Department’s National Institute of Standards and Technology.

C. The system must establish and maintain a database of FIs that participate in the agency’s AVS.

D. Verification requests also must be sent to FIs other than those identified by applicants and recipients, based on some logic such as geographic proximity to the applicant’s home address, or other reasonable factors whenever the agency determines that such requests are needed to determine or re-determine the individual’s eligibility.

E. The verification requests must include a request for information on both open and closed accounts, going back up to five years as determined by the State.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Texas

ASSET VERIFICATION SYSTEM (continued)

2. System Development

☐ A. The agency itself will develop an AVS. In 3 below, provide any additional information the agency wants to include.

☒ B. The agency intends to hire a contractor to develop an AVS. In 3 below, provide any additional information the agency wants to include.

☐ C. The agency will be joining a consortium to develop an AVS. In 3 below, provide any additional information the agency wants to include. Also provide any other information the agency wants to include pertaining to how the consortium will implement the AVS requirements.

☐ D. The agency already has a system in place that meets the requirements for an acceptable AVS. In 3 below, provide any additional information the agency wants to include.

☐ E. Other alternative not included in A. – D. above. In 3 below, provide any additional information the agency wants to include.

3. Provide the AVS implementation information request for the implementation approach in section 2, and any other information the agency may want to provide.

Texas Health and Human Services Commission intends to implement an AVS using the agency's current data broker system.

STATE Texas
DATE REC'D 6-18-12
DATE APP'VD 9-14-12
DATE EFF 9-1-12
HCFA 179 12-26

TN: 12-26 Approval Date: 9-14-12 Effective Date: 9-1-12

Supersedes TN: SUPERSEDES: NONE - NEW PAGE
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Texas

DISQUALIFICATION FOR LONG-TERM CARE ASSISTANCE FOR INDIVIDUALS WITH SUBSTANTIAL HOME EQUITY

1917(f) The State agency denies reimbursement for nursing facility services and other long-term care services covered under the State plan for an individual who does not have a spouse, child under 21 or adult disabled child residing in the individual’s home, when the individual’s equity interest in the home exceeds the following amount:

$500,000 (increased by the annual percentage increase in the urban component of the consumer price index beginning with 2011, rounded to the nearest $1,000).

An amount that exceeds $500,000 but does not exceed $750,000 (increased by the annual percentage increase in the urban component of the consumer price index beginning with 2011, rounded to the nearest $1,000).

The amount chosen by the State is ________________.

This higher standard applies statewide.

This higher standard does not apply statewide. It only applies in the following areas of the State:

This higher standard applies to all eligibility groups.

This higher standard only applies to the following eligibility groups:

The State has a process under which this limitation will be waived in cases of undue hardship.
## SUPERSEDING PAGES OF STATE PLAN MATERIAL

**TRANSMITTAL NUMBER:** 14-0002 MM1  
**STATE:** Texas

Pages or sections of pages being superseded by S25, S28, S30, S51, S52, S53, S57, and S14 and related pages or sections of pages being deleted as obsolete

<table>
<thead>
<tr>
<th>State Plan Section</th>
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Page 4  
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Page 14  
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Page 2, A.2.c  
Page 9, B.1  
Page 9c, B.1 for pregnant women and parents/caretaker relatives  
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Page 6 related to AFDC recipients, pregnant women, infants, and children  
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<th>Supplement 2 to Attachment 2.6-A</th>
<th>Pages 1-5</th>
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<tr>
<td>Supplement 8a to Attachment 2.6-A</td>
<td>Page 1 Page 4</td>
<td>Page 1b, Related to pregnant women and children Page 3, Related to pregnant women and children</td>
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<td>Supplement 8b to Attachment 2.6-A</td>
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<td>Page 5, Remove all groups listed except medically needy</td>
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<th>PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:</th>
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<tr>
<td>S10 - MAGI Income Methodology</td>
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<table>
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<th>PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):</th>
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<tbody>
<tr>
<td>Notwithstanding any other provisions of the Texas Medicaid State Plan, the financial eligibility methodologies described in State Plan Amendment TX-14-0003-MM3 will apply to all MAGI-based eligibility groups covered under Texas’ Medicaid State Plan. The MAGI financial methodologies set forth in 42 CFR § 435.603 apply to everyone except those individuals described at 42 CFR § 435.603(j) for whom MAGI-based methods do not apply. This State Plan Amendment supersedes the current financial eligibility provisions of the Medicaid State Plan only with respect to the MAGI-based eligibility groups.</td>
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State: Texas  
Date Received: 3/1/14  
Date Approved: 9/24/14  
Date Effective: 1/1/14  
Transmittal Number: 14-003 MM3
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State: Texas  
Date received: 3-31-14  
Date Approved: 10-16-14  
Date Effective: 1-1-14  
Transmittal Number: 14-004 MM5
The state will apply Modified Adjusted Gross Income (MAGI)-based methodologies as described below, and consistent with 42 CFR 435.603.

In the case of determining ongoing eligibility for beneficiaries determined eligible for Medicaid on or before December 31, 2013, MAGI-based income methodologies will not be applied until March 31, 2014, or the next regularly-scheduled renewal of eligibility, whichever is later, if application of such methods results in a determination of ineligibility prior to such date.

In determining family size for the eligibility determination of a pregnant woman, she is counted as herself plus each of the children she is expected to deliver.

In determining family size for the eligibility determination of the other individuals in a household that includes a pregnant woman:

- The pregnant woman is counted just as herself.
- The pregnant woman is counted as herself, plus one.
- The pregnant woman is counted as herself, plus the number of children she is expected to deliver.

Financial eligibility is determined consistent with the following provisions:

When determining eligibility for new applicants, financial eligibility is based on current monthly income and family size.

When determining eligibility for current beneficiaries, financial eligibility is based on:

- Current monthly household income and family size
- Projected annual household income and family size for the remaining months of the current calendar year

In determining current monthly or projected annual household income, the state will use reasonable methods to:

- Include a prorated portion of a reasonably predictable increase in future income and/or family size.
- Account for a reasonably predictable decrease in future income and/or family size.

Except as provided at 42 CFR 435.603(d)(2) through (d)(4), household income is the sum of the MAGI-based income of every individual included in the individual's household.

In determining eligibility for Medicaid, an amount equivalent to 5 percentage points of the FPL for the applicable family size will be deducted from household income in accordance with 42 CFR 435.603(d).

Household income includes actually available cash support, exceeding nominal amounts, provided by the person claiming an individual described at §435.603(f)(2)(i) as a tax dependent.
Medicaid Eligibility

The age used for children with respect to 42 CFR 435.603(f)(3)(iv) is:

☐ Age 19
☐ Age 19, or in the case of full-time students, age 21

PRA Disclosure Statement
According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

State: Texas
Date Received: 3/1/14
Date Approved: 9/24/14
Date Effective: 1/1/14
Transmittal Number: 14-003 MM3

TN: TX 14-03 MM3 Date Approved: 9-24-14 Date Effective: 1/1/14
AFDC Income Standards

Enter the AFDC Standards below. All states must enter:

MAGI-equivalent AFDC Payment Standard in Effect As of May 1, 1988 and
AFDC Payment Standard in Effect As of July 16, 1996

Entry of other standards is optional.

MAGI-equivalent AFDC Payment Standard in Effect As of May 1, 1988

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<td>☐ Standard varies by region</td>
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<tr>
<td>☒ Standard varies by living arrangement</td>
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<tr>
<td>☐ Standard varies in some other way</td>
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Enter the standard by living arrangement

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State: Texas
Date Received: 3/31/14
Date Approved: 8/25/14
Date Effective: 1/1/14
Transmittal Number: TX 14-0002 MM1

Transmittal Number: TX 14-02 MM1  Date Approved: 8/25/14  Date Effective 1/1/14
### Medicaid Eligibility

**Additional incremental amount**
- **Yes**
- **No**

Increment amount $ 52

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**Remove Living Arrangement**

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**Household size**

- **1**
- **2**
- **3**
- **4**
- **5**
- **6**
- **7**
- **8**
- **9**
- **10**
- **11**
- **12**

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<td>8</td>
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<td>9</td>
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<td>10</td>
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<td>11</td>
<td>X</td>
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<td>12</td>
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**State:** Texas  
**Date Received:** 3/31/14  
**Date Approved:** 8/25/14  
**Date Effective:** 1/1/14  
**Transmittal Number:** TX 14-0002 MM1

**Transmittal Number:** TX 14-02 MM1  
**Date Approved:** 8/25/14  
**Date Effective 1/1/14**
Medicaid Eligibility

Additional incremental amount

- Yes  - No

Increment amount $ 52

The dollar amounts increase automatically each year

- Yes  - No

AFDC Payment Standard in Effect As of July 16, 1996

Income Standard Entry - Dollar Amount - Automatic Increase Option

The standard is as follows:

- Statewide standard
- Standard varies by region
- Standard varies by living arrangement
- Standard varies in some other way

Enter the standard by living arrangement

Name of living arrangement

One Parent/Careaker

Description

<table>
<thead>
<tr>
<th>Household size</th>
<th>Standard ($)</th>
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<tbody>
<tr>
<td>+ 1</td>
<td>78</td>
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<tr>
<td>+ 2</td>
<td>163</td>
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<td>+ 3</td>
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<td>+ 4</td>
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State: Texas
Date Received: 3/31/14
Date Approved: 8/25/14
Date Effective: 1/1/14
Transmittal Number: TX 14-0002 MM1

Transmittal Number: TX 14-02 MM1  Date Approved: 8/25/14  Date Effective 1/1/14
### Medicaid Eligibility

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<th>Additional incremental amount</th>
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<tbody>
<tr>
<td>Increment amount</td>
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</table>

<table>
<thead>
<tr>
<th>Remove Living Arrangement</th>
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#### Name of living arrangement: Two Parents/Caretakers

<table>
<thead>
<tr>
<th>Household size</th>
<th>Standard ($)</th>
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<tbody>
<tr>
<td>1</td>
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<td>X</td>
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<td>8</td>
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**State:** Texas  
**Date Received:** 3/31/14  
**Date Approved:** 8/25/14  
**Date Effective:** 1/1/14  
**Transmittal Number:** TX 14-0002 MM1
### Medicaid Eligibility

<table>
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<tr>
<th>Additional incremental amount</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Increment amount</td>
<td>$43</td>
<td></td>
</tr>
</tbody>
</table>

The dollar amounts increase automatically each year  
☐ Yes  ☐ No

### MAGI-equivalent AFDC Payment Standard in Effect As of July 16, 1996

**Income Standard Entry - Dollar Amount - Automatic Increase Option**  
S13a

The standard is as follows:

- ☐ Statewide standard
- ☐ Standard varies by region
- ☐ Standard varies by living arrangement
- ☐ Standard varies in some other way

The dollar amounts increase automatically each year  
☐ Yes  ☐ No

### AFDC Need Standard in Effect As of July 16, 1996

**Income Standard Entry - Dollar Amount - Automatic Increase Option**  
S13a

The standard is as follows:

- ☐ Statewide standard
- ☐ Standard varies by region
- ☐ Standard varies by living arrangement

- [State: Texas]  
  - Date Received: 3/31/14  
  - Date Approved: 8/25/14  
  - Date Effective: 1/1/14  
  - Transmittal Number: TX 14-0002 MM1

- [Transmittal Number: TX 14-02 MM1]  
  - Date Approved: 8/25/14  
  - Date Effective 1/1/14
Medicaid Eligibility

<table>
<thead>
<tr>
<th>Standard varies in some other way</th>
</tr>
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<tr>
<td>The dollar amounts increase automatically each year</td>
</tr>
<tr>
<td>☐ Yes ☐ No</td>
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### AFDC Payment Standard

**AFDC Payment Standard in Effect As of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date.**

<table>
<thead>
<tr>
<th>Income Standard Entry - Dollar Amount - Automatic Increase Option</th>
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<tbody>
<tr>
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<tr>
<td>☐ Statewide standard</td>
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<td>☐ Standard varies by living arrangement</td>
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<td>☐ Standard varies in some other way</td>
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<tr>
<td>The dollar amounts increase automatically each year</td>
</tr>
<tr>
<td>☐ Yes ☐ No</td>
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### MAGI-equivalent AFDC Payment Standard

**MAGI-equivalent AFDC Payment Standard in Effect As of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date.**

<table>
<thead>
<tr>
<th>Income Standard Entry - Dollar Amount - Automatic Increase Option</th>
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<tbody>
<tr>
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<td>☐ Standard varies by living arrangement</td>
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<tr>
<td>☐ Standard varies in some other way</td>
</tr>
<tr>
<td>The dollar amounts increase automatically each year</td>
</tr>
</tbody>
</table>
| ☐ Yes ☐ No                                                       | **State:** Texas  
**Date Received:** 3/31/14  
**Date Approved:** 8/25/14  
**Date Effective:** 1/1/14  
**Transmittal Number:** TX 14-0002 MM1

### TANF payment standard

<table>
<thead>
<tr>
<th>Income Standard Entry - Dollar Amount - Automatic Increase Option</th>
</tr>
</thead>
<tbody>
<tr>
<td>The dollar amounts increase automatically each year</td>
</tr>
</tbody>
</table>
| ☐ Yes ☐ No                                                       | **Transmittal Number:** TX 14-02 MM1  
**Date Approved:** 8/25/14  
**Date Effective 1/1/14**
Medicaid Eligibility

The standard is as follows:
- ☐ Statewide standard
- ☐ Standard varies by region
- ☐ Standard varies by living arrangement
- ☐ Standard varies in some other way

The dollar amounts increase automatically each year
- ☐ Yes   ☐ No

MAGI-equivalent TANF payment standard

<table>
<thead>
<tr>
<th>Income Standard Entry - Dollar Amount - Automatic Increase Option</th>
<th>S13a</th>
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</thead>
<tbody>
<tr>
<td>The standard is as follows:</td>
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<td>- ☐ Standard varies in some other way</td>
<td></td>
</tr>
<tr>
<td>The dollar amounts increase automatically each year</td>
<td></td>
</tr>
<tr>
<td>- ☐ Yes   ☐ No</td>
<td></td>
</tr>
</tbody>
</table>

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Presumptive Eligibility by Hospitals

42 CFR 435.1110

One or more qualified hospitals are determining presumptive eligibility under 42 CFR 435.1110, and the state is providing Medicaid coverage for individuals determined presumptively eligible under this provision.

☐ Yes  ☐ No

☑ The state attests that presumptive eligibility by hospitals is administered in accordance with the following provisions:

☐ A qualified hospital is a hospital that:

☐ Participates as a provider under the Medicaid state plan or a Medicaid 1115 Demonstration, notifies the Medicaid agency of its election to make presumptive eligibility determinations and agrees to make presumptive eligibility determinations consistent with state policies and procedures.

☐ Has not been disqualified by the Medicaid agency for failure to make presumptive eligibility determinations in accordance with applicable state policies and procedures or for failure to meet any standards that may have been established by the Medicaid agency.

☐ Assists individuals in completing and submitting the full application and understanding any documentation requirements.

☐ Yes  ☐ No

☐ The eligibility groups or populations for which hospitals determine eligibility presumptively are:

☐ Pregnant Women

☐ Infants and Children under Age 19

☐ Parents and Other Caretaker Relatives

☐ Adult Group, if covered by the state

☐ Individuals above 133% FPL under Age 65, if covered by the state

☐ Individuals Eligible for Family Planning Services, if covered by the state

☐ Former Foster Care Children

☐ Certain Individuals Needing Treatment for Breast or Cervical Cancer, if covered by the state

☐ Other Family/Adult groups:

☐ Eligibility groups for individuals age 65 and over

☐ Eligibility groups for individuals who are blind

☐ Eligibility groups for individuals with disabilities

☐ Other Medicaid state plan eligibility groups

☐ Demonstration populations covered under section 1115

The state establishes standards for qualified hospitals making presumptive eligibility determinations.
Medicaid Eligibility

☐ Yes  ☐ No

Select one or both:

☒ The state has standards that relate to the proportion of individuals determined presumptively eligible who submit a regular application, as described at 42 CFR 435.907, before the end of the presumptive eligibility period.

95% of individuals who are determined presumptively eligible by qualified hospitals submit a regular application.

95% of presumptive eligibility determinations by qualified hospitals and corresponding regular Medicaid applications are electronically submitted within one working day.

100% of presumptive eligibility determinations by qualified hospitals and corresponding regular Medicaid applications are electronically submitted within five working days.

The state's implementation timeline for hospital presumptive eligibility provides approximately eleven months before a hospital could be disqualified for not meeting state performance standards. This includes approximately:

• 3 months for hospitals to submit presumptive eligibility determinations, and 6 weeks for the state to analyze performance data for this 3-month time period;
• 6 weeks for HHS to provide notice of the need for corrective action and to negotiate corrective action plans with hospitals;
• 3 months for hospitals to implement corrective action plans, and one month for the state to analyze performance data for the corrective action period; and
• 1 month advance notice to hospitals of disqualification, if the process results in disqualification.

☒ The state has standards that relate to the proportion of individuals who are determined eligible for Medicaid based on the submission of an application before the end of the presumptive eligibility period.

97% of individuals determined presumptively eligible by a qualified hospital are determined eligible for Medicaid based on the submission of a regular application for Medicaid.

The state's implementation timeline for hospital presumptive eligibility provides approximately eleven months before a hospital could be disqualified for not meeting state performance standards. This includes approximately:

• 3 months for hospitals to submit presumptive eligibility determinations, and 6 weeks for the state to analyze performance data for this 3-month time period;
• 6 weeks for HHS to provide notice of the need for corrective action and to negotiate corrective action plans with hospitals;
• 3 months for hospitals to implement corrective action plans, and one month for the state to analyze performance data for the corrective action period; and
• 1 month advance notice to hospitals of disqualification, if the process results in disqualification.

☐ The presumptive period begins on the date the determination is made.

☐ The end date of the presumptive period is the earlier of:

The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or

The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.

☐ Periods of presumptive eligibility are limited as follows:
Medicaid Eligibility

☐ No more than one period within a calendar year.
☐ No more than one period within two calendar years.
☐ No more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.
☐ Other reasonable limitation:

<table>
<thead>
<tr>
<th>Name of limitation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>+ Pregnant Women</td>
<td>Pregnant women are allowed only one presumptive eligibility period per pregnancy. X</td>
</tr>
<tr>
<td>+ All other groups</td>
<td>All other groups are limited to no more than one presumptive eligibility period per two calendar years. X</td>
</tr>
</tbody>
</table>

The state requires that a written application be signed by the applicant, parent or representative, as appropriate.

☐ Yes ☐ No.

☒ The presumptive eligibility determination is based on the following factors:

☒ The individual’s categorical or non-financial eligibility for the group for which the individual’s presumptive eligibility is being determined (e.g., based on age, pregnancy status, status as a parent/caretaker relative, disability, or other requirements specified in the Medicaid state plan or a Medicaid 1115 demonstration for that group)

☒ Household income must not exceed the applicable income standard for the group for which the individual’s presumptive eligibility is being determined, if an income standard is applicable for this group.

☒ State residency

☒ Citizenship, status as a national, or satisfactory immigration status.

☒ The state assures that it has communicated the requirements for qualified hospitals, and has provided adequate training to the hospitals. A copy of the training materials has been included.

An attachment is submitted.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0998-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

State: Texas
Date Received: 3/31/14
Date approved: 12/5/14
Date Effective: 1/1/14
Transmittal Number: TX 14-06-MM7
Eligibility Groups - Mandatory Coverage

Parents and Other Caretaker Relatives

Parents and Other Caretaker Relatives - Parents and other caretaker relatives of dependent children with household income at or below a standard established by the state.

☑ The state attests that it operates this eligibility group in accordance with the following provisions:

☐ Individuals qualifying under this eligibility group must meet the following criteria:

☐ Are parents or other caretaker relatives (defined at 42 CFR 435.4), including pregnant women, of dependent children (defined at 42 CFR 435.4) under age 18. Spouses of parents and other caretaker relatives are also included.

The state elects the following options:

☐ This eligibility group includes individuals who are parents or other caretakers of children who are 18 years old, provided the children are full-time students in a secondary school or the equivalent level of vocational or technical training.

☒ Options relating to the definition of caretaker relative (select any that apply):

☐ The definition of caretaker relative includes the domestic partner of the parent or other caretaker relative, even after the partnership is terminated.

Definition of domestic partner:

☒ The definition of caretaker relative includes other relatives of the child based on blood (including those of half-blood), adoption or marriage.

Description of other relatives:

A person meets the relationship requirement if the person is by law, marriage, or adoption a child's father or mother; grandparent, to the degree of a "great, great" grandparent; brother or sister; uncle or aunt, to the degree of a "great, great" uncle or aunt; first cousin; nephew or niece, to the degree of a "great, great" nephew or niece; stepfather or stepmother; stepbrother or stepsister; or first cousin once removed.

☐ The definition of caretaker relative includes any adult with whom the child is living and who assumes primary responsibility for the dependent child's care.

☒ Options relating to the definition of dependent child (select the one that applies):

The state elects to eliminate the requirement that a dependent child must be deprived of parental support or care by reason of the death, physical or mental incapacity, or absence from the home or unemployment of at least one parent.
The child must be deprived of parental support or care, but a less restrictive standard is used to measure unemployment of the parent (select the one that applies):

- Have household income at or below the standard established by the state.
- MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.
- Income standard used for this group
  - Minimum income standard
    The minimum income standard used for this group is the state's AFDC payment standard in effect as of May 1, 1988, converted to MAGI-equivalent amounts by household size. The standard is described in S14 AFDC Income Standards.
    ✔ The state certifies that it has submitted and received approval for its converted May 1, 1988 AFDC payment standard.

- Maximum income standard
  The state certifies that it has submitted and received approval for its converted income standard(s) for parents and other caretaker relatives to MAGI-equivalent standards and the determination of the maximum income standard to be used for parents and other caretaker relatives under this eligibility group.
  ✔ An attachment is submitted.

The state's maximum income standard for this eligibility group is:

- The state's effective income level for section 1931 families under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.
- The state's effective income level for section 1931 families under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.
  ✔ The state's effective income level for any population of parents/caretaker relatives under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.
  ✔ The state's effective income level for any population of parents/caretaker relatives under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

Enter the amount of the maximum income standard:

【State: Texas】
【Date Received: 3/31/14】
【Date Approved: 8/25/14】
【Date Effective: 1/1/14】
【Transmittal Number: TX 14-0002 MM1】
Medicaid Eligibility

- A percentage of the federal poverty level: %

- The state's AFDC payment standard in effect as of July 16, 1996, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.

- The state's AFDC payment standard in effect as of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.

- The state's TANF payment standard, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.

- Other dollar amount

- Income standard chosen:
  - Indicate the state's income standard used for this eligibility group:
    - The minimum income standard
    - The maximum income standard
    - The state's AFDC payment standard in effect as of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date. The standard is described in S14 AFDC Income Standards.
    - Another income standard in-between the minimum and maximum standards allowed

- There is no resource test for this eligibility group.

Presumptive Eligibility

- The state covers individuals under this group when determined presumptively eligible by a qualified entity. The state assures it also covers individuals under the Pregnant Women (42 CFR 435.116) and/or Infants and Children under Age 19 (42 CFR 435.118) eligibility groups when determined presumptively eligible.

- Yes  No

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

State: Texas
Date Received: 3/31/14
Date Approved: 8/25/14
Date Effective: 1/1/14
Transmittal Number: TX 14-0002 MM1

Transmittal Number: TX 14-02 MM1  Date Approved: 8/25/14  Date Effective 1/1/14
The agency continues to apply the waiver of provisions of Part A of Title IV in effect as of July 16, 1996, submitted prior to August 22, 1996, and approved by the Secretary on or before July 1, 1997, which allows removal of the 100-hour rule for meeting the Medicaid deprivation eligibility criteria for two-parent families. Unemployment is defined as an individual working 0 hours. Underemployment is defined as an individual working, but not earning enough to make the household ineligible for Parents and Caretaker Relatives Medicaid.

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<tr>
<th>TRANSMITTAL NUMBER:</th>
<th>STATE:</th>
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<tbody>
<tr>
<td>14-0002 MM1</td>
<td>Texas</td>
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</table>

State: Texas
Date Received: 3/31/14
Date Approved: 8/25/14
Date Effective: 1/1/14
Transmittal Number: TX 14-0002 MM1
Pregnant Women - Women who are pregnant or post-partum, with household income at or below a standard established by the state.

- The state attests that it operates this eligibility group in accordance with the following provisions:
  - Individuals qualifying under this eligibility group must be pregnant or post-partum, as defined in 42 CFR 435.4.
  - Pregnant women in the last trimester of their pregnancy without dependent children are eligible for full benefits under this group in accordance with section 1931 of the Act, if they meet the income standard for state plan Parents and Other Caretaker Relatives at 42 CFR 435.110.
  - Yes  No

- MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

- Income standard used for this group
  - Minimum income standard (Once entered and approved by CMS, the minimum income standard cannot be changed.)
    - The state had an income standard higher than 133% FPL established as of December 19, 1989 for determining eligibility for pregnant women, or as of July 1, 1989, had authorizing legislation to do so.
    - Yes  No
    - The minimum income standard for this eligibility group is 133% FPL.
  - Maximum income standard
    - The state certifies that it has submitted and received approval for its converted income standard(s) for pregnant women to MAGI-equivalent standards and the determination of the maximum income standard to be used for pregnant women under this eligibility group.

  An attachment is submitted.

Medicaid Eligibility


- The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

- The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

- 185% FPL

  The amount of the maximum income standard is: 198% FPL

- Income standard chosen

  Indicate the state's income standard used for this eligibility group:
  - The minimum income standard
  - The maximum income standard
  - Another income standard in-between the minimum and maximum standards allowed.

- There is no resource test for this eligibility group.

- Benefits for individuals in this eligibility group consist of the following:

  - All pregnant women eligible under this group receive full Medicaid coverage under this state plan.

  - Pregnant women whose income exceeds the income limit specified below for full coverage of pregnant women receive only pregnancy-related services.

- Presumptive Eligibility

  The state covers ambulatory prenatal care for individuals under this group when determined presumptively eligible by a qualified entity.

  - Yes
  - No

  - The presumptive period begins on the date the determination is made.

  - The end date of the presumptive period is the earlier of:

    - The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or

    - The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.

  - There may be no more than one period of presumptive eligibility per pregnancy.

  A written application must be signed by the applicant or representative.

State: Texas
Date Received: 3/31/14
Date Approved: 8/25/14
Date Effective: 1/1/14
Transmittal Number: TX 14-0002 MM1
Yes  No

- The state uses a single application form for Medicaid and presumptive eligibility, approved by CMS.
- The state uses a separate application form for presumptive eligibility, approved by CMS. A copy of the application form is included.
- An attachment is submitted.

The presumptive eligibility determination is based on the following factors:

- The woman must be pregnant
- Household income must not exceed the applicable income standard at 42 CFR 435.116.
- State residency
- Citizenship, status as a national, or satisfactory immigration status

The state uses qualified entities, as defined in section 1920A of the Act, to determine eligibility presumptively for this eligibility group.

### List of Qualified Entities

A qualified entity is an entity that is determined by the agency to be capable of making presumptive eligibility determinations based on an individual’s household income and other requirements, and that meets at least one of the following requirements. Select one or more of the following types of entities used to determine presumptive eligibility for this eligibility group:

- Furnishes health care items or services covered under the state's approved Medicaid state plan and is eligible to receive payments under the plan
- Is authorized to determine a child's eligibility to participate in a Head Start program under the Head Start Act
- Is authorized to determine a child's eligibility to receive child care services for which financial assistance is provided under the Child Care and Development Block Grant Act of 1990
- Is authorized to determine a child's eligibility to receive assistance under the Special Supplemental Food Program for Women, Infants and Children (WIC) under section 17 of the Child Nutrition Act of 1966
- Is authorized to determine a child's eligibility under the Medicaid state plan or for child health assistance under the Children's Health Insurance Program (CHIP)
- Is an elementary or secondary school, as defined in section 14101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8801)
- Is an elementary or secondary school operated or supported by the Bureau of Indian Affairs
- Is a state or Tribal child support enforcement agency under title IV-D of the Act
- Is an organization that provides emergency food and shelter under a grant under the Stewart B. McKinney Homeless Assistance Act
- Is a state or Tribal office or entity involved in enrollment in the program under Medicaid, CHIP, or title IV-A of the Act
Medicaid Eligibility

Is an organization that determines eligibility for any assistance or benefits provided under any program of public or assisted housing that receives Federal funds, including the program under section 8 or any other section of the United States Housing Act of 1937 (42 U.S.C. 1437) or under the Native American Housing Assistance and Self Determination Act of 1996 (25 U.S.C. 4101 et seq.)

☑️ Is a health facility operated by the Indian Health Service, a Tribe, or Tribal organization, or an Urban Indian Organization

☑️ Other entity the agency determines is capable of making presumptive eligibility determinations:

<table>
<thead>
<tr>
<th>Name of entity</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family planning agency</td>
<td>X</td>
</tr>
</tbody>
</table>

The state assures that it has communicated the requirements for qualified entities, at 1920A(b)(3) of the Act, and has provided adequate training to the entities and organizations involved. A copy of the training materials has been included.

An attachment is submitted.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Medicaid Eligibility

Eligibility Groups - Mandatory Coverage
Infants and Children under Age 19

42 CFR 435.118
1902(a)(10)(A)(i)(III), (IV), (VI) and (VII)
1902(a)(10)(A)(ii)(IV) and (IX)
1931(b) and (d)

Infants and Children under Age 19 - Infants and children under age 19 with household income at or below standards established by the state based on age group.

☑ The state attests that it operates this eligibility group in accordance with the following provisions:

☐ Children qualifying under this eligibility group must meet the following criteria:

☐ Are under age 19

☐ Have household income at or below the standard established by the state.

☐ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

☐ Income standard used for infants under age one

☐ Minimum income standard

The state had an income standard higher than 133% FPL established as of December 19, 1989 for determining eligibility for infants under age one, or as of July 1, 1989, had authorizing legislation to do so.

☐ Yes ☐ No

The minimum income standard for infants under age one is 133% FPL.

☐ Maximum income standard

The state certifies that it has submitted and received approval for its converted income standard(s) for infants under age one to MAGI-equivalent standards and the determination of the maximum income standard to be used for infants under age one.

An attachment is submitted.

The state's maximum income standard for this age group is:


Transmittal Number: TX 14-02 MM1  Date Approved: 8/25/14  Date Effective 1/1/14
Medicaid Eligibility


The state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

The state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

185% FPL

Enter the amount of the maximum income standard: 198 % FPL

Income standard chosen

The state's income standard used for infants under age one is:

- The maximum income standard

If not chosen as the maximum income standard, the state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income standard for this age group in the state plan as of March 23, 2010.

Income standard for children age one through age five, inclusive

Minimum income standard

State: Texas
Date Received: 3/31/14
Date Approved: 8/25/14
Date Effective: 1/1/14
Transmittal Number: TX 14-0002 MM1
The minimum income standard used for this age group is 133% FPL.

- **Maximum income standard**

  The state certifies that it has submitted and received approval for its converted income standard(s) for children age one through five to MAGI-equivalent standards and the determination of the maximum income standard to be used for children age one through five.

  An attachment is submitted.

The state's maximum income standard for children age one through five is:

- The state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

- The state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

- The state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

- The state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

  Enter the amount of the maximum income standard: 144% FPL

- **Income standard chosen**

  The state's income standard used for children age one through five is:

  - The maximum income standard

    If not chosen as the maximum income standard, the state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

    If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.
If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income standard for this age group in the state plan as of March 23, 2010.

- Minimum income standard
  - The minimum income standard used for this age group is 133% FPL.

- Maximum income standard
  - The state certifies that it has submitted and received approval for its converted income standard(s) for children age six through eighteen to MAGI-equivalent standards and the determination of the maximum income standard to be used for children age six through age eighteen.
  - An attachment is submitted.

The state's maximum income standard for children age six through eighteen is:


- The state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

- The state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

- 133% FPL

- Income standard chosen
  - The state's income standard used for children age six through eighteen is:
Medicaid Eligibility

- The maximum income standard
  
  If not chosen as the maximum income standard, the state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

  If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

  If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

  If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

  Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income standard for this age group in the state plan as of March 23, 2010.

- There is no resource test for this eligibility group.

- Presumptive Eligibility
  
  The state covers children when determined presumptively eligible by a qualified entity.

  - Yes  - No

PRA Disclosure Statement

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State: Texas  
Date Received: 3/31/14  
Date Approved: 8/25/14  
Date Effective: 1/1/14  
Transmittal Number: TX 14-0002 MM1
### Medicaid Eligibility

**Eligibility Groups - Mandatory Coverage**

**Adult Group**

<table>
<thead>
<tr>
<th>1902(a)(10)(A)(i)(VIII)</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>42 CFR 435.119</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The state covers the Adult Group as described at 42 CFR 435.119.

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**PRA Disclosure Statement**

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**State: Texas**
**Date Received:** 3/31/14  
**Date Approved:** 8/25/14  
**Date Effective:** 1/1/14  
**Transmittal Number:** TX 14-0002 MM1
### Medicaid Eligibility

#### Eligibility Groups - Mandatory Coverage

**Former Foster Care Children**

- 42 CFR 435.150
- 1902(a)(10)(A)(i)(IX)

<table>
<thead>
<tr>
<th>Former Foster Care Children</th>
<th>S33</th>
</tr>
</thead>
</table>

- Individuals under the age of 26, not otherwise mandatorily eligible, who were on Medicaid and in foster care when they turned age 18 or aged out of foster care.

The state attests that it operates this eligibility group under the following provisions:

- Individuals qualifying under this eligibility group must meet the following criteria:
  - Are under age 26.
  - Are not otherwise eligible for and enrolled for mandatory coverage under the state plan, except that eligibility under this group takes precedence over eligibility under the Adult Group.
  - Were in foster care under the responsibility of the state or Tribe and were enrolled in Medicaid under the state's state plan or 1115 demonstration when they turned 18 or at the time of aging out of that state's or Tribe's foster care program.
  - The state elects to cover children who were in foster care and on Medicaid in any state at the time they turned 18 or aged out of the foster care system.

The state covers individuals under this group when determined presumptively eligible by a qualified entity. The state assures it also covers individuals under the Pregnant Women (42 CFR 435.116) and/or Infants and Children under Age 19 (42 CFR 435.118) eligibility groups when determined presumptively eligible.

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

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**PRA Disclosure Statement**

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Eligibility Groups - Options for Coverage

Individuals above 133% FPL

1902(a)(10)(A)(ii)(XX)
1902(hh)
42 CFR 435.218

Individuals above 133% FPL - The state elects to cover individuals under 65, not otherwise mandatorily or optionally eligible, with income above 133% FPL and at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.218.

☐ Yes ☐ No

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

State: Texas
Date Received: 3/31/14
Date Approved: 8/25/14
Date Effective: 1/1/14
Transmittal Number: TX 14-0002 MM1

Transmittal Number: TX 14-02 MM1 Date Approved: 8/25/14 Date Effective 1/1/14
### Eligibility Groups - Options for Coverage

<table>
<thead>
<tr>
<th>Optional Coverage of Parents and Other Caretaker Relatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>42 CFR 435.220</td>
</tr>
<tr>
<td>1902(a)(10)(A)(ii)(I)</td>
</tr>
</tbody>
</table>

Optional Coverage of Parents and Other Caretaker Relatives - The state elects to cover individuals qualifying as parents or other caretaker relatives who are not mandatorily eligible and who have income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.220.

- Yes
- No

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**PRA Disclosure Statement**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Medicaid Eligibility

Eligibility Groups - Options for Coverage
Reasonable Classification of Individuals under Age 21

42 CFR 435.222
1902(a)(10)(A)(ii)(I)
1902(a)(10)(A)(ii)(IV)

Reasonable Classification of Individuals under Age 21 - The state elects to cover one or more reasonable classifications of individuals under age 21 who are not mandatorily eligible and who have income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.222.

☐ Yes  ☐ No

The state attests that it operates this eligibility group in accordance with the following provisions:

☐ Yes  ☐ No

1. Individuals qualifying under this eligibility group must qualify under a reasonable classification by meeting the following criteria:
   - Be under age 21, or a lower age, as defined within the reasonable classification.
   - Have household income at or below the standard established by the state, if the state has an income standard for the reasonable classification.
   - Not be eligible and enrolled for mandatory coverage under the state plan.

☐ Yes  ☐ No

MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

The state covered at least one reasonable classification under this eligibility group under its Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013, with income standards higher (including disregarding all income) than the current mandatory income standards for the individual's age.

☐ Yes  ☐ No

The state also covered at least one reasonable classification under this group in the Medicaid state plan as of March 23, 2010 with income standards higher (including disregarding all income) than the current mandatory income standards for the individual's age.

☐ Yes  ☐ No

Reasonable Classifications Covered in the Medicaid State Plan as of March 23, 2010

☐ The state attaches the approved pages from the Medicaid state plan as of March 23, 2010 to indicate the age groups, reasonable classifications, and income standards used at that time for this eligibility group.

An attachment is submitted.

Current Coverage of All Children under a Specified Age

State: Texas
Date Received: 3/31/14
Date Approved: 8/25/14
Date Effective: 1/1/14
Transmittal Number: TX 14-0002 MM1

Transmittal Number: TX 14-02 MM1  Date Approved: 8/25/14  Date Effective 1/1/14

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The state covers all children under a specified age limit, equal to or higher than the age limit and/or income standard used in the Medicaid state plan as of March 23, 2010, provided the income standard is higher than the current mandatory income standard for the individual's age. The age limit and/or income standard used must be no higher than any age limit and/or income standard covered in the Medicaid state plan as of December 31, 2013 or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013. Higher income standards may include the disregard of all income.

☐ Yes  ☐ No

Current Coverage of Reasonable Classifications Covered in the Medicaid State Plan as of March 23, 2010

The state covers reasonable classifications of children previously covered in the Medicaid state plan as of March 23, 2010, with income standards higher than the current mandatory income standard for the age group. Age limits and income standards are equal to or higher than the Medicaid state plan as of March 23, 2010, but no higher than any age limit and/or income standard for this classification covered in the Medicaid state plan as of December 31, 2013 or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013. Higher income standards may include the disregard of all income.

☐ Yes  ☐ No

Indicate the reasonable classifications of children that were covered in the state plan in effect as of March 23, 2010 with income standards higher than the mandatory standards used for the child's age, using age limits and income standards that are not more restrictive than used in the state plan as of as March 23, 2010 and are not less restrictive than used in the Medicaid state plan as of December 31, 2013 or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

Current Coverage of Reasonable Classifications Covered in the Medicaid State Plan as of March 23, 2010

Reasonable Classifications of Children

☐ Individuals for whom public agencies are assuming full or partial financial responsibility.

☐ Individuals placed in foster care homes by public agencies

Indicate the age which applies:

☐ Under age 21  ☐ Under age 20  ☐ Under age 19  ☐ Under age 18

☐ Individuals placed in foster care homes by private, non-profit agencies

Indicate the age which applies:

☐ Under age 21  ☐ Under age 20  ☐ Under age 19  ☐ Under age 18

☐ Individuals placed in private institutions by public agencies

Indicate the age which applies:

☐ Under age 21  ☐ Under age 20  ☐ Under age 19  ☐ Under age 18

☐ Individuals placed in private institutions by private, non-profit agencies

Indicate the age which applies:

☐ Under age 21  ☐ Under age 20  ☐ Under age 19  ☐ Under age 18

☐ Individuals in adoptions subsidized in full or part by a public agency
Individuals in nursing facilities, if nursing facility services are provided under this plan

Individuals receiving active treatment as inpatients in psychiatric facilities or programs, if such services are provided under this plan

Other reasonable classifications

<table>
<thead>
<tr>
<th>Name of classification</th>
<th>Description</th>
<th>Age Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>AFDC</td>
<td>Children in the community who are under the age of 18 (or under age 19 if expected to graduate by their 19th birthday and who live with relative(s)) within the Aid for Families with Dependent Children (AFDC) required degree of relationship.</td>
<td>Under age 19</td>
</tr>
<tr>
<td>TJJD</td>
<td>Children under the age of 21 who have been committed to the custody of the Texas Juvenile Justice Department.</td>
<td>Under age 21</td>
</tr>
<tr>
<td>Jurisdiction of juvenile court</td>
<td>Children ages 10 through 17 who are under the continuing jurisdiction of the juvenile court and who are placed in a setting such as a group home, a residential treatment facility, or a foster home which will permit children to receive Medicaid services.</td>
<td>Under age 18</td>
</tr>
</tbody>
</table>

Enter the income standard used for these classifications. The income standard must be higher than the mandatory standard for the child's age. It may be no lower than the income standard used in the state plan as of March 23, 2010 and no higher than the highest standard used in the Medicaid state plan as of December 31, 2013 or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

Click here once S11 form above is complete to view the income standards form.

Individuals placed in foster care homes by public agencies

- Income standard used
  - Minimum income standard
    - The minimum income standard for this classification of children is the AFDC payment standard in effect as of July 16, 1996, not converted to MAGI-equivalent. This standard is described in S14 AFDC Income Standards.

- Maximum income standard
  - No income test was used (all income was disregarded) for this classification either in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.
    - Yes
    - No
No income test was used (all income was disregarded) for this classification under:

(check all that apply)

- Yes [ ] The Medicaid state plan as of December 31, 2013.
- A Medicaid 1115 Demonstration as of December 31, 2013.

The state's maximum standard for this classification of children is no income test (all income is disregarded).

Income standard chosen

Individuals qualify under this classification under the following income standard:

- This classification does not use an income test (all income is disregarded).
- The minimum standard.
- Another income standard higher than both the minimum income standard and the effective income level for this classification in the state plan as of March 23, 2010, converted to a MAGI equivalent.

Individuals placed in foster care homes by private, non-profit agencies

Income standard used

Minimum income standard

The minimum income standard for this classification of children is the AFDC payment standard in effect as of July 16, 1996, not converted to MAGI-equivalent. This standard is described in S14 AFDC Income Standards.

Maximum income standard

No income test was used (all income was disregarded) for this classification either in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

- Yes [ ] No

No income test was used (all income was disregarded) for this classification under:

(check all that apply)

- Yes [ ] The Medicaid state plan as of December 31, 2013.
- A Medicaid 1115 Demonstration as of December 31, 2013.
The state's maximum standard for this classification of children is no income test (all income is disregarded).

- **Income standard chosen**

  Individuals qualify under this classification under the following income standard:
  - This classification does not use an income test (all income is disregarded).
  - The minimum standard.
  - Another income standard higher than both the minimum income standard and the effective income level for this classification in the state plan as of March 23, 2010, converted to a MAGI equivalent.

### Individuals placed in private institutions by public agencies

- **Income standard used**
  - Minimum income standard
    - The minimum income standard for this classification of children is the AFDC payment standard in effect as of July 16, 1996, not converted to MAGI-equivalent. This standard is described in S14 AFDC Income Standards.
  - Maximum income standard
    - No income test was used (all income was disregarded) for this classification either in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

  - Yes  
  - No

  - No income test was used (all income was disregarded) for this classification under:

    (check all that apply)
    - The Medicaid state plan as of December 31, 2013.
    - A Medicaid 1115 Demonstration as of December 31, 2013.

  The state's maximum standard for this classification of children is no income test (all income is disregarded).

- **Income standard chosen**

  Individuals qualify under this classification under the following income standard:
  - This classification does not use an income test (all income is disregarded).
  - The minimum standard.
Another income standard higher than both the minimum income standard and the effective income level for this classification in the state plan as of March 23, 2010, converted to a MAGI equivalent.

Individuals placed in private institutions by private, non-profit agencies

- **Income standard used**
  - **Minimum income standard**
    - The minimum income standard for this classification of children is the AFDC payment standard in effect as of July 16, 1996, not converted to MAGI-equivalent. This standard is described in S14 AFDC Income Standards.
  - **Maximum income standard**
    - No income test was used (all income was disregarded) for this classification either in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.
    - Yes  No
    - No income test was used (all income was disregarded) for this classification under:
      - (check all that apply)
        - The Medicaid state plan as of December 31, 2013.
        - A Medicaid 1115 Demonstration as of December 31, 2013.
    - The state's maximum standard for this classification of children is no income test (all income is disregarded).
  - **Income standard chosen**
    - Individuals qualify under this classification under the following income standard:
      - This classification does not use an income test (all income is disregarded).
      - The minimum standard.
      - Another income standard higher than both the minimum income standard and the effective income level for this classification in the state plan as of March 23, 2010, converted to a MAGI equivalent.

AFDC

- **Income standard used**
  - **Minimum income standard**

State: Texas
Date Received: 3/31/14
Date Approved: 8/25/14
Date Effective: 1/1/14
Transmittal Number: TX 14-0002 MM1
The minimum income standard for this classification of children must exceed the lowest income standard chosen for children under this age under the Infants and Children under Age 19 eligibility group.

☐ Maximum income standard

No income test was used (all income was disregarded) for this classification either in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

☐ Yes ☐ No

☐ No income test was used (all income was disregarded) for this classification under:

(check all that apply)

☐ The Medicaid state plan as of March 23, 2010.
☒ The Medicaid state plan as of December 31, 2013.
☐ A Medicaid 1115 Demonstration as of December 31, 2013.

The state's maximum standard for this classification of children is no income test (all income is disregarded).

☐ Income standard chosen

Individuals qualify under this classification under the following income standard:

☐ This classification does not use an income test (all income is disregarded).

☐ Another income standard higher than both the minimum income standard and the effective income level for this classification in the state plan as of March 23, 2010, converted to a MAGI equivalent.

TJJD

☐ Income standard used

☐ Minimum income standard

The minimum income standard for this classification of children is the AFDC payment standard in effect as of July 16, 1996, not converted to MAGI-equivalent. This standard is described in S14 AFDC Income Standards.

☐ Maximum income standard

No income test was used (all income was disregarded) for this classification either in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

☐ Yes ☐ No

☐ No income test was used (all income was disregarded) for this classification under:
Medicaid Eligibility

(check all that apply)

☐ The Medicaid state plan as of March 23, 2010.
☒ The Medicaid state plan as of December 31, 2013.
☐ A Medicaid 1115 Demonstration as of December 31, 2013.

The state's maximum standard for this classification of children is no income test (all income is disregarded).

☐ Income standard chosen

Individuals qualify under this classification under the following income standard:

☐ This classification does not use an income test (all income is disregarded).
☐ The minimum standard.
☐ Another income standard higher than both the minimum income standard and the effective income level for this classification in the state plan as of March 23, 2010, converted to a MAGI equivalent.

Jurisdiction of juvenile court

☐ Income standard used

☐ Minimum income standard

The minimum income standard for this classification of children must exceed the lowest income standard chosen for children under this age under the Infants and Children under Age 19 eligibility group.

☐ Maximum income standard

No income test was used (all income was disregarded) for this classification either in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

☐ Yes  ☐ No

☐ No income test was used (all income was disregarded) for this classification under:

(check all that apply)

☐ The Medicaid state plan as of March 23, 2010.
☒ The Medicaid state plan as of December 31, 2013.
☐ A Medicaid 1115 Demonstration as of December 31, 2013.

The state's maximum standard for this classification of children is no income test (all income is disregarded).
Medicaid

Income standard chosen

Individuals qualify under this classification under the following income standard:

☐ This classification does not use an income test (all income is disregarded).

☐ Another income standard higher than both the minimum income standard and the effective income level for this classification in the state plan as of March 23, 2010, converted to a MAGI equivalent.

Other Reasonable Classifications Previously Covered

The state covers reasonable classifications of children not covered in the Medicaid state plan as of March 23, 2010, but covered under the Medicaid state plan as of December 31, 2013 or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013 with an income standard higher than the current mandatory income standard for the age group.

☐ Yes  ☐ No

The additional previously covered reasonable classifications to be included are:

Additional Previously Covered Reasonable Classifications Included

<table>
<thead>
<tr>
<th>Reasonable Classifications of Children</th>
<th>S11</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Individuals for whom public agencies are assuming full or partial financial responsibility.</td>
<td></td>
</tr>
<tr>
<td>☐ Individuals in adoptions subsidized in full or part by a public agency</td>
<td></td>
</tr>
<tr>
<td>☐ Individuals in nursing facilities, if nursing facility services are provided under this plan</td>
<td></td>
</tr>
<tr>
<td>☐ Individuals receiving active treatment as inpatients in psychiatric facilities or programs, if such services are provided under this plan</td>
<td></td>
</tr>
<tr>
<td>☑ Other reasonable classifications</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of classification</th>
<th>Description</th>
<th>Age Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICPC</td>
<td>Former foster care youth under the age of 21 who had been placed inside or outside of Texas under the Interstate Compact on the Placement of Children in accordance with Texas Family Code 162.102.</td>
<td>Under age 21</td>
</tr>
</tbody>
</table>

Enter the income standard used for these classifications (which must be higher than the mandatory standard for the child's age but may be no higher than the highest standard used in the state plan as of December 31, 2013 or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013).

Click here once S11 form above is complete to view the income standards form.

ICPC
Medicaid Eligibility

Income standard used

- Minimum income standard

  The minimum income standard for this classification of children is the AFDC payment standard in effect as of July 16, 1996, not converted to MAGI-equivalent. This standard is described in S14 AFDC Income Standards.

- Maximum income standard

  No income test was used (all income was disregarded) for this classification either in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

  - Yes
  - No

  No income test was used (all income was disregarded) for this classification under:

    - Check all that apply
    - The Medicaid state plan as of December 31, 2013.
    - A Medicaid 1115 Demonstration as of December 31, 2013.

  The state's maximum standard for this classification of children is no income test (all income is disregarded).

Income standard chosen

- Individuals qualify under this classification under the following income standard:

  - This classification does not use an income test (all income is disregarded).
  - The minimum standard.
  - Another income standard higher than both the minimum income standard and the effective income level for this classification in the state plan as of March 23, 2010, converted to a MAGI equivalent.

Additional new age groups or reasonable classifications covered

If the state has not elected to cover the Adult Group (42 CFR 435.119), it may elect to cover additional new age groups or reasonable classifications that have not been covered previously. If the state covers the Adult Group, this additional option is not available, as the standard for the new age groups or classifications is lower than that used for mandatory coverage.

The state does not cover the Adult Group and elects the option to include in this eligibility group additional age groups or reasonable classifications that have not been covered previously in the state plan or under a Medicaid 1115 Demonstration. Any additional age groups or reasonable classifications not previously covered are restricted to the AFDC income standard from July 16, 1996, not converted to a MAGI-equivalent standard.

- Yes
- No
Medicaid Eligibility

There is no resource test for this eligibility group.

PRA Disclosure Statement
According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

State: Texas  
Date Received:  3/31/14  
Date Approved:  8/25/14  
Date Effective:  1/1/14  
Transmittal Number:  TX 14-0002 MM1

Transmittal Number: TX 14-02 MM1  Date Approved: 8/25/14  Date Effective 1/1/14
Eligibility Groups - Options for Coverage
Children with Non IV-E Adoption Assistance

<table>
<thead>
<tr>
<th>42 CFR 435.227</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(a)(10)(A)(ii)(VIII)</td>
</tr>
</tbody>
</table>

**Children with Non IV-E Adoption Assistance** - The state elects to cover children with special needs for whom there is a non IV-E adoption assistance agreement in effect with a state, who were eligible for Medicaid, or who had income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.227.

- Yes
- No

The state attests that it operates this eligibility group in accordance with the following provisions:

- **Individuals qualifying under this eligibility group must meet the following criteria:**
  - The state adoption agency has determined that they cannot be placed without Medicaid coverage because of special needs for medical or rehabilitative care;
  - Are under the following age (see the Guidance for restrictions on the selection of an age):
    - Under age 21
    - Under age 20
    - Under age 19
    - Under age 18
  - MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

The state covered this eligibility group in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

- Yes
- No

The state also covered this eligibility group in the Medicaid state plan as of March 23, 2010.

- Yes
- No

Individuals qualify under this eligibility group if they were eligible under the state's approved state plan prior to the execution of the adoption agreement.

The state used an income standard or disregarded all income for this eligibility group either in the Medicaid state plan as of March 23, 2010 or December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

- Yes
- No

Income standard used for this eligibility group

- Minimum income standard
  - The minimum income standard for this eligibility group is the AFDC payment standard in effect as of July 16, 1996, not converted to MAGI-equivalent. This standard is described in S14 AFDC Income Standards.
- Maximum income standard
No income test was used (all income was disregarded) for this eligibility group either in the Medicaid state plan as of March 23, 2010 or December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

☐ Yes  ☐ No

☐ No income test was used (all income was disregarded) for this eligibility group under
(check all that apply):

☐ The Medicaid state plan as of March 23, 2010.
☒ The Medicaid state plan as of December 31, 2013.
☐ A Medicaid 1115 Demonstration as of December 31, 2013.

The state's maximum standard for this eligibility group is no income test (all income is disregarded).

☐ Income standard chosen

Individuals qualify under this eligibility group under the following income standard, which must be higher than the minimum for this child's age:

☐ The minimum standard.

☒ This eligibility group does not use an income test (all income is disregarded).

☐ Another income standard higher than both the minimum income standard and the effective income level for this eligibility group in the state plan as of March 23, 2010, converted to a MAGI-equivalent.

☐ There is no resource test for this eligibility group.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
## Medicaid Eligibility

### Eligibility Groups - Options for Coverage

**Optional Targeted Low Income Children**

<table>
<thead>
<tr>
<th>Eligibility Group</th>
<th>Details</th>
</tr>
</thead>
</table>
| S54               | 1902(a)(10)(A)(ii)(XIV)  
| 42 CFR 435.229 and 435.4  
| 1905(u)(2)(B) | |

**Optional Targeted Low Income Children** - The state elects to cover uninsured children who meet the definition of optional targeted low income children at 42 CFR 435.4, who have household income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.229.

- [ ] Yes
- [ ] No

### PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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State: Texas  
Date Received: 3/31/14  
Date Approved: 8/25/14  
Date Effective: 1/1/14  
Transmittal Number: TX 14-0002 MM1

Transmittal Number: TX 14-02 MM1  
Date Approved: 8/25/14  
Date Effective 1/1/14
Eligibility Groups - Options for Coverage

Individuals with Tuberculosis

- The state elects to cover individuals infected with tuberculosis who have income at or below a standard established by the state, limited to tuberculosis-related services.

☐ Yes ☐ No

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Eligibility Groups - Options for Coverage

Independent Foster Care Adolescents

42 CFR 435.226
1902(a)(10)(A)(ii)(XVII)

Independent Foster Care Adolescents - The state elects to cover individuals under an age specified by the state, less than age 21, who were in state-sponsored foster care on their 18th birthday and who meet the income standard established by the state and in accordance with the provisions described at 42 CFR 435.226.

☐ Yes  ☐ No

The state attests that it operates this eligibility group in accordance with the following provisions:

- Individuals qualifying under this eligibility group must meet the following criteria:
  - Are under the following age
    - Under age 21
    - Under age 20
    - Under age 19
  - Were in foster care under the responsibility of a state on their 18th birthday.
  - Are not eligible and enrolled for mandatory coverage under the Medicaid state plan.
  - Have household income at or below a standard established by the state.
  - MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

The state covered this eligibility group under its Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 demonstration as of March 23, 2010 or December 31, 2013.

☐ Yes  ☐ No

The state also covered this eligibility group in the Medicaid state plan as of March 23, 2010.

☐ Yes  ☐ No

The state covers children under this eligibility group, as follows (selection may not be more restrictive than the coverage in the Medicaid state plan as of March 23, 2010 until October 1, 2019, nor more liberal than the most liberal coverage in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 demonstration as of March 23, 2010 or December 31, 2013):

- All children under the age selected
- A reasonable classification of children under the age selected:
  - Individuals for whom foster care maintenance payments or independent living services were furnished under a program funded under title IV-E before the date the individual turned 18 years old.
  - Other reasonable classification

Description:

Individuals who were in foster care when they left the Texas Department of Family and Protective Services conservatorship on their 18th birthday or later, until they reach age 21.
Medicaid

Income standard used for this eligibility group

- Minimum income standard
  
  The minimum income standard for this classification of children is the AFDC payment standard in effect as of July 16, 1996, not converted to MAGI-equivalent. This standard is described in S14 AFDC Income Standards.

- Maximum income standard
  
  No income test was used (all income was disregarded) for this eligibility group either in the Medicaid state plan as of March 23, 2010 or December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

  ☐ Yes   ☑ No

  The state certifies that it has submitted and received approval for its converted income standard(s) for Independent Foster Care Adolescents to MAGI-equivalent standards and the determination of the maximum income standard to be used for individuals under this eligibility group.

  An attachment is submitted.

The state's maximum income standard for this eligibility group (which must exceed the minimum) is:

  The state's effective income level for independent foster care adolescents under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

  The state's effective income level for independent foster care adolescents under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

  The state's effective income level for independent foster care adolescents under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

  The state's effective income level for independent foster care adolescents under the Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

Enter the amount of the maximum income standard:

  ☐ A percentage of the federal poverty level: 413 %

  The state's AFDC payment standard in effect as of July 16, 1996, converted to a MAGI-equivalent standard. This standard is described in S14 AFDC Income Standards. This option should be selected only if Under age 21 or Under age 20 was selected, and if the state has not elected to cover the Adult Group.

  The state's TANF payment standard, converted to a MAGI-equivalent standard. This standard is described in S14 AFDC Income Standards. This option should be selected only if Under age 21 or Under age 20 was selected, and if the state has not elected to cover the Adult Group.

  ☐ Other dollar amount

Income standard chosen

Individuals qualify under this eligibility group under the following income standard:
Medicaid Eligibility

- The minimum standard.
- The maximum income standard.
  
  If not chosen as the maximum income standard, the state's effective income level for independent foster care adolescents under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

  If not chosen as the maximum income standard, and if higher than the effective income level used under the Medicaid state plan as of March 23, 2010, the state's effective income level for independent foster care adolescents under a Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL, or amounts by household size.

  If not chosen as the maximum income standard, and if higher than the effective income level used under the Medicaid state plan as of March 23, 2010, the state's effective income level for independent foster care adolescents under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

  If not chosen as the maximum income standard, and if higher than the effective income level used under the Medicaid state plan as of March 23, 2010, the state's effective income level for independent foster care adolescents under the Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

- Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income level for independent foster care adolescents in the Medicaid state plan as of March 23, 2010, converted to a MAGI equivalent.

There is no resource test for this eligibility group.

PRA Disclosure Statement
According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

State: Texas
Date Received: 3/31/14
Date Approved: 8/25/14
Date Effective: 1/1/14
Transmittal Number: TX 14-0002 MM1

Transmittal Number: TX 14-02 MM1  Date Approved: 8/25/14  Date Effective 1/1/14
## Eligibility Groups - Options for Coverage

### Individuals Eligible for Family Planning Services


**Individuals Eligible for Family Planning Services** - The state elects to cover individuals who are not pregnant, and have household income at or below a standard established by the state, whose coverage is limited to family planning and related services and in accordance with provisions described at 42 CFR 435.214.

☐ Yes ☒ No

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### PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Non-Financial Eligibility

State Residency

The state provides Medicaid to otherwise eligible residents of the state, including residents who are absent from the state under certain conditions.

- Individuals are considered to be residents of the state under the following conditions:
  - Non-institutionalized individuals age 21 and over, or under age 21, capable of indicating intent and who are emancipated or married, if the individual is living in the state and:
    - Intends to reside in the state, including without a fixed address, or
    - Entered the state with a job commitment or seeking employment, whether or not currently employed.
  - Individuals age 21 and over, not living in an institution, who are not capable of indicating intent, are residents of the state in which they live.
  - Non-institutionalized individuals under 21 not described above and non IV-E beneficiary children:
    - Residing in the state, with or without a fixed address, or
    - The state of residency of the parent or caretaker, in accordance with 42 CFR 435.403(h)(1), with whom the individual resides.
  - Individuals living in institutions, as defined in 42 CFR 435.1010, including foster care homes, who became incapable of indicating intent before age 21 and individuals under age 21 who are not emancipated or married:
    - Regardless of which state the individual resides, if the parent or guardian applying for Medicaid on the individual's behalf resides in the state, or
    - Regardless of which state the individual resides, if the parent or guardian resides in the state at the time of the individual's placement, or
    - If the individual applying for Medicaid on the individual's behalf resides in the state and the parental rights of the institutionalized individual's parent(s) were terminated and no guardian has been appointed and the individual is institutionalized in the state.
  - Individuals living in institutions who became incapable of indicating intent at or after age 21, if physically present in the state, unless another state made the placement.
  - Individuals who have been placed in an out-of-state institution, including foster care homes, by an agency of the state.
  - Any other institutionalized individual age 21 or over when living in the state with the intent to reside there, and not placed in the institution by another state.
  - IV-E eligible children living in the state, or

TN: TX 14-004 MM5   Date Approved: 10-16-2014   Date Effective: 1-1-2014
Otherwise meet the requirements of 42 CFR 435.403.
Medicaid Eligibility

Meet the criteria specified in an interstate agreement.

☐ Yes  ☐ No

☐ The state has interstate agreements with the following selected states:

- Alabama
- Alaska
- Arizona
- Arkansas
- California
- Colorado
- Connecticut
- Delaware
- District of Columbia
- Florida
- Georgia
- Hawaii
- Idaho
- Illinois
- Indiana
- Iowa
- Kansas
- Kentucky
- Louisiana
- Maine
- Maryland
- Massachusetts
- Michigan
- Minnesota
- Mississippi
- Missouri
- Montana
- Nebraska
- Nevada
- New Hampshire
- New Jersey
- New Mexico
- New York
- North Carolina
- North Dakota
- Ohio
- Oklahoma
- Oregon
- Pennsylvania
- Rhode Island
- South Carolina
- South Dakota
- Tennessee
- Texas
- Utah
- Vermont
- Virginia
- Washington
- West Virginia
- Wisconsin
- Wyoming

☐ The interstate agreement contains a procedure for providing Medicaid to individuals pending resolution of their residency status and criteria for resolving disputed residency of individuals who (select all that apply):

- Are IV-E eligible
- Are in the state only for the purpose of attending school
- Are out of the state only for the purpose of attending school
- Retain addresses in both states
- Other type of individual

☐ The state has a policy related to individuals in the state only to attend school.

☐ Yes  ☐ No

☐ Otherwise meet the criteria of resident, but who may be temporarily absent from the state.

☐ The state has a definition of temporary absence, including treatment of individuals who attend school in another state.

☐ Yes  ☐ No

State: Texas  
Date received: 3-31-14  
Date Approved: 10-16-14  
Date Effective: 1-1-14  
Transmittal Number: 14-004 MM5

TN: TX 14-004 MM5  Date Approved: 10-16-2014  Date Effective: 1-1-2014
Medicaid Eligibility

Provide a description of the definition:

An individual may be temporarily absent from the State and maintain Texas residency if the person intends to return when the purpose of the absence has been accomplished, unless another State has determined that the person is a resident there for Medicaid purposes.

PRA Disclosure Statement

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Medicaid Eligibility

General Eligibility Requirements
Eligibility Process

42 CFR 435, Subpart J and Subpart M

Eligibility Process

☑ The state meets all the requirements of 42 CFR 435, Subpart J for processing applications, determining and verifying eligibility, and furnishing Medicaid.

Application Processing

Indicate which application the agency uses for individuals applying for coverage who may be eligible based on the applicable modified adjusted gross income standard.

☐ The single, streamlined application for all insurance affordability programs, developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act.

☐ An alternative single, streamlined application developed by the state in accordance with section 1413(b)(1)(B) of the Affordable Care Act and approved by the Secretary, which may be no more burdensome than the streamlined application developed by the Secretary.

☐ An attachment is submitted.

An alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single or alternative application used only for insurance affordability programs to individuals seeking assistance only through such programs.

☐ An attachment is submitted.

Indicate which application the agency uses for individuals applying for coverage who may be eligible on a basis other than the applicable modified adjusted gross income standard:

☐ The single, streamlined application developed by the Secretary or one of the alternate forms developed by the state and approved by the Secretary, and supplemental forms to collect additional information needed to determine eligibility on such other basis, submitted to the Secretary.

☐ An attachment is submitted.

☐ An application designed specifically to determine eligibility on a basis other than the applicable MAGI standard which minimizes the burden on applicants, submitted to the Secretary.

☐ An attachment is submitted.

The agency's procedures permit an individual, or authorized person acting on behalf of the individual, to submit an application via the internet website described in 42 CFR 435.1200(f), by telephone, via mail, and in person.

☐ Yes ☐ No

The agency also accepts applications by other electronic means.
# Medicaid Eligibility

Indicate the other electronic means below:

<table>
<thead>
<tr>
<th>Name of Method</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facsimile</td>
<td>Applications for Medicaid can be submitted by fax to 1-877-HHSC-TEX (1-877-447-2839).</td>
</tr>
</tbody>
</table>

The agency has procedures to take applications, assist applicants and perform initial processing of applications for the eligibility groups listed below at locations other than those used for the receipt and processing of applications for the title IV-A program, including Federally-qualified health centers and disproportionate share hospitals.

- Parents and Other Caretaker Relatives
- Pregnant Women
- Infants and Children under Age 19

**Redetermination Processing**

- Redeterminations of eligibility for individuals whose financial eligibility is based on the applicable modified adjusted gross income standard are performed as follows, consistent with 42 CFR 435.916:
  - ☑ Once every 12 months
  - ☑ Without requiring information from the individual if able to do so based on reliable information contained in the individual’s account or other more current information available to the agency.
  
  If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional information to complete the redetermination, it provides the individual with a pre-populated renewal form containing the information already available.
  
- Redeterminations of eligibility for individuals whose financial eligibility is not based on the applicable modified adjusted gross income standard are performed, consistent with 42 CFR 435.916 (check all that apply):
  - ☑ Once every 12 months
  - ☑ Once every 6 months
  - ☐ Other, more often than once every 12 months

**Coordination of Eligibility and Enrollment**

The state meets all the requirements of 42 CFR 435, Subpart M relative to coordination of eligibility and enrollment between Medicaid, CHIP, Exchanges and other insurance affordability programs. The single state agency has entered into agreements with the Exchange and with other agencies administering insurance affordability programs.

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**PRA Disclosure Statement**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, 2500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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State: Texas  
Date Received: 12/31/2013  
Date Approved: 07/15/2014  
Date Effective: 10/01/2013  
Transmittal Number: 13-0045-MM2
USE OF THE ALTERNATIVE SINGLE STREAMLINED APPLICATION

<table>
<thead>
<tr>
<th>Paper Application</th>
<th>Online Application</th>
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**TRANSMITTAL NUMBER:** TX-13-0045-MM2  
**STATE:** Texas

Through August 31, 2014, the state is using an interim paper alternative single streamlined application. After August 31, 2014, the state will use a revised paper application. The revised application will address the issues outlined in the CMS letter, which was issued with the approval of this state plan amendment, concerning the state’s application. The revised application will be incorporated by reference into the state plan.

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**State:** Texas  
**Date Received:** 12/31/2013  
**Date Approved:** 07/15/2014  
**Date Effective:** 10/1/2013  
**Transmittal Number:** 13-0045-MM2

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**TN No:** 13-0045-MM2  
**APPROVAL DATE:** 07/15/2014  
**EFFECTIVE DATE:** 10/1/2013  
**STATE:** TEXAS  
**PAGE:** Attachment 1
Through December 31, 2014, the state is using an interim alternative single streamlined application. After December 31, 2014, the state will use a revised alternative single streamlined application. The revised application will address the issues outlined in the CMS letter, which was issued with the approval of this state plan amendment, concerning the state’s application. The revised application will be incorporated by reference into the state plan.
AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

1. Inpatient hospital services other than those provided in an institution for mental diseases.

Provided: ☐ No limitations ☑ With limitations*

2. a. Outpatient hospital services.

Provided: ☐ No limitations ☑ With limitations*

b. Rural health clinic services and other ambulatory services furnished by a rural health clinic and covered under the Plan.

Provided: ☑ No limitations ☑ With limitations*

Not provided.

c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

Provided: ☑ No limitations ☑ With limitations*

3. Other laboratory and X-ray services.

Provided: ☑ No limitations ☑ With limitations*

*Description provided on attachment.

TN No. 91-34 Supersedes Approval Date JAN 14 1992
TN No. 90-50, Attachment 3.1-A, pgs 1, items 1-3 Effective Date OCT 01 1991
HCFA ID: 7986E

STATE Texas
DATE REC'D DEC 1 1 1991
DATE APP'D JAN 14 1992
DATE EFF OCT 01 1991
HCFA 179 91-34
AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older:

Provided: ☐ No Limitations  ☑ With Limitations*

4.b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.*

Provided: ☐ No Limitations  ☑ With Limitations*

4.c. Family planning services and supplies for individuals of child-bearing age.

Provided: ☐ No Limitations  ☑ With Limitations*

4.d. Tobacco cessation counseling services for pregnant women.

Provided: ☐ No Limitations  ☑ With Limitations*

5.a. Physicians services whether furnished in the office, the patient’s home, a hospital, a nursing facility, or elsewhere.

Provided: ☐ No Limitations  ☑ With Limitations*

b. Medical and surgical services furnished by a dentist (in accordance with 1905(a)(5)(B) of the Act).

Provided: ☐ No Limitations  ☑ With Limitations*

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners under the scope of their practice as defined by State law.

Provided: ☐ No Limitations  ☑ With Limitations*

a. Podiatrists’ services.

Provided: ☐ No Limitations  ☑ With Limitations* ☐ Not Provided

* Description provided on attachment.

SUPERSEDES: TN: 03-21

TN: 12-07  Approval Date: 6-07-12  Effective Date: 1-1-12

Supersedes TN: 03-21
b. Optometrists' services.

\( \checkmark \) Provided: \( / \) No limitations \( / \) With limitations*
\( / \) Not provided.

c. Chiropractors' services.

\( \checkmark \) Provided: \( / \) No limitations \( / \) With limitations*
\( / \) Not provided.

d. Other practitioners' services.

\( \checkmark \) Provided: Identified on attached sheet with description of limitations, if any.
\( / \) Not provided

7. Home health services.

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

Provided: \( / \) No limitations \( / \) With limitations*

b. Home health aide services provided by a home health agency.

Provided: \( / \) No limitations \( / \) With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

Provided: \( / \) No limitations \( / \) With limitations*

*Description provided on attachment.
AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

  XXX Provided  No Limitations  XXX with Limitations*
  PA*  Not Provided

8. Private Duty Nursing services

  XXX Provided  No Limitations  XXX with Limitations*
  Not Provided

*Description provided on attachment.
9. Clinic services.
   [ ] Provided  [ ] No limitations  [x] With limitations*
   [ ] Not Provided

10. Dental services.
    [ ] Provided  [ ] No limitations  [ ] With limitations*
    [x] Not Provided

11. Physical therapy and related services.
    a. Physical therapy.
       [x] Provided  [ ] No limitations  [x] With limitations*
       [ ] Not Provided
    b. Occupational therapy.
       [ ] Provided  [ ] No limitations  [ ] With limitations*
       [x] Not Provided
    c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist).
       [x] Provided  [ ] No limitations  [x] With limitations*
       [ ] Not Provided

*Description provided on attachment

SUPERSEDES: TN. 90-06

Revision: HCFA-PM-85-3
MAY 1985
State of Texas
Attachment 3.1-A
Page 4
12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

/✓/ Provided: // No limitations X/ With limitations*
// Not provided.

b. Dentures.

/✓/ Provided: // No limitations // With limitations*
// Not provided.

c. Prosthetic devices.

/✓/ Provided: // No limitations /X/ With limitations*
// Not provided.

d. Eyeglasses.

/✓/ Provided: // No limitations /X/ With limitations*
// Not provided.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostic services.

/// Provided: // No limitations // With limitations*
/// Not provided.

*Description provided on attachment.
AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Screening services.
   - Provided ☑ No limitations ☐ With limitations
   - Not Provided

c. Preventive services.
   - Provided ☑ No limitations ☐ With limitations*
   - Not Provided

d. Rehabilitative services.
   - Provided ☑ No limitations ☐ With limitations*
   - Not Provided

14. Services for individuals age 65 or older in institutions for mental diseases.
   a. Inpatient hospital services.
      - Provided ☑ No limitations ☐ With limitations*
      - Not Provided

b. Nursing facility services.
   - Provided ☑ No limitations ☐ With limitations
   - Not Provided

*Description provided on attachment

<table>
<thead>
<tr>
<th>STATE</th>
<th>Texas</th>
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<tbody>
<tr>
<td>DATE REC'D</td>
<td>6-26-09</td>
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<tr>
<td>DATE APP'ED</td>
<td>3-4-10</td>
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<tr>
<td>DATE EFF</td>
<td>1-1-2010</td>
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SUPERSEDES: TN-94-30
AMOUNT, DURATION AND SCOPE OF MEDICAL AND 
REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

15. Services in an intermediate care facility for the mentally retarded, as defined in section 1905(d), (other than in an institution for mental diseases) for individuals who are determined, in accordance with sanction 1902(a)(31)(A), to be in need of such care.

☒ Provided: ☐ No Limitations ☒ With Limitations*

☐ Not provided

16. Inpatient psychiatric facility services for individuals under 21 years of age.

☒ Provided: ☒ No Limitations* ☐ With Limitations

☐ Not provided

17. Nurse-midwife services.

☒ Provided: ☐ No Limitations ☒ With Limitations*

☐ Not provided

18. Hospice care (in accordance with section 1905(o) of the Act.

☒ Provided: ☐ No Limitations ☒ With Limitations*

☐ Not provided

*Description provided on attachment.

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SUPERSEDES: TN. 90-50

STATE TEXAS
DATE REC'D 9-29-08
DATE APPV'D 9-1-09 A
DATE EFF 9-1-08
HCFA 179 08-26
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: TEXAS

19. Case management services and Tuberculosis related services
   a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).
      X Provided: X With limitations
      ___ Not provided.
   b. Special tuberculosis (TB) related services under section 1902(a)(2)(F) of the Act.
      ___ Provided: ___ With limitations*
      X Not provided.

20. Extended services for pregnant women
   a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.
      ___ Additional coverage ++
   b. Services for any other medical conditions that may complicate pregnancy.
      ___ Additional coverage ++

++ Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

*Description provided on attachment.

[Provided: XXX No limitations ☐ With limitations]
[Not provided: ]

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

[Provided: XXX No limitations ☐ With limitations]
[Not provided: ]

23. Pediatric or family nurse practitioners' services.

[Provided: No limitations XXX With limitations]

*Description provided on attachment.
AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.
   - Provided: ☑   No limitations ☑   With limitations*
   - Not Provided.

b. Services provided in Religious Nonmedical Health Care Institutions.
   - Provided: ☑   No limitations ☑   With limitations*
   - Not Provided.

c. Reserved

d. Nursing facility services for patients under 21 years of age.
   - Provided: ☑   No limitations ☑   With limitations*
   - Not Provided.

e. Emergency hospital services.
   - Provided: ☑   No limitations ☑   With limitations*
   - Not Provided.

f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.
   - Provided: ☑   No limitations ☑   With limitations*
   - Not Provided.

* Description provided on attachment
State/Territory: ________________ Texas ________________

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

g. Ambulatory Surgical Center Services.
   ☑ Provided: ☐ No limitations ☑ With limitations*
   ☐ Not Provided.

h. Birthing Center Facility Services.
   ☑ Provided: ☐ No limitations ☑ With limitations*
   ☐ Not Provided.

* Description provided on attachment

STATE  TEXAS
DATE REC'D  03-14-03
DATE APPV'D  03-24-03
DATE EFF  01-01-03
HCFA 179  TY-03-06

TN No. TK-03-06
Supersedes
TN No. TK-87-10

Approval Date 03-24-03 Effective Date 01-01-03
AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A_G to Supplement 2 to Attachment 3.1-A.

   _X_ Provided  ___ Not Provided

26. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home.

   _X_ Provided:  _X_ State Approved (not physician) Service Plan allowed

   _X_ Services outside the home also allowed

   _X_ Limitations described on Attachment

   ___ Not Provided.
AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDICAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

27. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 to Attachment 3.1-A.

    _X_ Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

    ___ No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.
State/Territory: __TX_______

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

30. Coverage of Routine Patient Cost in Qualifying Clinical Trials

Provided: ✓

I. General Assurances:

Routine Patient Cost – Section 1905(gg)(1)

✓ Coverage of routine patient cost for items and services as defined in section 1905(gg)(1) that are furnished in connection with participation in a qualified clinical trial.

Qualifying Clinical Trial – Section 1905(gg)(2)

✓ A qualified clinical trial is a clinical trial that meets the definition at section 1905(gg)(2).

Coverage Determination – Section 1905(gg)(3)

✓ A determination with respect to coverage for an individual participating in a qualified clinical trial will be made in accordance with section 1905(gg)(3).

PRA Disclosure Statement - This information is being collected to assist the Centers for Medicare & Medicaid Services in implementing Section 210 of the Consolidated Appropriations Act of 2021 amending section 1905(a) of the Social Security Act (the Act), by adding a new mandatory benefit at section 1905(a)(30). Section 210 mandates coverage of routine patient services and costs furnished in connection with participation by Medicaid beneficiaries in qualifying clinical trials effective January 1, 2022. Section 210 also amended sections 1902(a)(10)(A) and 1937(b)(5) of the Act to make coverage of this new benefit mandatory under the state plan and any benchmark or benchmark equivalent coverage (also referred to as alternative benefit plans, or ABPs). Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #74). Public burden for all of the collection of information requirements under this control number is estimated to take about 56 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
Targeted Case Management for Individuals with Chronic Mental Illness

1) Target Group:
   a) Individuals, regardless of age, who have a single chronic mental disorder, excluding mental retardation or pervasive developmental disorder, or a combination of chronic mental disorders as defined in the latest edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders and who have been determined via a uniform assessment process to be in need of case management services.
   b) Individuals transitioning to a community setting up to 180 consecutive days prior to leaving the institution who have a single chronic mental disorder, excluding mental retardation or pervasive developmental disorder, or a combination of chronic mental disorders as defined in the latest edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders and who have been determined via a uniform assessment process to be in need of case management services.
   c) The target group does not include individuals between ages 22 and 64 who are served in an IMD or individuals who are inmates of public institutions.

2) Areas of state in which services will be provided:
   a) Entire State

3) Comparability of services:
   a) Services are not comparable in amount duration and scope. Under section 1915(g) of the Social Security Act, a state may provide services without regard to the comparability requirements of section 1902(a)(10)(B).

4) Definition of services:
   a) Case management services are services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational, and other services and supports. Case management includes the following assistance:
      i) Comprehensive assessment and periodic reassessment, as clinically necessary, of individual needs to determine the need for any medical, educational, social, or other services. These assessment activities include:
         (1) taking a client's history;
         (2) identifying the individual's needs and completing related documentation;
         and
         (3) gathering information from other sources, such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.
Targeted Case Management for Individuals with Chronic Mental Illness (continued)

4) Definition of services (continued)

   ii) Development (and periodic revision, as clinically necessary) of a specific care plan that:
       (1) is based on the information collected through the assessment;
       (2) specifies the goals and actions to address the medical, social, educational, and other services and supports needed by the individual;
       (3) includes activities such as ensuring the active participation of the eligible individual and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and
       (4) identifies a course of action to respond to the assessed needs of the eligible individual.

   iii) Referral and related activities to help an eligible individual obtain needed services and supports, including activities that help link an individual with:
       (1) medical, social, and educational providers; and
       (2) other programs and services that provide needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.

   iv) Monitoring and follow-up activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the individual's needs.
       (1) Such activities may be with the individual, family members, providers, or other entities or individuals and conducted as frequently as necessary, and at least once annually, to determine whether the following conditions are met:
           (a) services are being furnished in accordance with the individual's care plan;
           (b) services in the care plan are adequate in amount, scope and duration to meet the needs of the individual; and
           (c) the care plan and service arrangements are modified when the individual's needs or status change.
       (2) Case management may include contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services, providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs.
       (3) Case management services are coordinated with and do not duplicate activities provided as part of institutional services and discharge planning activities.
Targeted Case Management for Individuals with Chronic Mental Illness (continued)

5) Levels of case management
   a) Site based – primarily face-to-face contact with the Medicaid-eligible individual provided primarily at the provider's place of business (e.g., clinic outpatient office) with telephone contacts with community based agencies, support groups, providers, and other individuals as required to meet the needs of the individual.
   b) Community-based – face-to-face contact with the Medicaid-eligible individual provided primarily at the consumer's home, work place, school, or other location that best meets the consumer's needs with telephone or face-to-face contacts with community based agencies, support groups, providers, and other individuals as required to meet the needs of the individual.

6) Qualifications of providers:
   a) Effective August 31, 2004, a provider of case management must:
      i) demonstrate competency in the work performed; and
      ii) possess a bachelor's degree from an accredited college or university with a minimum number of hours that is equivalent to a major in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education, or early childhood intervention; or
      iii) be a Registered Nurse (RN); or
      iv) complete an alternative credentialing process identified by the Texas Department of State Health Services (the State's mental health agency).
   b) Individuals authorized to provide case management services prior to August 31, 2004, may provide case management services without meeting the minimum qualifications described above if they meet the following criteria:
      i) high school diploma or high school equivalency;
      ii) three continuous years of documented full-time experience in the provision of mental health case management services as of August 30, 2004; and
      iii) demonstrated competency in the provision and documentation of case management services.
      iv) A case manager must be clinically supervised by another qualified case manager who meets the criteria in subsection 6a above.
Targeted Case Management for Individuals with Chronic Mental Illness (continued)

7) Freedom of choice:
   a) Section 1915(g)(1) of the Social Security Act is invoked to limit the providers of case management services to the State Mental Health Authority, which is the Texas Department of State Health Services and community mental health centers and community mental health and mental retardation centers, which are established in accordance with §534.001, Texas Health and Safety Code. In §534.001, the term "department" means, for mental health services, the Department of State Health Services, the successor agency to the Department of Mental Health and Mental Retardation for mental health services. Eligible recipients will have free choice of available providers within these agencies.
   b) The Department of State Health Services has implemented rules, standards, and procedures to ensure that case management activities are:
      i) Available on a statewide basis with procedures to ensure continuity of services without duplication;
      ii) Provided by individuals who meet the requirements of education and work experience commensurate with their job responsibilities as specified by DSHS; and
      iii) In compliance with federal, state, or local laws, including directives, settlements, and resolutions applicable to the target population.
   c) Eligible recipients will have free choice of the providers of other medical care under the plan.

8) Access to Services:
   a) The State assures that case management services will not be used to restrict an individual's access to other services under the plan.
   b) The State assures that individuals will not be compelled to receive case management services, condition receipt of case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services.
   c) Providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

SUPERSEDES: TN__04-08__

STATE Texas A SUPEREDES: TN__04-08__
DATE REC'D 2-3-11
DATE APPVD 4-26-11
DATE EFF 9-1-11
HCFA 179 11-04

TN 11-04 Approval Date 4-26-11 Effective Date 9-1-11
Supersedes TN 04-08
9) Case Records:
   a) Providers maintain case records that document for all individuals receiving case management:
      i) the name of the individual;
      ii) dates of the case management services;
      iii) the name of the provider agency (if relevant) and the person providing the case management service;
      iv) the nature, content, units of case management services provided, including:
         (1) whether the outcomes specified in the care plan have been achieved;
         (2) whether the individual has declined services in the care plan;
         (3) collateral contacts including coordination with other case managers;
         (4) the timeline for obtaining needed services; and
         (5) a timeline for reevaluation of the need for services.

10) Payment:
    a) Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.
    b) Case management providers are paid based on the reimbursement methodology described in Attachment 4.19 B, 14(e).

11) Limitations:
    a) Case Management does not include:
       i) Case management activities that are an integral component of another covered Medicaid service;
       ii) The direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred;
       iii) Activities integral to the administration of foster care programs; and
       iv) Services provided to individuals with a single diagnosis of mental retardation or a developmental disability or disorder who, if an adult, do not also have a co-occurring diagnosis of mental illness or, if a child, do not have a co-occurring diagnosis of serious emotional disturbance.
    b) FFP only is available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program except for case management that is included in an individualized education program or individualized family service plan consistent with §1903(c) of the Act.
A. Target Group: Mental retardation or related conditions or pervasive developmental disability
   
   See attachment

B. Areas of State in which services will be provided:
   - [x] Entire State.
   - [ ] Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide

C. Comparability of Services
   - [x] Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.
   - [ ] Services are provided in accordance with section 1902(a)(10)(B) of the Act.

D. Definition of Services
   See attachment

E. Qualification of Providers:
   See attachment

SUPERSEDES: TN 88-24
Case Management Services for Persons with Mental Retardation or Related Conditions or Pervasive Developmental Disability

1) Target Group:
   a) Individuals with mental retardation or a related condition or pervasive developmental disability who require long-term care in the community.
      i) Mental retardation is defined as significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior and originating during the developmental period. Sub-average general intellectual functioning refers to measured intelligence on standardized psychometric instruments of two or more standard deviations below the age group mean for the tests used. Developmental period means the period of time from conception to 18 years. Arrest or deterioration of intellectual ability that occurs after this period is functional retardation and does not meet the definition of mental retardation.
      ii) Related condition is defined as a severe, chronic disability that meets the criteria outlined in 42 CFR 435.1010.
      iii) Pervasive developmental disorder (PDD) is characterized by severe and pervasive impairment in several areas of development: reciprocal social interaction skills, communication skills, or the presence of stereotyped behavior, interests, and activities that meet the criteria outlined in the current version of the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.
   b) Individuals who meet the criteria in a) who are transitioning to a community setting from a medical institution during the last 180 days of a covered long-term stay.

2) Areas of state in which services will be provided:
   Entire State

3) Comparability of services:
   Services are not comparable in amount, duration and scope. Under section 1915(g) of the Social Security Act, a state may provide case management services without regard to the comparability requirements of section 1902(a)(10)(B).

4) Definition of services:
   a) Case management services are services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational, and other services that will help them achieve a quality of life and community participation acceptable to each individual. Case management includes the following assistance:

   TN No. 07-43 Approval Date 5-25-10 Effective Date 10-1-07
   Supersedes TN No. 04-27
i) Comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social or other services. These assessment activities include:

(1) taking a client's history;

(2) identifying the individual’s presenting problem and service needs and completing related documentation; and

(3) gathering information from other sources, such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.

ii) Development (and periodic revision) of a specific care plan that:

(1) is based on the information collected through the assessment;

(2) conforms to the principles of person-directed planning, which is a process that empowers the individual (and the legally authorized representative (LAR) on the individual’s behalf) to direct the development of a plan of supports and services that meet the individual's personal outcomes or goals;

(3) specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;

(4) includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual’s authorized health care decision maker) and others to develop those goals; and

(5) identifies a course of action to respond to the assessed needs of the eligible individual and includes a description of the desired outcomes identified by the individual (or LAR) and a description of the services and supports (including service coordination) to be provided to the individual, with specifics concerning frequency and duration.

iii) Referral and related activities to help an eligible individual obtain needed services, including activities that help link an individual with:

(1) medical, social, and educational providers, or

(2) other programs and services that can provide needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.
(Case Management Services for Persons with Mental Retardation or Related Conditions or Pervasive Developmental Disability, Continued.)

iv) Monitoring and follow-up activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the individual's needs.

(1) Such activities may be with the individual, family members, providers, or other entities or individuals and conducted as frequently as necessary, and at least every 90 calendar days, to determine whether the following conditions are met:

(a) services are being furnished in accordance with the individual's care plan;

(b) services in the care plan are adequate; and

(c) the care plan and service arrangements are modified when the individual's needs or status change.

(2) Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CFR 440.169(e)).

(3) Case management services are coordinated with and do not duplicate activities provided as part of institutional services and discharge planning activities.

5) Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):
Specify provider qualifications that are reasonably related to the population being served and the case management services furnished:

a) A provider agency of case management must be an entity that is designated as the local intellectual and developmental disability authority (LIDDA). Only an employee of a provider agency may provide case management services.

b) Effective November 1, 2022, an employee of a provider agency who provides case management services must have:

i) a bachelor's or advanced degree from an accredited college or university;

ii) an associate degree in a social, behavioral, human service, or health-related field including, but not limited to, psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human development, gerontology, educational psychology, education, and criminal justice; or

a high school diploma or a certificate recognized by the state as the equivalent of a high school diploma and two years of paid or unpaid experience with individuals with intellectual or developmental disabilities.
c) Effective April 1, 1999 through November 1, 2022, an employee of a provider agency who provides case management services must have:

i) a bachelor’s or advanced degree from an accredited college or university with a major in a social, behavioral, or human service field, including, but not limited to, psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human development, gerontology, educational psychology, education, and criminal justice; or

ii) a high school diploma or a certificate recognized by the state as the equivalent of a high school diploma; and

(1) two years of paid experience as a case manager in a state or federally funded Parent Case Management Program or have graduated from Partners in Policy Making; and

(2) personal experience as an immediate family member of an individual with mental retardation

d) A person who was authorized by a provider agency to provide case management services to an individual with an intellectual disability or related condition or pervasive developmental disability prior to April 1, 1999, may provide case management services without meeting the minimum qualifications described in c) above.

e) Until December 31, 2011, a provider agency may hire a person to provide case management services who does not meet the minimum qualifications described in c) above if the person was employed as a case manager in the Home and Community-based Services (HCS) waiver program for any period of time prior to June 1, 2010.

f) Beginning January 1, 2012, a provider agency may hire a person to provide case management services who does not meet the minimum qualifications described in c) above if the person had been hired by another provider agency in accordance with d) above.

g) Supervision of case managers (service coordinators) is provided by the provider agency. Supervisors are staff with considerable experience in the provision of service and supports to persons with intellectual disabilities. Supervisors are knowledgeable about local resources available to provide supports. Additionally, state rules require specific training for staff that supervise or oversee the provision of service coordination. Additionally, provider agencies are required to conduct quality assurance activities that review processes and outcomes of service coordination activities.
(Case Management Services for Persons with Mental Retardation or Related Conditions or Pervasive Developmental Disability, Continued.)

6) Freedom of choice of provider agency (42 CFR 441.18(a)(1)):
The State assures that the provision of case management services will not restrict an individual’s free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):
Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services:

Section 1915(g)(1) of the Social Security Act is invoked to limit the provider agencies of case management services to each local intellectual and developmental disability authority (LIDDA) that is designated as such by the Executive Commissioner of the Texas Health and Human Services Commission.

Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.
7) Access to Services

a) The State assures that case management services will not be used to restrict an individual’s access to other services under the plan.

b) The State assures that individuals will not be compelled to receive case management services, condition receipt of case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services.

c) The State assures that providers of case management services do not exercise the agency’s authority to authorize or deny the provision of other services under the plan.

d) The State assures that the amount, duration, and scope of the case management activities will be documented in an individual’s plan of care, which includes case management activities prior to and post-discharge, to facilitate a successful transition to the community.

e) The State assures that case management is only provided by and reimbursed to provider agencies.

8) Case Records:

a) A provider agency maintains case records that document for all individuals receiving case management the following:

i) the name of the individual;

ii) dates of the case management services;

iii) the name of the provider agency and the employee providing the case management service;

iv) the nature, content, and units of the case management services received and whether goals specified in the plan of care have been achieved;

v) whether the individual has declined services in the plan of care;

vi) the need for, and occurrences of, coordination with other case managers;

vii) a timeline for obtaining needed services; and

viii) a timeline for reevaluation of the plan of care.
(Case Management Services for Persons with Mental Retardation or Related Conditions or Pervasive Developmental Disability, Continued.)

9) Payment:

a) Payment for case management services under the state plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

b) Provider agencies are paid based on the reimbursement methodology described in Attachment 4.19 B, Page 15.

10) Limitations:

a) Case Management does not include the following:

   i) Case management activities that are an integral component of another covered Medicaid service;
   
   ii) Direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred;
   
   iii) Activities integral to the administration of foster care programs; or
   
   iv) Activities for which an individual may be eligible that are integral to the administration of another non-medical program, except for case management that is included in an individualized education program or individualized family service plan consistent with section 1903(c) of the Social Security Act.
Blind and Visually Impaired Children Pages were deleted in SPA 17-0001:

Page 1C (TN-10-070)
Page 1C.1 (TN-10-070)
Page 1C.2 (TN-10-070)
Page 1C.3 (TN-10-070)
CASE MANAGEMENT SERVICES
High Risk Pregnant Women Age 21 and Over

1) **Target Group:**

   a) Women age 21 and over who are pregnant and have one or more high-risk medical and/or personal/psychosocial condition(s) during pregnancy.

2) **Areas of state in which services will be provided:**

   a) Entire State

3) **Comparability of services:**

   a) Services are not comparable in amount duration and scope. Under section 1915(g) of the Social Security Act, a state may provide services without regard to the comparability requirements of section 1902(a)(10)(B) of the Act.

4) **Definition of services:**

   a) Case management services are services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational, and other services. Case Management includes the following assistance:

   i) Comprehensive face-to-face assessment of individual needs to determine the need for any medical, educational, social, or other services required to address short- and long-term health and well-being. All eligible clients are assessed at the initiation of services. If a client later transitions to a new provider or has a major change in his or her health status or environment, a second assessment may be necessary and can be requested. These assessment activities include:

      (1) taking a client’s history;

      (2) identifying the individual’s needs and assessing and addressing family issues that impact the client’s health condition/risk or high-risk condition and completing related documentation; and

      (3) gathering information from other sources, such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.
ii) Development (and periodic revision) of a specific care plan that:

(1) is based on the information collected through the face-to-face needs assessment, face-to-face follow-up contacts, or telephone follow-up contacts;

(2) specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;

(3) includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and

(4) identifies a course of action to respond to the assessed needs of the eligible individual, including identifying the individual responsible for contacting the appropriate health and human service providers; and designating the time frame within which the eligible recipient should access services.

iii) Referral and related activities to help an eligible individual obtain needed services, including activities that help link an individual with:

(1) medical, social, and educational providers, and

(2) other programs and services that can provide needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.

iv) Follow-up activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the individual's needs.

(1) Such activities may be with the individual, family members, providers, or other entities or individuals and conducted as frequently as necessary up to the 59th day postpartum, and including at least one annual follow-up contact for clients who are eligible for case management for longer than 12 consecutive months, to determine whether the following conditions are met:

(a) services are being furnished in accordance with the individual's care plan;

(b) services in the care plan are adequate, and

(c) the care plan and service arrangement are modified when the individual's needs or status change.
(1) Case management may include contacts with non-eligible individuals that are directly related to identify the needs and supports for helping the eligible individual access services.

b) Qualifications of providers:

i) Registered nurse (with a bachelor’s or advanced degree), registered nurse (without a bachelor’s or advanced degree and with two years of experience) or social worker (with bachelor’s or advanced degree), currently licensed by the respective Texas licensure board and whose license is not temporary, limited, or provisional in nature; and

ii) Completion of a standardized Department of State Health Services case management training.

5) Freedom of choice:

a) The State assures that the provision of case management services will not restrict an individual’s free choice of providers in violation of section 1902(a)(23) of the Act.

i) Eligible recipients will have free choice of the providers of case management services within the specified geographic area identified in this plan.

b) Eligible recipients will have free choice of the providers of other medical care under the plan.

6) Access to Services:

a) The State assures that case management services will be provided in a manner consistent with the best interest of the recipient and will not be used to restrict an individual’s access to other services under the plan.

b) The State assures that individuals will not be compelled to receive case management services, condition receipt of case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services.

c) The State assures that providers of case management services do not exercise the agency’s authority to authorize or deny the provision of other services under the plan.
7) Case Records

a) Providers maintain case records that document for all individuals receiving case management as follows:
   i) The name of the individual;
   ii) The dates of the case management services;
   iii) The name of the provider agency (if relevant) and the person providing the case management service;
   iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved;
   v) Whether the individual has declined services in the care plan;
   vi) The need for, and occurrences of, coordination with other case managers;
   vii) A timeline for obtaining needed services, and
   viii) A timeline for reevaluation of the plan.

8) Limitations:

a) Case Management does not include:
   i) Activities for which third parties are liable to pay;
   ii) Activities not consistent with the definition of case management services under section 6052 of the Deficit Reduction Act, codified at section 1915(g)(2) of the SSA; and
   iii) The direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred.

b) Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

9) Other Limitations:

a) Case management services are prior authorized by the Department of State Health Services. The number of billable contacts that are prior authorized is based on the client's level of need, level of medical involvement, and complicating psychosocial factors.

b) Case management services are available only through the 59th day post partum.

Supersedes TN 07-16
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Texas

CASE MANAGEMENT SERVICES

A. Target Group: Infants and Toddlers with Developmental Disabilities

B. Areas of State in which services will be provided:

☒ Entire State.

☐ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than Statewide:

C. Comparability of Services

☒ Services are provided in accordance with section 1902(a)(10)(B) of the Act.

☐ Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services: See Attached.

E. Qualification of Providers: See Attached.

HCFA ID: 1040P/0016P

Supersedes

Approval Date SEP 29 1992 Effective Date JUL 01 1992

STATE AUST
DATE REC'D AUG 31 1992
DATE APPVD SEP 24 1992
DATE EFF JUL 01 1992
Case Management Services - Infants and Toddlers with Developmental Disabilities

Target Population:

Infants and toddlers from birth to three years of age who meet the criteria for developmental disabilities set forth in the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Public Law 106-402) and have been referred to a qualified Texas Early Childhood Intervention (ECI) program.

D. Definition of Services:

Case management services are provided to assist eligible individuals in gaining access to needed medical, social, educational, developmental and other appropriate services. Case management services are limited to those that directly benefit the Medicaid eligible individual. The case management service is provided to assist targeted Medicaid clients in gaining access to these other services, and not to deliver the services. Case management services may be delivered either face-to-face or by telephone, for the purpose of enabling the client to obtain services as specified above.

Case management services include:

Intake and Needs Assessment: The intake process begins with telephone or face-to-face contact with the Medicaid client's family. The service coordinator provides information concerning case management and early intervention to the child's family and assists the child and family in gaining access to the evaluation and assessment process, including providing notice and obtaining consent. The needs assessment is then conducted and documented by the service coordinator in conjunction with the Medicaid client's family. The comprehensive needs assessment includes taking applicable history of the child; identifying the child's needs and completing related documentation; and gathering information from other sources, such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the child's needs. The documentation lists medical, social, nutritional, educational, developmental, and other appropriate needs of the Medicaid client. Pre-Plan of Care service coordination is provided as needed.
Case Management Services - Infants and Toddlers with Developmental Disabilities

D. Definition of Services (continued)

Plan of Care: Information gathered from the comprehensive needs assessment is incorporated into an individualized family services plan of care (IFSP). With family consent, family concerns, priorities and resources are identified and documented in the plan. The plan summarizes assessment results, includes the services necessary to enhance the development of the child and the capacity of the family to meet the child's unique needs, and must be coordinated with other service providers involved in delivery of services to the child and family. The plan specifies the goals, outcomes, and strategies to address the medical, social, educational, developmental, and other services needed by the child; includes activities such as ensuring the active participation of the eligible child and his or her family, and working with the child and the family (or child's authorized health care decision maker) and others to develop those goals and identified outcomes; and identifies a strategy or course of action to respond to the assessed needs of the eligible child.

Monitoring, referral and follow up: Through linkage, coordination, facilitation, assistance, and anticipatory guidance, the service coordinator ensures access to the care, resources and services to meet the client's needs. The service coordinator may assist the family in making applications for services; confirm service delivery dates with ECI staff, providers and supports; and assist the family with scheduling needs. The service coordinator assists the family in taking responsibility for ensuring that services are delivered, and works with medical providers, ECI staff, and other community resources to coordinate care and to monitor and follow up on the implementation, effectiveness and appropriateness of the child's plan of care and services. Monitoring and follow up will be conducted as needed and at least annually. The service coordinator documents each monitoring and follow up activity (face-to-face or telephone) in the child's case record.

Reassessment and Transition Planning: A reassessment of the child's progress and needs is conducted at least every six months. The service coordinator documents the reassessment in the child's case record. At reassessment, the service coordinator will determine if modifications to the plan of care are necessary. When services are no longer needed, or the child no longer qualifies for services, the service coordinator facilitates the planning, coordination, advocacy, and transition to other appropriate care.
Case Management Services - Infants and Toddlers with Developmental Disabilities

D. Definition of Services (continued)

Service Limitations:

Case management services are not reimbursable as Medicaid services when another payor is liable for payment or if case management services are associated with the proper and efficient administration of the state plan. Case management services associated with the following are not payable as optional targeted case management services under Medicaid:

1. Medicaid eligibility determinations and re-determinations;
2. Medicaid eligibility intake processing;
3. Medicaid pre-admission screening;
4. Prior authorization for Medicaid services;
5. Required Medicaid utilization review;
6. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program administration;
7. Medicaid "lock-in" provided for under the Social Security Act, section 1915(a);
8. Services that are an integral or inseparable part of another Medicaid service;
9. Outreach activities that are designed to locate individuals who are potential Medicaid eligibles; and
10. Any medical evaluation, examination, or treatment billable as a distinct Medicaid covered benefit. However, referral arrangements and staff consultation for such services are reimbursable as case management services.
11. Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.
Case Management Services - Infants and Toddlers with Developmental Disabilities

E. Qualification of Providers:

The Texas Early Childhood Intervention Program has implemented policies and procedures to ensure that case management services are:

1. Available on a statewide basis to ensure continuity of services without duplication;

2. Provided by service coordinators who meet the educational and work experience requirements commensurate with their job responsibilities as specified by the Texas Early Childhood Intervention Staff Qualification Policies and who have also completed, or are in the process of completing, the Texas Early Childhood Intervention case management curriculum;

Individuals providing case management must, at a minimum, have a high school diploma or a certificate recognized by the State as the equivalent of a high school diploma. Individuals must:

(i) Demonstrate knowledge and understanding of infants and toddlers who meet the criteria for the target population;

(ii) Understand Part C of the Individuals with Disabilities Education Act (IDEA);

(iii) Understand the scope of services available under the State’s early intervention program and the State’s medical assistance program;

(iv) Understand the State’s system of payments for services; and

(v) Have access to community resources and supports necessary to coordinate care for the eligible child.

Individuals must receive direct supervision from the enrolled ECI provider of case management services. Supervision includes consultation, record review or observation.

3. Made available to all eligible children; and

Case Management Services - Infants and Toddlers with Developmental Disabilities

F. Case Management Provider Conditions for Participation

Each case management provider must meet the following criteria to become a provider of case management services to infants and toddlers with developmental disabilities:

1. Must meet applicable State and Federal laws governing the participation of providers in the Medicaid program;
2. Must sign a provider agreement with the single state agency; and
3. Must meet the case management provider criteria and be approved by the Texas Early Childhood Intervention Program, the State program for infants and toddlers with developmental disabilities.

Freedom of choice:

Section 1915(g)(1) of the Social Security Act is invoked to limit the providers of case management services to the enrolled ECI provider agency under contract to the Texas Department of Assistive and Rehabilitative Services. The Department of Assistive and Rehabilitative Services has implemented rules, standards, and procedures to ensure that case management activities are:

1. Available on a statewide basis with procedures to ensure continuity of services without duplication; and
2. Provided by individuals who meet the requirements of education and work experience commensurate with their job responsibilities as specified by DARS.

Eligible recipients will have free choice of the providers of other medical care under the plan.

Case Records:

Providers are required to maintain case records that include the name of the participant, provider name, the date, time, duration and place of service, goals of the care plan, whether individuals have chosen not to receive case management services, coordination with other case managers, a timeline for obtaining services, and whether or not the goals have been met.

I. Access to Services:

Targeted case management services will not be used to restrict an individual’s access to other services under the plan. Individuals will not be compelled to receive case management services, condition receipt of targeted case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of targeted case management services. Providers of case management services cannot authorize or deny the provision of other services under the plan.
1. The State of Texas provides home and community care to functionally disabled individuals to the extent described and defined in this Supplement in accordance with section 1929 of the Social Security Act.

XXX yes __________ no

2. Home and community care services are available Statewide.

XXX yes __________ no

If no, these services will be available to individuals only in the following geographic areas or political subdivisions of the State (specify):


3. The home and community care services specified in this Supplement will be limited to the following target groups of recipients (specify all restrictions that will apply):

a. ________ aged (age 65 and older)

b. ________ In accordance with §1929(b)(2)(A) the Act, individuals age 65 or older who were served under a waiver granted pursuant to section 1915(c) of the Act on the date on which that waiver was terminated. Financial eligibility standards for these individuals are specified in Appendix A. Minimum disability standards for these individuals are specified in Appendix B.

c. ________ In accordance with §1929(b)(2)(A) the Act, individuals who were served under a waiver granted pursuant to section 1915(d) of the Act on the date on which that waiver was terminated. Financial eligibility standards for these individuals are specified in Appendix A. Minimum disability standards for these individuals are specified in Appendix B.
d. In accordance with §1929(b)(2)(B) of the Act, individuals who meet the test of disability under the State's §1115 waiver which provided personal care services under the State plan for functionally disabled individuals, and which was in effect on December 31, 1990. Financial eligibility standards for these individuals are specified in Appendix A. Functional disability standards for these individuals are specified in Appendix B.

4. Standards for financial eligibility are set forth in Appendix A. Each individual served shall meet applicable standards for financial eligibility.

5. Each individual served will meet the test of functional disability set forth in Appendix B.

6. Additional targeting restrictions (specify):
   a. Eligibility is limited to the following age groups (specify):

   b. Eligibility is limited by the severity of disease or condition, as specified in Appendix B.

   c. Other (specify): 

7. The State will provide for a comprehensive functional assessment for a financially eligible individual who meets the targeting requirements set forth in item 3 and 6 of this Supplement. This assessment will be provided at the request of the individual or another person acting on such individual's behalf. The individual will not be charged a fee for this assessment.
8. The comprehensive functional assessment will be used to determine whether the individual is functionally disabled, as defined in Appendix B. Procedures to ensure the performance of this assessment are specified in Appendix D.

9. In order to conduct the Comprehensive Functional Assessment: (Check one)

a. The State will use the assessment instrument designed by HCFA.

b. The State will use an assessment instrument consistent with the minimum data set of core elements, common definitions, and utilization guidelines specified by HCFA. A copy of the assessment instrument can be found at Appendix D.

c. The State will provide services under §1929(b)(2)(B) and use an assessment instrument which is consistent with the one in use for its §1115 waiver at the date of the waiver’s discontinuance.

10. The comprehensive functional assessment will be reviewed and revised not less often than every 12 months. Procedures to ensure this review and revision are specified in Appendix D.

11. The comprehensive functional assessment and review will be conducted by an interdisciplinary team designated by the State. Qualifications of the interdisciplinary team are specified in Appendix D.

12. Based on the comprehensive functional assessment or review, the interdisciplinary team will:

a. identify in each such assessment or review each individual’s functional disabilities and need for home and community care, including information about the individual’s health status; home and community environment, and informal support system; and
b. based on such assessment or review, determine whether the individual is (or continues to be) functionally disabled.

13. The results of the comprehensive functional assessment or review will be used in establishing, reviewing and revising the individual's Individual Community Care Plan (ICCP).

14. An ICCP will be developed by a qualified community care case manager for each individual who has been determined, on the basis of a comprehensive functional assessment, to be a functionally disabled elderly individual.

15. All services will be furnished in accordance with a written ICCP which:

a. is established, and periodically reviewed and revised, by a qualified community care case manager after a face-to-face interview with the individual or primary care giver,

b. is based upon the most recent comprehensive functional assessment of the individual;

c. specifies, within the amount, duration and scope limitations specified in Appendix C, the home and community care to be provided under the plan. The ICCP will specify the community care services to be provided, their frequency, and the type of provider to furnish each service;

d. indicates the individual's preferences for the types and providers of services; and

e. may specify other services required by the individual.

A copy of the ICCP to be used in implementing this benefit is included in Appendix E.

16. Each individual's ICCP will be established and periodically reviewed and revised by a qualified community care case manager, as provided in Appendix E.

17. A qualified community care case manager is a nonprofit or public agency or organization which meets the conditions and performs the duties specified in Appendix E.
18. The State will provide the following home and community care services, as defined, described and limited in Appendix C to the groups specified in items 4, 5 and 6 of this Supplement.

a. _______ Homemaker services
b. _______ Home health aide services
c. _______ Chore services
d. _______ Personal care services
e. _______ Nursing care services provided by, or under the supervision of, a registered nurse
f. _______ Respite care
g. _______ Training for family members in managing the individual
h. _______ Adult day care
i. _______ The following services will be provided to individuals with chronic mental illness:

1. _______ Day treatment
2. _______ Partial hospitalization
3. _______ Psychosocial rehabilitation services
4. _______ Clinic services (whether or not furnished in a facility)

j. _______ Other home and community-based services (other than room and board) as the Secretary may approve. The following other services will be provided:

1. _______ Habilitation
   A. _______ Residential habilitation
   B. _______ Day habilitation
2. _______ Environmental modifications
3. _______ Transportation
4. ______ Specialized medical equipment and supplies
5. ______ Personal emergency response systems
6. ______ Adult companion services
7. ______ Attendant care services
8. ______ Private duty nursing services
9. ______ Extended State plan services (check all that apply):
   A. _____ Physician services
   B. _____ Home health care services
   C. _____ Physical therapy services
   D. _____ Occupational therapy services
   E. _____ Speech, hearing and language services
   F. _____ Prescribed drugs
   G. _____ Other State plan services (specify):

10. ______ Other home and community based services -(specify):

19. The State assures that adequate standards for each provider of services exist and will be met. These provider standards are found at Appendix C-2.

20. The agency will provide an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to individuals who are adversely affected by the determinations of the interdisciplinary team, or who are denied the service(s) of their choice or the provider(s) of their choice, or who disagree with the ICCP which has been established.
21. Federal Financial Participation (FFP) will not be claimed for the home and community care services specified in item 7 of this Supplement prior to the development of the ICCP. FFP will not be claimed for home and community care services which are not included in the ICCP.

22. The State provides the following assurances to HCFA:

a. Home and community care services will not be furnished to recipients while they are inpatients of a hospital, NF, or ICF/MR.

b. FFP will not be claimed in expenditures for the cost of room and board, except when provided as part of respite care furnished in a facility which is (1) approved by the State, and (2) not a private residence. Meals furnished under any community care service (or combination of services) will not constitute a "full nutritional regimen" (3 meals a day).

c. FFP will not be claimed in expenditures for the cost of room and board furnished to a provider of services.

d. The agency will provide HCFA annually with information on the amount of funds obligated by the State with respect to the provision of home and community care to the functionally disabled elderly in that fiscal year. These reports will begin with information relative to FFY 1990. The State assures that it will provide data on its maintenance of effort, as required by section 1929(e) of the Social Security Act, in such format and at such times as are specified by HCFA.

e. The home and community care provided, in accordance with this Supplement and Appendices, will meet all requirements for individual's rights and quality of care as are published by HCFA.

1. All individuals providing care are competent to provide such care; and

2. Each individual receiving home and community care will be accorded the rights specified in Appendix F.
23. FFP will not be claimed for the home and community care services specified in item 7 of this Supplement in any quarter to the extent that cost of such care in the quarter exceeds 50 percent of the product of:

a. the average number of individuals in the quarter receiving home and community care;

b. the average per diem rate of Medicare payment for NF care furnished in the State during such quarter; and

c. the number of days in such quarter.

24. Community care settings in which home and community care is provided will meet the requirements set forth in Appendix G.

25. The State will refuse to provide Home and Community Care in settings which have been found not to meet the requirements of §1929(g) and (h).

26. The State will comply with the requirements of §1929(i) of the Act, regarding survey and certification of community care settings.

27. The State will comply with the requirements of §1929(i) of the Act, regarding the compliance of providers of Home and Community Care and reviews of this compliance.

28. The State will provide for an enforcement process for providers of Home and Community Care as required by §1929(j) of the Act.

29. The State assures that payment for home and community care services will be made through rates which are reasonable and adequate to meet the costs of providing care, efficiently and economically, in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

30. Payment will not be made for home and community care to reimburse (or otherwise compensate) a provider of such care for payment of a civil money penalty imposed under Title XIX or Title XI of the Social Security Act or for legal expenses in defense of an exclusion or civil money penalty under Title XIX or Title XI of the Social Security Act if there is no reasonable legal ground for the provider's case. The State
will consider that reasonable legal ground exists if the provider’s defense prevails.

31. The State will begin provision of services under section 1905(a)(23) of the Social Security Act effective (specify date): July 1, 1991

These services will be provided for a minimum of four calendar quarters, beginning on this date.

32. Services will be provided to eligible recipients for the duration of the period specified in item 31, above, without regard to the amount of FFP available to the State.
APPENDIX A - FINANCIAL ELIGIBILITY FOR SERVICES

APPENDIX A-1  MEDICAID ELIGIBILITY GROUPS SERVED

a. Home and community care services will be made available to individuals age 65 or older, when the individuals have been determined to be functionally disabled as specified in Appendix B. States operating under §1929(b)(2)(B) may serve additional age groups.

b. Individuals served under this provision must meet the following Medicaid eligibility criteria (check all that apply) (States covered by §1929(b)(2)(B) do not have to complete):

1. _______ SSI/SSP recipients, age 65 or older who have been determined to be functionally disabled as specified in Appendix B.
   
   A. _______ The agency uses the same methodologies for treatment of income and resources as used in the SSI program (or the optional State supplement program which meets the requirements of 42 CFR 435.230, as appropriate).
   
   B. _______ The agency uses methodologies for treatment of income and resources that differ from those of the SSI program. These differences result from restrictions applied under section 1902(f) of the Act. The methodologies are described in Supplement 5 to Attachment 2.6-A.

(Stamp)

STATE: TEXAS
DATE REC'D: SEP 30 1991
DATE APP'ED: JUL 01 1991
DATE EFF: JUL 01 1991
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2. ______ Medically needy, age 65 or older who have been determined to be functionally disabled as specified in Appendix B. In determining the individual's eligibility, the State may, at its option, provide for the determination of the individual's anticipated medical expenses (to be deducted from income). (Check one):

A. ______ The State does not consider anticipated medical expenses.

B. ______ The State considers anticipated medical expenses over a period of ____ months (not to exceed 6 months).
APPENDIX A-2 TO
SUPPLEMENT 2 TO ATTACHMENT 3.1-A
Page 1

APPENDIX A-2

INDIVIDUALS PREVIOUSLY COVERED UNDER A WAIVER

a. XXX The State used a health insuring organization before January 1, 1986, and had in effect a waiver under §1115 of the Act, which provides personal care services under the State plan for functionally disabled individuals, and which was in effect on December 31, 1990. In accordance with §1929(b)(2)(B) of the Act, individuals who meet the resource and income standard that apply in the State to individuals described in §1902(a)(10)(A)(ii)(V) will be financially eligible to receive home and community care services.

b. In accordance with §1929(b)(2)(A) the Act, individuals age 65 or older who were served under a waiver granted pursuant to section 1915(c) of the Act on the date on which that waiver was terminated. Financial eligibility standards for these individuals (which are the same as those in effect on the date on which the waiver was terminated) are attached to this Appendix.

c. In accordance with §1929(b)(2)(A) the Act, individuals who were served under a waiver granted pursuant to section 1915(d) of the Act on the date on which that waiver was terminated. Financial eligibility standards for these individuals (which are the same as those in effect on the date on which the waiver was terminated) are attached to this Appendix.

STATE: TEXAS
DATE REC'D: SEP 30 1991
DATE APP'D: DEC 27 1991
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TN NO.: 91-30
Supersedes: None

TN NO.: 91-30

APPENDIX B-1
FUNCTIONAL DISABILITY

Home and community care services, as defined in this Supplement, are provided to the following classifications of individuals who have been found on the basis of an assessment to be functionally disabled. Services will be limited to individuals who meet the following targeting criteria.

Check all that apply:

a. _______ Services are provided to individuals, who have been determined, on the basis of an assessment, to require substantial human assistance with at least two of the following activities of daily living: toileting, transferring, eating.

b. _______ Services are provided to individuals, who have been determined, on the basis of an assessment, to require substantial human assistance with each of the following activities of daily living: toileting, transferring, eating.

c. _______ Services are provided to individuals, who have been determined, on the basis of an assessment, to have a primary or secondary diagnosis of Alzheimer's Disease, and are unable to perform without substantial human assistance (including verbal reminding or physical cueing) or supervision, at least 2 of the following 5 activities of daily living: bathing, dressing, toileting, transferring and eating.

d. _______ Services are provided to individuals, who have been determined, on the basis of an assessment, to have a primary or secondary diagnosis of Alzheimer's Disease, and are unable to perform without substantial human assistance (including verbal reminding or physical cueing) or supervision, (check one):

1. _______ at least 3 of the following activities: 5 activities of daily living: bathing, dressing, toileting, transferring and eating.
2. _________ at least 4 of the following activities of daily living: bathing, dressing, toileting, transferring and eating.

3. _________ each of the following activities of daily living: bathing, dressing, toileting, transferring and eating.

e. XXX The State used a health insuring organization before January 1, 1986, and had in effect a waiver under §1115 of the Act, which provides personal care services under the State plan for functionally disabled individuals, and which was in effect on December 31, 1990. In accordance with §1929(b)(2)-(B) of the Act, services will be provided to individuals who meet the test of functional disability applied under the waiver as of December 31, 1990.

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DATE REC'D SEP 3 0 1991
DATE APPV'D DEC 27 1991
DATE EFF JUL 01 1991
HCFA 179 91-30

TN NO.: 91-30
Supersedes: None
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Effective Date: JUL 01 1991
APPENDIX B-2  AGE

Check all that apply:

a. _______ Services are provided to individuals age 65 and older.

b. _______ Services are provided to individuals who have reached at least the following age (specify):

   _______


c. _______ Services are provided to individuals who meet the criteria set forth in item 3.b. of Supplement 2, as set forth in Appendix B-3, who were 65 years of age or older on the date of the waiver's discontinuance.

d. _______ Services are provided to individuals who meet the criteria set forth in item 3.c. of Supplement 2, as set forth in Appendix B-3, who were served under the waiver on the date of its discontinuance.

e. _______ Services are provided to individuals who meet the criteria in item 3.d. of Supplement 2, who fall within the following age categories (check all that apply):

   1. _______ Age 65 and older

   2. _______ Age greater than 65. Services are limited to those who have attained at least the age of (specify):

       _______

   3. _______ Age less than 65. Services will be provided to those in the following age category (specify): _______

   4. XXX The State will impose no age limit.

All individuals under 65 must be disabled as defined under the Supplemental Security Income Program under Title XVI.
APPENDIX B-3 TO SUPPLEMENT 2 TO ATTACHMENT 3.1-A

APPENDIX B-3

INDIVIDUALS PREVIOUSLY SERVED UNDER WAIVER AUTHORITY

a. In accordance with §1929(b)(2)(A) of the Act, the State will discontinue the following home and community-based services waiver(s), approved under the authority of §1915(c) or §1915(d) of the Act. (Specify the waiver numbers)

    ______ Last date of waiver operation:

    ______ Last date of waiver operation:

    ______ Last date of waiver operation:

    ______ Last date of waiver operation:

b. For each waiver specified in Appendix B-3-a, above, the State will furnish at least 30 days notice of service discontinuance to those individuals under 65 years of age, and to those individuals age 65 or older who do not meet the test of functional disability specified in Appendix B-1 (except those individuals who will continue to receive home and community-based services under a different waiver program).

c. Individuals age 65 years of age or older, who were eligible for benefits under a waiver specified in Appendix B-3-a on the last date of waiver operation, who would, but for income or resources, be eligible for home and community care under the State plan, shall, be deemed functionally disabled elderly individuals for so long as they would have remained eligible for services under the waiver.

d. The financial eligibility standards which were in effect on the last date of waiver operation are attached to this Appendix.

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e. The following are the schedules, in effect on the last date of waiver operation, under which individuals served under a waiver identified in Appendix B-3-a were re-evaluated for financial eligibility (specify):

<table>
<thead>
<tr>
<th>Waiver Number</th>
<th>Re-evaluation schedule</th>
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STATE: **Texas**

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<td>SEP 3 0 1991</td>
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<td>JUL 01 1991</td>
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HCFA 179: **91-30**

TN NO.: **91-30**

Approval Date: **DEC 27 1991**  Effective Date: **JUL 01 1991**
APPENDIX C-1 TO SUPPLEMENT 2 TO ATTACHMENT 3.1-A

APPENDIX C - SERVICES

APPENDIX C-1 DEFINITION OF SERVICES

The State requests that the following services, as described and defined herein, be provided as home and community care services to functionally disabled elderly individuals under this program:

a. _______ Homemaker: services consisting of general household activities (meal preparation and routine household care) provided by a trained homemaker, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for him or herself or others in the home. Homemakers shall meet such standards of education and training as are established by the State for the provision of these activities. This service does not include medical care of the client. Hands-on care is limited to such activities as assistance with dressing, uncomplicated feeding, and pushing a wheelchair from one room to another. Direct care furnished to the client is incidental to care of the home. These standards are included in Appendix C-2.

Check one:

1. _______ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

2. _______ The State will impose the following limitations on the provision of this service (specify):

[Signature] SEP 8 0 1991
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Approval Date: DEC 27 1991 Effective Date: JUL 01 1991
b. Home health aide services: services defined in 42 CFR 440.70 with the exception that limitations on the amount, duration and scope of such services shall instead be governed by the limitations imposed below.

Check one:

1. This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

2. The State will impose the following limitations on the provision of this service (specify):

   ____________________________________________
   
   ____________________________________________
   
   ____________________________________________

STATE: Texas
DATE REC'D: SEP 30 1991
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c. XXX Personal care services: assistance with eating, bathing, dressing, personal hygiene, activities of daily living. This service includes meal preparation, when required by the Individual Community Care Plan (ICCP), but does not include the cost of the meals. When specified in the ICCP, this service also includes such housekeeping chores as making the bed, laundry, cleaning, shopping, or escort services which are appropriate to maintain the health and welfare of the recipient. Providers of personal care services must meet State standards for this service. These standards are included in Appendix C-2.

1. Services provided by family members. Check one:

Payment will not be made for personal care services furnished by a member of the recipient’s family or by a person who is legally or financially responsible for that recipient.

Personal care providers may be members of the recipient’s family. Payment will not be made for services furnished to a minor by the recipient’s parent (or stepparent), or to a recipient by the recipient’s spouse. Payment will not be made for services furnished to a recipient by a person who is legally or financially responsible for that recipient. Check one:

Family members who provide personal care services must meet the same standards as other personal care providers who are unrelated to the recipient. These standards are found in Appendix C-2.
Standards for family members who provide personal care services differ from those for other providers of this service. The standards for personal care services provided by family members are found in Appendix C-2.

2. Personal care providers will be supervised by:

- [ ] a registered nurse, licensed to practice nursing in the State
- [ ] case managers
- [X] other (specify): An employee designated as "supervisor" when provided by a contracted personal care agency.

Personal care providers in the Consumer Directed Services component of personal care services are supervised by the recipient/legal guardian.

3. Minimum frequency or intensity of supervision:

- [ ] as indicated in the client's ICCP
- [X] other (specify): At least every twelve months for personal care services provided by a contracted agency; or as often as deemed necessary by the recipient, with a written evaluation at least every twelve months, in the Consumer Directed Services component of personal care services.

4. Personal care services are limited to those furnished in a recipient's home.

- [ ] Yes
- [X] No

5. Limitations (check one):

- [ ] This service is provided to eligible individuals without limitations on the amount or duration of services furnished.
- [X] The State will impose the following limitations on the provision of this service (specify):

Services are limited to the lesser of:

- no more than fifty (50) hours per week per recipient, or
the number of hours per week per recipient that may be provided within the limit of the cost of the average Medicaid nursing facility rate. Services are for recipients whose assessed medical needs can be met by long-term, non-technical medical observation and authorized assistance with the activities of daily living which are necessary because of a chronic medical condition complicated by functional limitations.

- **Consumer Directed Services (CDS)** gives the recipient/legal guardian support to be the employer of record for their personal care services. The recipient chooses, directs, and manages their personal care services. To contract for CDS, providers must have an existing contract with the Texas Department of Human Services to provide community care services. CDS providers contract in the recipient's geographic area for the CDS program with the Texas Department of Human Services to provide CDS functions including training and ongoing support on being an employer; handling of employment-related activities, and budgeting for personal care services.

d. **Nursing care services provided by or under the supervision of a registered nurse.** Nursing services listed in the ICCP which are within the scope of State law, and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State. Standards for the provision of this service are included in Appendix C-2.

Check one:

1. This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

2. The State will impose the following limitations on the provision of this service (specify):

SUPERSEDES: TN- 92-21
e. Respite care: services given to individuals unable to care for themselves which are provided on a short-term basis because of the absence or need for relief of those persons normally providing the care. FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

1. Respite care will be provided in the following location(s):

- Recipient’s home or place of residence
- Foster home
- Facility approved by the State which is not a private residence

2. The State will apply the following limits to respite care provided in a facility.

- Hours per recipient per year
- Days per recipient per year

Respite care will be provided in accordance with the ICCP. There are no set limits on the amount of facility-based respite care which may be utilized by a recipient.

Not applicable. The State does not provide facility-based respite care.
3. Respite care will be provided in the following type(s) of facilities.

- Hospital
- NF
- ICF/MR
- Group home
- Licensed respite care facility
- Other (specify):

Not applicable. The State does not provide facility-based respite care.

4. The State will apply the following limits to respite care provided in a community setting which is not a facility (including respite care provided in the recipient’s home).

- Hours per recipient per year
- Days per recipient per year

Respite care will be provided in accordance with the ICCP. There are no set limits on the amount of community-based respite care which may be utilized by a recipient.

Not applicable. The State does not provide respite care outside a facility-based setting.

Qualifications of the providers of respite care services are included in Appendix C-2. Applicable Keys amendment (section 1616(e) of the Social Security Act) standards are cited in Appendix F-2.
Training for family members in managing the individual: includes training and counseling services for the families of functionally disabled elderly individuals. For purposes of this service, "family" is defined as the persons who live with or provide care to a disabled individual and may include a spouse, children, friends, relatives, foster family, or in-laws. "Family" does not include individuals who are employed to care for the functionally disabled individual. Training includes instruction about treatment regimens and use of equipment specified in the ICCP and shall include updates as may be necessary to safely maintain the individual at home. This service is provided for the purpose of increasing the ability of a primary caregiver or a member of the recipient's family to maintain and care for the individual at home. All training for family members must be included in the client's ICCP.

Check one:

1. _______ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

2. _______ The State will impose the following limitations on the provision of this service (specify):

Provider qualifications are specified in Appendix C-2.

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g. Adult day care: services furnished 4 or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the client. Meals provided as part of these services shall not constitute a "full nutritional regimen" (3 meals per day).

Check all that apply:

1. Physical therapy indicated in the individual's ICCP will be provided by the facility as a component part of this service. The cost of physical therapy will be included in the rate paid to providers of adult day care services.

2. Occupational therapy indicated in the individual's ICCP will be provided by the facility as a component part of this service. The cost of occupational therapy will be included in the rate paid to providers of adult day care services.

3. Speech therapy indicated in the individual's ICCP will be provided by the facility as a component part of this service. The cost of speech therapy will be included in the rate paid to providers of adult day care services.

4. Nursing care furnished by or under the supervision of a registered nurse, and indicated in the individual's ICCP, will be provided by the facility as a component part of this service.
5. Transportation between the recipient's place of residence and the adult day care center will be provided as a component part of this service. The cost of this transportation is included in the rate paid to providers of adult day care services.

6. Other therapeutic activities which will be provided by the facility as component parts of this service. (Specify):

Limitations. Check one:

1. This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

2. The State will impose the following limitations on the provision of this service (specify):

Qualifications of the providers of this service are found in Appendix C-2.
Services for individuals with chronic mental illness, consisting of:

1. Day Treatment or other Partial Hospitalization services that are necessary for the diagnosis or active treatment of the individual's mental illness. These services consist of the following elements:

   a. individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law),

   b. occupational therapy, requiring the skills of a qualified occupational therapist,

   c. services of social workers, trained psychiatric nurses, and other staff trained to work with psychiatric patients,

   d. drugs and biologicals furnished for therapeutic purposes,

   e. individual activity therapies that are not primarily recreational or diversionary,

   f. family counseling (the primary purpose of which is treatment of the individual's condition),

   g. patient training and education (to the extent that training and educational activities are closely and clearly related to the individual's care and treatment), and

   h. diagnostic services.
Meals and transportation are excluded from reimbursement under this benefit. The purpose of this benefit is to maintain the individual's condition and functional level and to prevent relapse or hospitalization.

Limitations. Check one:

a. ______ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

b. ______ The State will impose the following limitations on the provision of this service (specify):

Qualifications of the providers of this service are found in Appendix C-2.

2. ______ Psychosocial Rehabilitation Services. Medical or remedial services recommended by a physician or other licensed practitioner under State law, for the maximum reduction of physical or mental disability and the restoration of maximum functional level. Specific services include the following:

- Restoration and maintenance of daily living skills (grooming, personal hygiene, cooking, nutrition, health and mental health education, medication management, money management and maintenance of the living environment);

- Social skills training in appropriate use of community services;

[Approval and Effective Dates]
Development of appropriate personal support networks, therapeutic recreational services (which are focused on therapeutic intervention, rather than diversion); and

Telephone monitoring and counseling services.

The following services are specifically excluded from Medicaid payment:

Vocational services, Prevocational services, Supported employment services: Educational services, and Room and board.

Psychosocial rehabilitation services are furnished in the following locations (check all that apply):

a. _______ Individual's home or place of residence

b. _______ Facility in which the individual does not reside

c. _______ Other (specify): ______________________

Limitations. Check one:

a. _______ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

b. _______ The State will impose the following limitations on the provision of this service (specify): ______________________
Qualifications of the providers of this service are found in Appendix C-2.

3. ______ Clinic services (whether or not furnished in a facility) are services defined in 42 CFR 440.99.

Check one:

a. ______ This benefit is limited to those services furnished on the premises of a clinic.

b. ______ Clinic services may be furnished outside the clinic facility. Services may be furnished in the following locations (specify):

   
   
   

Check one:

a. ______ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.
b. The State will impose the following limitations on the provision of this service (specify):

Qualifications of the providers of this service are found ii, Appendix C-2.

i. Habilitation: services designed to assist individuals in acquiring, retaining and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community settings. This service includes:

1. Residential habilitation; assistance with acquisition, retention or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a home or community setting. Payments for residential habilitation are not made for room and board, or the costs of facility maintenance, upkeep, and improvement. Payment for residential habilitation does not include payments made, directly or indirectly, to members of the recipient’s immediate family. Payments will not be made for routine care and supervision, or for activities or supervision for which a payment is available from a source other than Medicaid. The methodology by which payments are calculated and made is described in Attachment 4.19-0.
2. **Day habilitation:** assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills which takes place in a non-residential setting, separate from the home or facility in which the recipient resides. Services shall normally be furnished 4 or more hours per day, on a regularly scheduled basis, for 1 or more days per week, unless provided as an adjunct to other day activities included in the recipient's ICCP. Day habilitation services shall focus on enabling the individual to attain or retain his or her maximum functional level.

Check all that apply:

A. Physical therapy indicated in the individual's ICCP will be provided by the facility as a component part of this service. The cost of physical therapy will be included in the rate paid to providers of habilitation services.

B. Occupational therapy indicated in the individual's ICCP will be provided by the facility as a component part of this service. The cost of occupational therapy will be included in the rate paid to providers of habilitation services.

C. Speech therapy indicated in the individual's ICCP will be provided by the facility as a component part of this service. The cost of speech therapy will be included in the rate paid to providers of habilitation services.
D. _____ Nursing care furnished by or under the supervision of a registered nurse and indicated in the individual's ICCP, will be provided by the facility as a component part of this service.

E. _____ Transportation between the recipient's place of residence and the habilitation center will be provided as a component part of this service. The cost of this transportation is included in the rate paid to providers of habilitation services.

F. _____ Other therapeutic activities which will be provided by the facility as component parts of this service. (Specify):

Check one:

1. _____ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

2. _____ The State will impose the following limitations on the provision of this service (specify):

[Table with dates and numbers]
Payment will not be made for the following:

Vocational Services;
Prevocational services;
Educational services; or
Supported employment services.

Qualifications of the providers of this service are specified in Appendix C-2.

j. Environmental modifications: those physical adaptations to the home, required by the individual's ICCP, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home.

Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies the need for which is identified in the client's ICCP.

Adaptations or improvements to the home which are of general utility, or which are not of direct medical or remedial benefit to the client, such as carpeting, roof repair, central air conditioning, etc., are specifically excluded from this benefit. All services shall be provided in accordance with applicable State or local building codes.

Check one:

1. This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

2. The State will impose the following limitations on the provision of this service (specify):

__________________________________________________________________________
__________________________________________________________________________
k. Transportation: service offered in order to enable individuals receiving home and community care under this section to gain access to services identified in the ICCP. Transportation services under this section shall be offered in accordance with the recipient's ICCP, and shall be used only when the service is not available without charge from family members, neighbors, friends, or community agencies, and when the appropriate type of transportation is not otherwise provided under the State plan. In no case will family members be reimbursed for the provision of transportation services under this section.

Check one:

1. This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

2. The State will impose the following limitations on the provision of this service (specify):

   ____________________________

   ____________________________

   ____________________________

Provider qualifications are specified in Appendix C-2.
1. Specialized Medical Equipment and Supplies:
   Specialized medical equipment and supplies which include devices, controls, or appliances, specified in the ICCP, which enable clients to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment and supplies not otherwise available under the State plan. Items which are not of direct medical or remedial benefit to the recipient are excluded from this service. All specialized medical equipment and supplies provided under this benefit shall meet applicable standards of manufacture, design and installation.

Check one:

1. This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

2. The State will impose the following limitations on the provision of this service (specify):

   [Blank space for limitations]

   [Blank space for limitations]
Chore Services. Services identified in the ICCP which are needed to maintain the individual's home in a clean, sanitary and safe environment. For purposes of this section, the term "home" means the abode of the individual, whether owned or rented by the client, and does not include the residence of a paid caregiver with whom the client resides (such as a foster care provider) or a small or large community care facility.

Covered elements of this service include heavy household chores such as washing floors, windows and walls, removal of trash, tacking down loose rugs and tiles, moving heavy items of furniture in order to provide safe access inside the home for the recipient, and shoveling snow to provide access and egress.

Chore services will be provided only in cases where neither the client, nor anyone else in the household, is capable of performing or financially providing for them, and where no other relative, caretaker, landlord, community volunteer/agency, or third party payor is capable of or responsible for their provision. In the case of rental property, the responsibility of the landlord, pursuant to the lease agreement, will be examined prior to any authorization of service.

Check one:

1. This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

2. The State will impose the following limitations on the provision of this service (specify):

Provider qualifications are specified in Appendix C-2.
n. Adult Companion Services. Non-medical care, supervision and socialization provided to a functionally disabled adult. Companions may assist the individual with such tasks as meal preparation, laundry and shopping, but do not perform these activities as discrete services. The provision of companion services does not entail hands-on medical care. Companion services may include non-medical care of the client, such as assistance with bathing, dressing and uncomplicated feeding. Providers may also perform light housekeeping tasks which are incidental to the care and supervision of the client. This service is provided in accordance with a therapeutic goal in the ICCP, and is not merely diversionary in nature.

Check one:

1. _______ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

2. _______ The State will impose the following limitations on the provision of this service (specify):

                                   

Provider qualifications are specified in Appendix C-2.

3. Services provided by family members. Check one:

   A. _______ Payment will not be made for adult companion services furnished by a member of the recipient's family or by a person who is legally or financially responsible for that recipient.
B. ______ Adult companion service providers may be members of the recipient's family. Payment will not be made for services furnished to a minor by the recipient's parent (or stepparent), or to a recipient by the recipient's spouse. Payment will not be made for services furnished to a recipient by a person who is legally or financially responsible for that recipient.

Check one:

1. ______ Family members who provide adult companion services must meet the same standards as other adult companion providers who are unrelated to the recipient. These standards are found in Appendix C-2.

2. ______ Standards for family members who provide adult companion services differ from those for other providers of this service. The standards for adult companion services provided by family members are found in Appendix C-2.
Attendant Care. Hands-on care, of both a medical and non-medical supportive nature; specific to the needs of a medically stable individual with physical impairments. This service may include skilled medical care to the extent permitted by State law. Housekeeping activities which are incidental to the performance of the client-based care may also be furnished as part of this activity.

Check all that apply:

1. ______ Supervision will be provided by a Registered Nurse, licensed to practice in the State. The frequency and intensity of supervision will be specified in the ICCP.

2. ______ Supervision may be furnished directly by the client, when the client has been trained to perform this function, and when the safety and efficacy of client-provided supervision has been certified in writing by a registered nurse or otherwise as provided in State law. This certification must be based on observation of the client and the specific attendant care provider, during the actual provision of care. Documentation of this certification will be maintained with the client’s ICCP.
Check one:

1. [ ] This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

2. [ ] The State will impose the following limitations on the provision of this service (specify):

   ___________________________________________________________________
   ___________________________________________________________________

Provider qualifications are specified in Appendix C-2.
Personal Emergency Response Systems (PERS). PERS is an electronic device which enables certain high-risk clients to secure help in the event of an emergency. The client may also wear a portable "help" button to allow for mobility. The system is connected to the client’s phone and programmed to signal a response center once the "help" button is activated. The response center is staffed by individuals with the qualifications specified in Appendix C-2.

Check one:

1. ________ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

2. ________ The State will impose the following limitations on the provision of this service (specify):

_________________________________________________________________________
_________________________________________________________________________
q. ______ Private Duty Nursing. Private Duty Nursing services consist of individual and continuous care (in contrast to part time or intermittent care) provided by licensed nurses within their scope of practice under State law.

Check one:

1. ________ Private duty nursing services are limited to services provided in the individual's home or place of residence.

2. ________ Private duty nursing services are not limited to services provided in the individual's home or place of residence. Check one:

   A. ____ Services may also be provided in the following locations (Specify):

   B. ____ The State will not place limits on the site of private duty nursing services.

Check one:

1. ________ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

2. ________ The State will impose the following limitations on the provision of this service (specify):

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STATE: Texas
DATE REC'D: SEP 30 1991
DATE APPV'D: DEC 27 1991
DATE EFF: JUL 01 1991
HCFA 179 91-30

Approval Date: DEC 27 1991
Effective Date: JUL 01 1991

TN NO.: 91-30 Supersedes None-New Page
Extended State Plan Services. The following services are available under the State plan, but with limitations. Under this benefit, these services will be provided in excess of the limitations otherwise specified in the plan. Provider standards will remain unchanged from those otherwise indicated in the State plan. When these services are provided as home and community care, the limitations on each service will be as specified in this section.

1. _______ Physician services.

Check one:

A. _______ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

B. _______ The State will impose the following limitations on the provision of this service (specify):

2. _______ Home Health Care Services

Check one:

A. _______ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

B. _______ The State will impose the following limitations on the provision of this service (specify):

---
3. ________ Physical Therapy Services

Check one:

A. ___ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

B. ___ The State will impose the following limitations on the provision of this service (specify):

4. ________ Occupational Therapy Services

Check one:

A. ___ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

B. ___ The State will impose the following limitations on the provision of this service (specify):

5. ________ Speech, Hearing and Language Services

Check one:

A. ___ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.
APPENDIX C-1 TO
SUPPLEMENT 2 TO ATTACHMENT 3.1-A
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B. ___ The State will impose the following limitations on the provision of this service (specify):

________________________________________________________________________
________________________________________________________________________

6. _____ Prescribed Drugs

Check one:

A. ___ This service is provided to eligible individuals without limitations on the amount or duration of services furnished.

B. ___ The State will impose the following limitations on the provision of this service (specify):

________________________________________________________________________
________________________________________________________________________

s. _____ Other services (specify):

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Provider standards for each "other" service identified are found in Appendix C-2.
APPENDIX C-2 PROVIDER QUALIFICATIONS

a. The following are the minimum qualifications for the provision of each home and community care service under the plan.

**LICENSURE AND CERTIFICATION CHART**

Cite relevant portions of State licensure and certification rules as they apply to each service to be provided.

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>PROVIDER TYPE</th>
<th>LICENSURE</th>
<th>CERTIFICATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>HOMEMAKER</td>
<td></td>
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<tr>
<td>HOME HEALTH AIDE</td>
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<tr>
<td>PERSONAL CARE</td>
<td>Agency</td>
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<tr>
<td></td>
<td></td>
<td>A legal entity or one of its divisions must:</td>
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<td></td>
<td></td>
<td>1. be licensed by the State as a Class A home health agency and be authorized to do business in the State (the personal care services do not have to be delivered out of its licensed home health agency or home health agency division);</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>2. be certified for reimbursement under Titles XVIII and XIX of the Social Security Act; and</td>
<td></td>
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<td></td>
<td></td>
<td>3. not be delinquent in its payment of the State franchise tax.</td>
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<tr>
<td>ATTENDANT CARE</td>
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<tr>
<td>NURSING CARE</td>
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<td></td>
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<tr>
<td>RESPITE CARE IN HOME</td>
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<tr>
<td>IN HOME</td>
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<tr>
<td>FACILITY BASED</td>
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<tr>
<td>FAMILY TRAINING</td>
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<tr>
<td>ADULT DAY CARE</td>
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</tbody>
</table>
Identify any licensure and certification standards applicable to the providers of "other" services defined in Appendix C-1 on a separate sheet of paper. Attach the paper to this Appendix.
b. ASSURANCE THAT REQUIREMENTS ARE MET

1. The State of Texas assures that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under this section.

2. The State will require each provider furnishing services under this section to furnish proof that all applicable requirements for service provision, specified in this Appendix, are met prior to the provision of services for which FFP is claimed.

3. The State assures that it will review each provider at least once a year, to ensure that provider requirements continue to be met.

c. PROVIDER REQUIREMENTS APPLICABLE TO ALL SERVICES

In addition to standards of licensure and certification, each individual furnishing services under this section must demonstrate the following to the satisfaction of the State:

1. Familiarity with the needs of the individuals being served. The degree of familiarity must be commensurate with the type of service to be provided.

2. If the provider is to furnish services targeted to individuals with Alzheimer's Disease or to recipients with other mental impairments, familiarity with the course and management of this disease, commensurate with the type of service to be provided.

3. The provider must be able to communicate with the client or primary caregiver. To be considered sufficient, this ability must be commensurate with the type of service to be provided.

4. Each provider must have received training, appropriate to the demands of the service to be provided, on proper response to emergency situations.

5. Each provider must be qualified by education, training, experience and or examination in the skills necessary for the performance of the service.
6. Providers may meet these standards by the following methods:

A. _______ Education, including formal degree requirements specified in the provider qualifications for the service to be furnished.

B. _______ Specific course(s), identified in the provider qualifications for the service to be furnished.

C. _______ Documentation that the provider has completed the equivalent of the course(s) identified in item c.5.B, above.

D. _______ Training provided by the Medicaid agency or its designee.

   The Medicaid agency or its designee will also make this training available to unpaid providers of service.

   _______ Yes       ______ No

E. _______ Appropriate experience (specified in the provider qualifications for the applicable service) which may substitute for the education and training requirements otherwise applicable.

F. _____ XXX The provider may demonstrate competence through satisfactory performance of the duties attendant upon the specified service. With regard to particular providers and particular services, the State may also choose to substitute satisfactory completion of a written or oral test. Test requirements are included in the provider requirements applicable to the specific service.
d. PROVIDER REQUIREMENTS SPECIFIC TO EACH SERVICE

In addition to the licensure and certification standards cited in Appendix, the State will impose the following qualifications for the providers of each service -

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>MINIMUM QUALIFICATIONS OF PROVIDERS</th>
</tr>
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<tbody>
<tr>
<td>HOMEMAKER</td>
<td></td>
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<tr>
<td>HOME HEALTH AIDE</td>
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<tr>
<td>PERSONAL CARE</td>
<td>The attendant must be 18 years of age or older; cannot be a: (1) spouse of the client, (2) parent of a client that is a minor, (3) person with a legal duty to support the client, (4) person already available to meet the needs of the client, or (5) person who is not competent, dependable, or capable of performing the work; attendant must be oriented to the services to be provided by the supervisor of the contracted personal care agency, or by the recipient/legal guardian in CDS, and/or meet other testing or license requirements that the State may require. New hires must pass a criminal background check.</td>
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<tr>
<td>ATTENDANT CARE</td>
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<tr>
<td>NURSING CARE</td>
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<td>RESPITE CARE IN HOME</td>
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<td>FACILITY BASED</td>
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<tr>
<td>FAMILY TRAINING</td>
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<tr>
<td>ADULT DAY CARE</td>
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<tr>
<td>DAY TREATMENT / PARTIAL HOSPITALIZATION</td>
<td></td>
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<tr>
<td>PSYCHOSOCIAL REHABILITATION</td>
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<tr>
<td>CLINIC SERVICES</td>
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<td>CHORE SERVICES</td>
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<tr>
<td>HABILITATION GENERAL STANDARDS</td>
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<td>RESIDENTIAL HABILITATION</td>
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SUPERSEDES: TN- 02-01

STATE: Texas
DATE RECOD: 9-1-03
DATE AMND: 12-2-03
DATE EFF: 9-1-03
HCFA: 179 03-17
<table>
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<tr>
<th>SERVICE</th>
<th>MINIMUM QUALIFICATIONS OF PROVIDERS</th>
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<tr>
<td>DAY HABILITATION</td>
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<tr>
<td>ENVIRONMENTAL MODIFICATIONS</td>
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<tr>
<td>TRANSPORTATION</td>
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<tr>
<td>MEDICAL EQUIPMENT AND SUPPLIES</td>
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<td>PERS</td>
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<tr>
<td>ADULT COMPANION</td>
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<td>ATTENDANT CARE</td>
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<tr>
<td>PVT DUTY NURSING</td>
<td></td>
</tr>
</tbody>
</table>

Identify the provider requirements applicable to the providers of each "other" service specified in Appendix C-1 on a separate sheet of paper. Attach the paper to this Appendix.
CONSUMER DIRECTED SERVICES

Consumer Directed Services (CDS) gives the recipient/legal guardian support to be the employer of record for their personal care services. The recipient chooses, directs, and manages their personal care services. To contract for CDS, providers must have an existing contract with the Texas Department of Human Services to provide community care services. CDS providers contract in the recipient's geographic area for the CDS program with the Texas Department of Human Services to provide CDS functions including training and ongoing support on being an employer; handling of employment-related activities, and budgeting for personal care services.
APPENDIX D-1 ASSESSMENT

a. The State will provide for a comprehensive functional assessment for a financially eligible individual who meets the targeting requirements set forth in item 3 of Supplement 2.

b. This assessment will be provided at the request of the individual, or another person acting on the individual's behalf.

c. The individual will not be charged a fee for this assessment.

d. In order to ensure the performance of the assessment the State will follow the following procedures:

   1. The case manager will meet with the client and other appropriate parties to assess the needs of the individual, to determine the presence of functional disability according to the State's definition, and to develop a suggested ICCP.

   2. A supervisor employed by the contracted personal care agency will collect information about the client's medically related functional needs in relation to the case manager's ICCP. The supervisor forwards the information along with the case manager's ICCP to the State Agency RN.

   3. The State Agency RN verifies the individual's functional disability, medical need for service, medical appropriateness of the ICCP, and gives final approval to begin service. During this process the State Agency RN consults with the case manager as necessary.

e. The assessment will be reviewed and revised not less often than (check one):

   1. XXX Every 12 months

   2. ________ Every 6 months

   3. ________ Other period not to exceed 12 months (Specify): ___________
f. The assessment will be based on the uniform minimum data set specified by HCFA. In the case of a state using §1929(b)(2)(B), the assessment will be based on the State's process in place for its §1115 waiver which provided personal care for functionally disabled as of December 31, 1990 (refer to (g)(3) of this Appendix).

g. Check one:

1. _____ The State will use the assessment instrument specified by HCFA.

2. _____ The State will use a different assessment instrument than that specified by HCFA. A copy of this instrument is attached to this Appendix. The State certifies that this instrument is consistent with the minimum data set of core elements, common definitions, and utilization guidelines specified by HCFA. The State requests that HCFA approve the use of this instrument.

3. _____ The State used a health insuring organization before January 1, 1986, and had in effect a waiver under §1115 of the Act, which provides personal care services under the State plan for functionally disabled individuals, and which was in effect on December 31, 1990. The State will use an assessment instrument that is consistent with the process, data set of core elements, common definitions, and utilization guidelines in place for its §1115 waiver which provided for personal care for functionally disabled as of December 31, 1990.

h. In conducting the assessment (or the periodic review of the assessment), the interdisciplinary team must:

1. Identify in each such assessment or review each individual's functional disabilities; and

2. Identify in each such assessment or review each individual's need for home and community care. This identification shall include:
A. Information about the individual's health status;
B. Information about the individual's home and community environment; and
C. Information about the individual's informal support system.

3. Determine whether the individual is, or continues to be, functionally disabled. This determination will be made on the basis of the assessment or review.

i. The interdisciplinary team conducting the assessment shall furnish the results to the Medicaid agency and to the qualified community care case manager designated by the Medicaid agency (as specified in Appendix E) to establish, review and revise the individual's ICCP.

j. The Medicaid agency will monitor the appropriateness and accuracy of the assessments and periodic reviews on an ongoing basis, and whenever it is informed by a qualified community care case manager that inaccuracies appear to exist in the assessment of an individual. Through its monitoring, the State will ensure the appropriateness and accuracy of the assessments and periodic reviews. The State assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the nature and severity of any deficiencies noted.
APPENDIX D-2 INTERDISCIPLINARY TEAM

a. Initial assessments will be performed by interdisciplinary teams designated by the State. The agency will designate interdisciplinary teams that meet the following criteria (check all that apply):

1. XXX The interdisciplinary teams will be employed directly by the Medicaid agency.

2. _____ The interdisciplinary teams will be employed directly by other agencies of State government, under contract with the Medicaid agency.

3. _____ The interdisciplinary teams will be employed directly by agencies of local government under contract with the Medicaid agency.

4. _____ The interdisciplinary teams will be employed directly by nonpublic organizations which do not provide home and community care or nursing facility services and do not have a direct or indirect ownership or control interest in, or direct or indirect affiliation or relationship with, an entity that provides community care or nursing facility services.

Interdisciplinary teams may utilize data gathered by other professionals, and may consult with service providers in conducting comprehensive functional assessments.

When assessments are provided under contract with an agency or organization which is not part of the Medicaid agency, the Medicaid agency will specify, as part of the contract, that the contracting agency or organization may not subcontract with another entity for the performance of the assessments without the prior written approval of the Medicaid agency.
b. Periodic reviews of assessments will be performed by interdisciplinary teams designated by the State. The agency will designate interdisciplinary teams that meet the following criteria (check all that apply):

1. [ ] The interdisciplinary teams will be employed directly by the Medicaid agency.

2. [ ] The interdisciplinary teams will be employed directly by other agencies of State government, under contract with the Medicaid agency.

3. [ ] The interdisciplinary teams will be employed directly by agencies of local government under contract with the Medicaid agency.

4. [ ] The interdisciplinary teams will be employed directly by nonpublic organizations which do not provide home and community care or nursing facility services and do not have a direct or indirect ownership or control interest in, or direct or indirect affiliation or relationship with, an entity that provides community care or nursing facility services.

Interdisciplinary teams may utilize data gathered by other professionals, and may consult with service providers in conducting periodic reviews of the individuals' comprehensive functional assessments.

When periodic reviews of assessments are provided under contract with an agency or organization which is not part of the Medicaid agency; the Medicaid agency will specify, as part of the contract, that the contracting agency or organization may not subcontract with another entity for the performance of the periodic reviews without the prior written approval of the Medicaid agency.
c. The interdisciplinary teams conducting initial assessments shall consist, at a minimum, of (check all that apply):

1. XXX Registered nurse, licensed to practice in the State
2. ______ Licensed Practical or Vocational nurse, acting within the scope of practice under State law
3. ______ Physician (M.D. or D.O.), licensed to practice in the State
4. ______ Social Worker (qualifications attached to this Appendix)
5. XXX Case manager
6. ______ Other (specify): ____________________________


d. The interdisciplinary teams conducting periodic reviews of assessments shall consist, at a minimum, of (check all that apply):

1. XXX Registered nurse, licensed to practice in the State
2. ______ Licensed Practical or Vocational nurse, acting within the scope of practice under State law
3. ______ Physician (M.D. or D.O.), licensed to practice in the State
4. ______ Social Worker (qualifications attached to this Appendix)
5. XXX Case manager
6. ______ Other (specify): ____________________________
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SUPPLEMENT 2 TO ATTACHMENT 3.1-A
Page 1

APPENDIX E-1 INDIVIDUAL COMMUNITY CARE PLAN (ICCP)

a. A written Individual Community Care Plan (ICCP) will be developed for each individual who has been determined, on the basis of a comprehensive functional assessment performed in accordance with Appendix D, to be a functionally disabled elderly individual, according to the criteria set forth in Appendices A and B.

b. The ICCP will be established and periodically reviewed and revised, by a Qualified Community Care Case Manager after a face-to-face interview with the individual or primary caregiver.

c. The ICCP will be based on the most recent comprehensive functional assessment of the individual conducted according to Appendix D.

d. The ICCP will specify, within the amount, duration and scope of service limitations set forth in Appendix C, the home and community care to be provided to such individual under the plan.

e. The ICCP will indicate the individual's preferences for the types and providers of services.

f. The ICCP will specify home and community care and other services required by such individual. (Check one):

1. _____ Yes 2. XXX No

g. The ICCP will designate the specific Medicaid vendor (who meets the qualifications specified in Appendix C-2 [a], unless in Consumer Directed Services where the recipient/legal guardian is the employer of record, and whose providers meet the qualifications in Appendix C-2 [d]) which will provide the home and community care. (Check one):

1. XXX Yes 2. _____ No

h. Neither the ICCP, nor the State shall restrict the specific persons or individuals (who meet the requirements of Appendix C-2) who will provide the home and community care specified in the ICCP.
APPENDIX E-2 QUALIFIED COMMUNITY CARE CASE MANAGERS

a. A "Qualified Community Care Case Manager" will meet each of the following qualifications for the provision of community case management.

1. Be a nonprofit or public agency or organization;
2. Have experience or have been trained in:
   A. Establishing and periodically reviewing and revising ICCPs; and
   B. The provision of case management services to the elderly.

The "Qualified Community Care Case Manager" in Texas will be a State agency. The minimum standards of experience and training that will be used by the State are referenced in (a)(4)(D) of this Appendix.

3. Have procedures for assuring the quality of case management services. These procedures will include a peer review process.

4. The State will assure that community care case managers are competent to perform case management functions, by requiring the following educational or professional qualifications be met. (Check all that apply):
   A. _______ Registered nurse, licensed to practice in the State
   B. _______ Physician (M.D. or D.O.), licensed to practice in the State
   C. _______ Social Worker (qualifications attached to this Appendix)
D. XXX Other (specify): A bachelor's degree from an accredited college or university. One year of full-time experience in direct social service work or in clerical or Community Service Aide work in the Texas Department of Human Services Community Care program may be substituted for each year (30 semester hours) of the required education.

b. When community care case management is provided by a nonprofit, nonpublic agency, the agency providing the community case management will not have a direct or indirect ownership or control interest in, or direct or indirect affiliation or relationship with, an entity that provides home and community care or nursing facility services. (Check one):

1. ______ Yes
2. XXX Not applicable. The State will not use nonprofit, nonpublic agencies to provide community care case management.

C. The State will employ procedures to assure that individuals whose home and community care is managed by qualified community care case managers are not at risk of financial exploitation due to such case managers. The "Qualified Community Care Case Manager" will be a state agency whose staff are governed by personnel policies and state law concerning fiduciary responsibilities and appropriate behavior in dealing with clients.

d. The State requests that the requirements of item E-2-b be waived in the case of a nonprofit agency located in a rural area. The State's definition of "rural area" is attached to this Appendix. (Check one):

1. ______ Yes 2. ______ No
3. XXX Not applicable. The State will not use nonprofit: nonpublic agencies to provide community care case management.
APPENDIX E-3 COMMUNITY CARE CASE MANAGEMENT FUNCTIONS

a. A qualified community care case manager is responsible for:

1. Assuring that home and community care covered under the State plan and specified in the ICCP is being provided;

2. Ensuring that a qualified employee of the case management agency visits each individual's home or community care setting at least every 90 days.

3. Informing the individual or primary caregiver how to contact the case manager if service providers fail to properly provide services or other similar problems occur. This information will be provided verbally and in writing.

b. Whenever a qualified community care case manager has reason to believe that an individual's assessment or periodic review (conducted under Appendix D) appears to contain inaccuracies, the community care case manager will bring these apparent discrepancies to the attention of the agency which has performed the assessment or review. If the assessors and the community care case manager are unable to resolve the apparent conflict, the case manager shall report the situation to the component of the Medicaid agency which is responsible for monitoring the program.

c. Whenever a qualified community care case manager is informed by an individual or primary caregiver that provider(s) have failed to provide services, or that other similar problems have occurred, the community care case manager shall take whatever steps are necessary to verify or disprove the complaint. If a problem is confirmed by this monitoring, the community care case manager shall address the problem in an appropriate and timely manner, consistent with the nature and severity of any deficiencies noted. This may include reporting the situation to the component of the Medicaid agency which is responsible for monitoring the program.

SUPERSEDES: TN 91-30
d. Whenever a qualified community care case manager is informed by a provider of service (whether paid or unpaid) that there has been a change in the individual's condition, or that a problem may have arisen which is not currently being addressed, the community care case manager shall take whatever steps are necessary to verify or disprove the information. If a problem is confirmed by this monitoring, the community care case manager shall address it in an appropriate and timely manner, consistent with the nature and severity of the situation.

e. Community care case managers shall verify the qualifications of each individual or agency providing home and community care services prior to the initiation of services, and at such intervals as are specified in Appendix C, thereafter. (Check one):

1. ______ Yes 2. ____ XXX No

f. Where the provision of services in an individual's ICCP is not governed by State licensure or certification requirements, the community care case manager shall provide or arrange for the training specified in Appendix C-2. (Check one):

1. ______ Yes 2. ______ No

3. ____ XXX Not Applicable, all services are governed by state licensure or certification requirements.

g. Community care case managers shall inform each elderly individual for whom an ICCP is established of the person's right to a fair hearing should the individual disagree with the contents of the ICCP.

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APPENDIX E-3 TO
SUPPLEMENT 2 TO ATTACHMENT 3.1-A
Page 2

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TN NO.: 91-80
Supersede:
TN NO.: None

State: Texas
Date Rec'd: SEP 30 1991
Date App'd: DEC 27 1991
Date Eff: JUL 01 1991
HCFA 179: 91-30

Approval Date: DEC 27 1991
Effective Date: JUL 01 1991
h. Texas' ICCP

Texas Department of Human Resources

APPROVAL FOR CCAD SERVICES—Referral Response

1. Date
3. Type Authorization
4. Time-limited Elig.
5. 2060 Score

<table>
<thead>
<tr>
<th>1-Initial</th>
<th>2-Update</th>
<th>3-Termini</th>
<th>1-Yes</th>
<th>2-No</th>
</tr>
</thead>
</table>

6. Dates of Coverage

7. Client Name—Last First

8. Client No.

9. Reason for Term.

TO:


11. Unis

12. 13.


16. TASKS (check all that apply):

| 01—Bathing | 07—Toileting |
| 02—Dressing | 08—Transfer/Ambulation |
| 03—Exercising | 09—Cleaning |
| 04—Feeding | 10—Laundry |
| 05—Grooming | 11—Meal Preparation |
| 06—Routine Hair/Skin Care | 12—Escort |

13—Shopping

14—Assistance with Self-administered Medication

15—Protective Supervision (Supervised Living)

16—Transportation (DAHS and Supervised Living)

17—Other (specify):

Comments:

18: BJN
19: MC
20. Telephone No. (Inc. A/C)

17. Signature—Caseworker

21. Caseworker Address

CONTRACTED AGENCY TO COMPLETE AND RETURN FIRST COPY TO DHR

Service Initiation Date: ..........................................................

Schedule: SUNDAY MONDAY TUESDAY WEDNESDAY THURSDAY FRIDAY SATURDAY

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Total Hours

Agency Contact Person

Comments:

Signature—Agency Representative Date

STATE Texas

DATE REC'D SEP 30 1991

DATE APPV'D DEC 27 1991

DATE EFF JUL 01 1991

HCFA 179 91-30

Approval Date: DEC 27 1991

Effective Date: JUL 01 1991
APPENDIX F-1 TO
SUPPLEMENT 2 TO ATTACHMENT 3.1-A
Page 1

APPENDIX F-1  RIGHTS SPECIFIED IN THE STATUTE

The State assures that home and community care provided under the State plan will meet the following requirements:

a. Individuals providing care are competent to provide such care. The State will maintain documentation to show that each provider of care meets or exceeds the applicable minimum qualifications specified in Appendix C-2.

b. Individuals receiving home and community care shall be assured the following rights:

1. The right to be fully informed in advance, orally and in writing, of the following:
   a. the care to be provided,
   b. any changes in the care to be provided; and
   c. except with respect to an individual determined incompetent, the right to participate in planning care or chances in care.

2. The right to voice grievances with respect to services that are (or fail to be) furnished without discrimination or reprisal for voicing grievances, and to be told how to complain to State and local authorities. Complaint procedures of the Medicaid provider and a list of the Community Care client's rights and responsibilities will be given and explained to the client.

3. The right to confidentiality of personal and clinical records.

4. The right to privacy and to have one's property treated with respect.

5. The right to refuse all or part of any care and to be informed of the likely consequences of such refusal.

6. The right to education or training for oneself and for members of one's family or household on the management of care.
7. The right to be free from physical or mental abuse, corporal punishment, and any physical or chemical restraints imposed for purposes of discipline or convenience and not included in the individual's ICCP.

8. The right to be fully informed orally and in writing of the individual's rights.
APPENDIX F-2 ADDITIONAL RIGHTS

The State assures that home and community care provided under the State plan will meet the following additional requirements:

a. The State assures that all facilities covered by section 1616(e) of the Social Security Act, in which home and community care services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities. Copies of these standards are maintained at the Medicaid agency.

b. In the case of an individual who resides in his or her own home, or in the home of a relative, when the individual has been determined to be incompetent, all rights to be informed of the care to be provided, and to have input into the development of the ICCP specified in Appendix F-1-b shall rest with the principal caregiver.

c. In the case of an individual who resides in a community care setting, and who has been determined to be incompetent, the rights specified in Appendix F-1-b shall rest with the legal guardian or custodian of that individual, unless the guardian or custodian has assigned these rights, in writing, to another person.
GUIDELINES FOR PROVIDER COMPENSATION

a. The following guidelines are provided for such minimum compensation for individuals providing home and community care. These guidelines will be used to assure the availability and continuity of competent individuals to provide such care for functionally disabled individuals who have functional disabilities of varying levels of severity.

1. For services which are the same as, or similar (in content, complexity and provider qualifications) to those provided under the approved Medicaid State plan, the State will compensate the providers on the same basis as that which is approved as part of the plan.

2. For services which are the same as, or similar (in content, complexity and provider qualifications) to those provided under another program funded and operated by the State, the State will compensate the providers on a basis which is equivalent to that used by the other publicly funded program.

3. For services which are dissimilar to those provided under the plan or another program funded and operated by the State, the State will develop methods of compensation which are sufficient to enlist an adequate number of providers, taking into account the number of individuals receiving the service and their geographic location.

b. The State assures that it will comply with these guidelines.
APPENDIX G COMMUNITY CARE SETTINGS

a. The State will provide home and community care to individuals in the following settings:

1. _______ Nonresidential settings that serve 3 to 8 people.

2. _______ Residential settings that serve 3 to 8 people, and in which personal services (other than merely board) are provided in conjunction with residing in the setting.

3. _______ Nonresidential settings that serve more than 8 people.

4. _______ Residential settings that serve more than 8 people, and in which personal services (other than merely board) are provided in conjunction with residing in the setting.

5. XXX Not applicable. The State will not provide services in these types of community care settings.

b. The State assures that the requirements of sections 1929(g) and (h) of the Act (as applicable to the specific setting) will be met for each setting in which home and community care is provided under this section.

c. The state will refuse to provide home and community care in settings which have been found not to meet the requirements of sections 1929(g) and (h) of the Act.
I. Eligibility

The State determines eligibility for PACE enrollees under rules applying to community groups.

A. [X] The State determines eligibility for PACE enrollees under rules applying to institutional groups as provided for in section 1902(a)(10)(A)(ii)(VI) of the Act (42 CFR 435.217 in regulations). The State has elected to cover under its State plan the eligibility groups specified under these provisions in the statute and regulations. The applicable groups are:

(If this option is selected, please identify, by statutory and/or regulatory reference, the institutional eligibility group or groups under which the State determines eligibility for PACE enrollees. Please note that these groups must be covered under the State’s Medicaid plan.)

42 CFR 435.120 & 42 CFR 435.236 - Institution

B. _____ The State determines eligibility for PACE enrollees under rules applying to institutional groups, but chooses not to apply post-eligibility treatment of income rules to those individuals. (If this option is selected, skip to II - Compliance and State Monitoring of the PACE Program.)

C. [X] The State determines eligibility for PACE enrollees under rules applying to institutional groups, and applies post-eligibility treatment of income rules to those individuals as specified below. Note that the post-eligibility treatment of income rules specified below are the same as those that apply to the State’s approved HCBS waiver(s).

Regular Post Eligibility

1. [X] SSI State. The State is using the post-eligibility rules at 42 CFR 435.726. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee’s income.
(a) Sec. 435.726--States which do not use more restrictive eligibility requirements than SSI.

1. Allowances for the needs of the:
   (A) Individual (check one)
   1. ___ The following standard included under the State plan (check one):
      (a) ___ SSI
      (b) ___ Medically Needy
      (c) ___ The special income level for the institutionalized
      (d) ___ Percent of the Federal Poverty Level: _____% 
      (e) ___ Other (specify): ________________________________
   2. ___ The following dollar amount: $________
      Note: If this amount changes, this item will be revised.
   3. X ___ The following formula is used to determine the needs allowance:
      In community residence - individual needs allowance is the special income level for the institutionalized. For individuals requiring nursing facility care for more than three months, the personal needs allowance is the needs allowance for institutional residents (ref. State Plan 2.6A, Page 4A).

   Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

(B) Spouse only (check one):
   1. ___ SSI Standard
   2. ___ Optional State Supplement Standard
   3. ___ Medically Needy Income Standard
   4. ___ The following dollar amount: $________
      Note: If this amount changes, this item will be revised.
   5. ___ The following percentage of the following standard that is not greater than the standards above: _____% of _________ standard.
   6. ___ The amount is determined using the following formula:
      ______________________________________________________________________
   7. X ___ Not applicable (N/A)

(C) Family (check one):
   1. ___ AFDC need standard
   2. ___ Medically needy income standard
The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State’s approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3. ____ The following dollar amount: $______
   Note: If this amount changes, this item will be revised.

4. ____ The following percentage of the following standard that is not greater than the standards above: ____% of _____ standard.

5. ____ The amount is determined using the following formula:

6. ____ Other

7. X Not applicable (N/A)

(b) Medical and remedial care expenses in 42 CFR 435.726.

Regular Post Eligibility

2. N/A 209(b) State, a State that is using more restrictive eligibility requirements than SSI. The State is using the post-eligibility rules at 42 CFR 435.735. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee’s income.

(a) 42 CFR 435.735—States using more restrictive requirements than SSI.

1. Allowances for the needs of the:
   (A) Individual (check one)
   1. ____ The following standard included under the State plan (check one):
      (a) ____ SSI
      (b) ____ Medically Needy
      (c) ____ The special income level for the institutionalized
      (d) ____ Percent of the Federal Poverty Level: ____%
      (e) ____ Other (specify):

2. ____ The following dollar amount: $____________
   Note: If this amount changes, this item will be revised.

3. ____ The following formula is used to determine the needs allowance:

   ________________________________

   Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.
(B) Spouse only (check one):
1. __ The following standard under 42 CFR 435.121:

2. __ The Medically needy income standard

3. __ The following dollar amount: $________
   Note: If this amount changes, this item will be revised.
4. __ The following percentage of the following standard that is
   not greater than the standards above: _____% of _____ standard.
5. __ The amount is determined using the following formula:

6. __ Not applicable (N/A)

(C) Family (check one):
1. _____ AFDC need standard
2. _____ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the
same size used to determine eligibility under the State’s approved AFDC plan or the medically
needy income standard established under 435.811 for a family of the same size.

3. __ The following dollar amount: $________
   Note: If this amount changes, this item will be revised.
4. __ The following percentage of the following standard that is
   not greater than the standards above: _____% of _____ standard.
5. __ The amount is determined using the following formula:

6. __ Other
7. __ Not applicable (N/A)

(b) Medical and remedial care expenses specified in 42 CFR 435.735.

Spousal Post Eligibility

3. ___ State uses the post-eligibility rules of Section 1924 of the Act (spousal
   impoverishment protection) to determine the individual’s contribution toward
   the cost of PACE services if it determines the individual’s eligibility under
   section 1924 of the Act. There shall be deducted from the individual’s
   monthly income a personal needs allowance (as specified below), and a
II. Rates and Payments (continued)

D. The State assures CMS that the capitated rates will be equal to or less than that cost to the agency of providing those same fee-for-service State Plan approved services on a fee-for-service basis, to an equivalent non-enrolled population group based upon the following methodology. Please attach a description of the negotiated rate setting methodology and how the State will ensure that rates are less than the cost in fee-for-service. See attachment ___ to Supplement 3 of Attachment 3.1A.

5. X Rates are set at a percent of fee-for-service costs
6. ___ Experience-based (contractors/State's cost experience or encounter date) (please describe).
7. ___ Adjusted community rate (please describe)
8. ___ Other (please describe)

E. X The rates were set in a reasonable and predictable manner. Please list the name, organizational affiliation of any actuary used, and attestation/description for the initial capitation rates.

No actuary was used.

F. X The State will submit all capitated rates to the CMS Regional Office for prior approval.
2. Experience-based (contractors/State's cost experience or encounter date) (please describe).

3. Adjusted community rate (please describe)

4. Other (please describe)

B. The rates were set in a reasonable and predictable manner. Please list the name, organizational affiliation of any actuary used, and attestation/description for the initial capitation rates.

No actuary was used.

C. The State will submit all capitated rates to the CMS Regional Office for prior approval.

III. Enrollment and Disenrollment

The State assures that there is a process in place to provide for dissemination of enrollment and disenrollment data between the State and the State Administering Agency. The State assures that it has developed and will implement procedures for the enrollment and disenrollment of participants in the State’s management information system, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment was based and the actual number of participants in that month.
IV. Reimbursement Methodology for Program for All-Inclusive Care for the Elderly (PACE) (continued)

(a) General specifications. The Texas Health and Human Services Commission (HHSC) determines the upper payment limits and reimbursement rates for each PACE contractor.

(b) Frequency of reimbursement determination. The upper payment limits and reimbursement rates are determined coincident with the state's biennium.

(c) Upper payment limit determination. There are three upper payment limits calculated for each PACE contract: one for clients eligible only for Medicaid services (Medicaid-only clients), one for clients eligible for both Medicare and Medicaid services (dual-eligible clients), and one for clients eligible for only Medicare services as Qualified Medicare Beneficiaries (QMBs). An average monthly historical cost per client receiving nursing facility services and Home and Community Based Services (HCBS) under the fee-for-service payment system or the managed care program is calculated for the counties served by each PACE contract for the upper payment limits for Medicaid-only clients and for dual-eligible clients.

(1) The upper payment limits for Medicaid-only and for dual-eligible clients for the biennium are calculated for the base period using historical claims data and member-month data from the most recent state fiscal year of complete claims available prior to the state's biennium.

(2) The historical costs are derived from claims data for clients receiving nursing facility services or HCBS services in the counties served by each PACE contract meeting the following criteria:
   (i) age 55 and older; and
   (ii) have Medicare coverage or who do not have Medicare coverage.

(3) The historical costs include:
   (i) acute care services, including inpatient, outpatient, professional, and other acute care services;
   (ii) prescriptions;
   (iii) medical transportation;
   (iv) nursing facility services;
   (v) hospice services;
   (vi) long-term care specialized services, such as physical therapy, occupational therapy, and speech therapy;
   (vii) HCBS services;
   (viii) Primary Home Care (including Family Care) services; and
   (ix) Day Activity and Health Services.

(4) To determine an average monthly historical cost for the counties served by each PACE contract, the total historical claims data for the counties served by each PACE contract are divided by the number of member months for the counties served by each PACE contract.

| TN: 16-0006 | Approval Date: 08/02/16 |
| Supersedes TN: 06-07 | Effective Date: 10/01/16 |
IV. Reimbursement Methodology for Program for All-Inclusive Care for the Elderly (PACE) (continued)

(5) An adjustment for administrative costs is added to the average monthly historical cost per client. The per member per month amount is added for:

(i) processing claims based on the state’s cost to process claims under the managed care payment system; and

(ii) case management based on the state’s cost to provide case management under the managed care payment system for HCBS clients.

(6) The sum of the average monthly historical cost per client for each PACE contract and the amounts from (5) above are projected from the claims data base period identified in (c)(1) to the rate period to account for anticipated changes in costs for each PACE contract. The methodology used for trending historical costs for calculating PACE UPLs and rates is comparable to that used for trending costs in the managed care program.

The PACE Upper Payment Limit (UPL) method can be adjusted as determined actuarially appropriate for statistical outliers, small populations, programmatic changes, catastrophic events, or other economic changes. Other sources of data may be considered and used as deemed necessary for the purpose of providing sufficient data for calculation of an appropriate UPL.

(d) The upper payment limit for QMBs is determined on a statewide basis using the average cost incurred by Medicaid for Medicare co-insurance and deductibles.
IV. Reimbursement Methodology for Program for All-Inclusive Care for the Elderly (PACE) (continued)

(e) Payment rate determination. There are three reimbursement rates calculated for each PACE contract: one for clients eligible only for Medicaid services (Medicaid Only rate), one for clients eligible for both Medicare and Medicaid services (Dual Eligible rate), and one for clients eligible for only Medicare services as Qualified Medicare Beneficiaries (QMBs). The payment rates for each of the three categories of clients for each PACE contract are determined by multiplying the upper payment limits calculated for each PACE contract by a factor less than 1.0. The factor may be reduced as necessary to establish a rate consistent with available funds.

(1) In setting the reimbursement rates under the PACE program, HHSC will ensure that:

(A) reimbursement rates for providers under the program are adequate to sustain the program; and

(B) the program is cost-neutral or costs less when compared to the cost to serve a population in the STAR + PLUS Medicaid managed care program that is comparable in:

(i) age;

(ii) eligibility factors, including:

(I) income level;

(II) health status; and

(III) impairment level;

(iii) geographic location;

(iv) living environment; and

(v) other factors HHSC determines to be necessary.

(2) For purposes of Subsection (e)(1)(B), HHSC will consider data on the cost of services provided to comparable recipients enrolled in the STAR + PLUS Medicaid managed care program to calculate the upper payment limit component of the PACE program reimbursement rates. The cost of those services includes the Medicaid capitation payment per recipient and Medicaid payments made on a fee-for-service basis for services not covered by the capitation payment.

(3) The PACE payment rate determined above is less than the amount that would otherwise have been paid under the Texas State Plan if the participants were not enrolled under the PACE program.

(f) Reporting of cost. HHSC may require the PACE contractor to submit financial and statistical information on a cost report or in a survey format designated by HHSC. Cost report completion is governed by the requirements of the Cost Determination Process. HHSC may also require the PACE contractor to submit audited financial statements.
State of Texas

1905(a)(29) Medication-Assisted Treatment (MAT)

Citation: 3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy
(Continued)

1915(a)(29) _____MAT as described and limited in Supplement _4___ to Attachment 3.1-A.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to
the categorically needy.
1905(a)(29) Medication-Assisted Treatment (MAT)

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Categorically Needy (continued)

i. General Assurance

MAT is covered under the Medicaid state plan for all Medicaid beneficiaries who meet the medical necessity criteria for receipt of the service for the period beginning October 1, 2020 and ending September 30, 2025.

ii. Assurances

a. The state assures coverage of Naltrexone, Buprenorphine, and Methadone and all of the forms of these drugs for MAT that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262).

b. The state assures that Methadone for MAT is provided by Opioid Treatment Programs that meet the requirements in 42 C.F.R. Part 8.

c. The state assures coverage for all formulations of MAT drugs and biologicals for opioid use disorder (OUD) that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological drugs licensed under section 351 of the Public Health Service Act (42 U.S.C. 262).

iii. Service Package

The state covers the following counseling and behavioral health therapies as part of MAT.

a) Please set forth each service and components of each service (if applicable), along with a description of each service and component service.

MAT for treatment of OUD is covered exclusively under section 1905(a)(29) of the Act from October 1, 2020, through September 30, 2025.

The state covers substance use disorder (SUD) counseling for MAT for the treatment of OUD consistent with the requirements of 1905(a)(29).

1. SUD counseling

a. SUD counseling is available on a group or individual basis.
State of Texas

1905(a)(29) Medication-Assisted Treatment (MAT)

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Categorically Needy (continued)

b. Counseling for SUDs is designed to assist a person in developing a better understanding of their SUD, help to establish treatment goals and plans for achieving those goals, and provide interventions to assist the person in accordance with the plan. SUD counseling assists a person in developing the skills and supports needed to address their SUD over time.

b) Please include each practitioner and provider entity that furnishes each service and component service.

**SUD counseling is provided by:**

- Qualified credentialed counselors (QCCs)
- Counselor interns under the supervision of a QCC

SUD counseling is payable to state-licensed and Medicaid-enrolled chemical dependency treatment facilities and opioid treatment programs that employ QCCs or counselor interns, but QCCs and counselor interns cannot directly bill Medicaid for their services.

c) Please include a brief summary of the qualifications for each practitioner or provider entity that the state requires. Include any licensure, certification, registration, education, experience, training and supervisory arrangements that the state requires.

**Qualified credentialed counselor (QCC)**

All QCCs must be licensed and in good standing in the State of Texas, and act within the scope of the individual’s license. The credentialing requirement minimums for a QCC is a licensed chemical dependency counselor (LCDC) or one of the following practitioners who have at least 1,000 hours of documented experience treating substance-related disorders:

- Licensed professional counselor (LPC)
- Licensed master social worker (LMSW)
State of Texas

1905(a)(29) Medication-Assisted Treatment (MAT)

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Categorically Needy (continued)

- Licensed marriage and family therapist (LMFT)
- Licensed psychologist
- Licensed physician
- Licensed physician assistant (PA)
- Certified addictions registered nurse (CARN) - Registered nurse with current certification in addictions nursing by a nationally recognized certification entity.
- Advanced practice registered nurse licensed by the Texas Board of Nurse Examiners as a clinical nurse specialist or nurse practitioner with a population focus area in psychiatric/mental health (APRN – P/MH)

Counselor Intern

A person in good standing seeking a license as a chemical dependency counselor who is registered with the state and pursuing a course of training in chemical dependency counseling. The counselor intern performing SUD counseling must be under the supervision of a QCC. Counselor interns must:

1. Be at least 18 years old.
2. Have a high school diploma or its equivalent
3. Have successfully completed 270 classroom hours, or 18 semester hours (or 27 quarter hours) of chemical dependency curricula*
4. Have completed 300 hours of approved supervised field work practicum*
5. Have passed the criminal history standards
6. Have signed a written agreement to abide by the state ethical standards
7. Be worthy of public trust and confidence.

*Applicants holding at least a baccalaureate degree in chemical dependency counseling, sociology, psychology, or a major approved by the Texas Department of State Health Services as one related to human behavior and development are exempt from the 270 hours of education and the 300-hour practicum.
State of Texas

1905(a)(29) Medication-Assisted Treatment (MAT)

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Categorically Needy (continued)

iv. Utilization Controls

   __X___ The state has drug utilization controls in place. (Check each of the following that apply)

   _____ Generic first policy
   _X___ Preferred drug lists
   _X___ Clinical criteria
   _X___ Quantity limits
   _____ The state does not have drug utilization controls in place.

v. Limitations

Describe the state’s limitations on amount, duration, and scope of MAT drugs, biologicals, and counseling and behavioral therapies related to MAT.

Pharmacy Benefits:

Texas applies limits to quantities and Morphine Milligram Equivalents for buprenorphine prescriptions through the pharmacy benefit. A quantity limit is applied to naltrexone. The MME limits vary depending on whether the opioid prescription is used for OUD treatment. Under the state’s opioid prescription policy, an opioid prescription cannot exceed 90 MME. However, exceptions can be made to bypass the limit of 90 MME for beneficiaries with an OUD through the safety-related prior authorization process.

Texas applies prospective drug utilization review alerts for concurrent use of certain drugs with opioids, including buprenorphine. Texas utilizes a preferred drug list, and drug utilization review safety-related prior authorization is applied to buprenorphine.
State of Texas

1905(a)(29) Medication-Assisted Treatment (MAT)

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Categorically Needy (continued)

Medical Benefits:

When obtained as a medical benefit, methadone and buprenorphine are limited to a certain quantity per day, as specified in the state’s medical policy, for any provider. Take-home doses of methadone or buprenorphine may be dispensed but are limited to one per date of service and no more than 30 per 30 days, by any provider.

PRA Disclosure Statement - This information is being collected to assist the Centers for Medicare & Medicaid Services in implementing section 1006(b) of the SUPPORT for Patients and Communities Act (P.L. 115-271) enacted on October 24, 2018. Section 1006(b) requires state Medicaid plans to provide coverage of Medication-Assisted Treatment (MAT) for all Medicaid enrollees as a mandatory Medicaid state plan benefit for the period beginning October 1, 2020, and ending September 30, 2025. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 # 60). Public burden for all of the collection of information requirements under this control number is estimated to take about 80 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE MEDICALLY NEEDY

1. Inpatient Hospital Services

Except as otherwise specified in Attachment 3.1-E, Standards for the Coverage of Organ Transplant Services, up to 30 days of care during each Title XIX spell of illness are covered if medically necessary. The Title XIX spell of illness limitations are waived for medically necessary inpatient services provided to recipients less than age 21 to comply with the EPSDT provisions of the Omnibus Budget Reconciliation Act of 1989 and the provisions of Section 4604 of the Omnibus Budget Reconciliation Act of 1990.

A. Full semi-private room, or an allowance of the hospital's most prevalent semi-private rate toward a private room. (Private room is covered in full if medically necessary.)

B. All other care in the nature of usual hospital services.

C. Maternity care, usual and customary care for all female recipients.

The benefits of this program do not extend to:

Any services or supplies provided, on or after November 1, 1988, to a hospital inpatient by practitioners, providers, or suppliers, regardless of where the services are provided, after total benefit expenditures related to the hospitalization(s) under the Texas Medical Assistance Program, per recipient per 12-month benefit period, reach $200,000. This limit does not apply to services provided to hospital inpatients by individuals licensed to practice medicine or osteopathy at the time and place the services are provided. This limit does not apply to medically necessary services provided to an inpatient less than age 21 in compliance with the EPSDT provisions of the Omnibus Budget Reconciliation Act of 1989 and the provisions of Section 4604 of the Omnibus Budget Reconciliation Act of 1990. For purposes of this limit, a 12-month benefit period is defined as the 12 consecutive months period beginning November 1 and ending October 31 each year. This limit will apply to hospitalization related services, while a recipient is a hospital inpatient, irrespective of when it is reached in the 12-month benefit period and irrespective of whether one or more inpatient hospital stays, per recipient, are involved. For purposes of this limit, the state agency or its designee will process claims and pay, if payable, on the basis of the first claim received by the agent.
2.a. Outpatient Hospital Services

These shall include diagnostic, therapeutic, rehabilitative, palliative, or telemonitoring items or services furnished by or under the direction of a physician except that no payment will be made for: (1) drugs and biologicals which can be self-administered; (2) occupational therapy that is not medically prescribed treatment designed to improve or restore an individual’s ability to perform those tasks required for independent functioning in the self-care activities of eating, personal hygiene, dressing, and communication.

State: Texas  
Date Received: 31 December, 2013  
Date Approved: 10 June, 2014  
Date Effective: 1 October, 2013  
Transmittal Number: 13-55
2.b. Rural Health Clinic Services.

The specifications, conditions and limitations established by the single state agency for coverage of services provided by a rural health clinic under the Texas Medical Assistance Program are as follows:

A. As a condition for receiving payment for rural health clinic services as defined at 42 CFR 440.20 (b), the services must be medically necessary and be provided to an eligible recipient by a certified and approved rural health clinic in accordance with applicable Federal, State and local laws and regulations.

B. As a condition for receiving payment for other ambulatory services which are covered under this State Plan and which are apart from and other than rural health clinic services as defined at 42 CFR 440.20 (c), a rural health clinic, as the provider, must meet the same conditions of participation as any other provider of the same services(s) and is subject to the qualifications, limitations, and exclusions in the amount, duration and scope of benefits and all other provisions specified in this State Plan and elsewhere.

C. The rural health clinic must contract with the single state agency.

D. The rural health clinic must provide reports and other information specified by the single state agency or its authorized representative.

E. Rural health clinic personnel providing primary health care must be licensed in Texas or in the State within the United States in which and at the time and place the service(s) is provided and/or meet all other established qualifications.

F. Any covered service furnished to an eligible recipient in a long term care facility must be ordered by the recipient's treating physician. A physician is defined as a M.D. or D.O.

G. The rural health clinic must be certified and participate under Title XVIII of the Social Security Act.

H. The plan of treatment to be used for visiting nurse services must be developed by the rural health clinic physician and be approved and ordered by the recipient's treating physician.
2.c. Federally Qualified Health Center Services.

(a) Effective for services on or after April 1, 1990, and subject to the specifications, conditions, limitations, and requirements established by the state agency, Federally Qualified Health Center (FQHC) services are available to eligible Medicaid recipients.

(b) Covered services are limited to:

1. services as described in 1861(aa)(1)(A)-(C) of the Social Security Act, and are medically necessary. These services include:
   (A) physician services;
   (B) physician assistant services;
   (C) nurse practitioner services;
   (D) clinical psychologist services;
   (E) clinical social worker services;
   (F) services and supplies incident to such services as would otherwise be covered if furnished by a physician or as an incident to a physician's services; and
   (G) visiting nurse services to a homebound individual, in the case of those FQHCs that are located in an area that has a shortage of home health agencies as determined by the state survey agency.

2. other ambulatory services which are covered by the Texas Medical Assistance program when provided by other enrolled providers.

(c) Covered services provided by an FQHC must be reasonable and medically necessary as determined by the state agency.

(d) To participate in the Texas Medical Assistance Program, a Federally Qualified Health Center (FQHC) must meet the following requirements:

1. be receiving a grant under Section 329, 330, or 340 of the Public Health Service Act or be designated by the Secretary of the Department of Health and Human Services as meeting the requirements to be receiving such a grant;

2. comply with all federal, state, and local laws and regulations applicable to the services provided;

3. be enrolled and approved for participation in the Texas Medical Assistance program.

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2.c. Federally Qualified Health Center Services. (Continued)

(4) sign a written provider agreement with the state agency;
(5) comply with the terms of the provider agreement and all requirements of the Texas Medical Assistance program including regulations, rules, handbooks, standards, and guidelines published by the state agency; and
(6) will bill for covered services in the manner and format prescribed by the state agency.
3. **Other Laboratory and X-ray Services.**

Laboratory Services are provided by facilities certified to perform testing on human specimens under the Clinical Laboratory Improvement Amendments of 1988 (CLIA) in accordance with 42 CFR §440.30 and 42 CFR Part 493.
4.a Nursing Facility Services for Individuals 21 Years of Age or Older.

Nursing facility services (other than services in an institution for mental disease) provided in a Title XIX nursing facility approved by the single state agency to eligible individuals are limited by a requirement for a medical necessity determination. The treating physician prescribes the nursing facility setting, and the state agency provides the medical necessity determination for which payment will be made.

Nursing facility services includes drugs that are reimbursed through the Vendor Drug Program. This encompasses all drugs contained in the resident's plan of care, subject to the drug rebate provision of Section 1927 of the Social Security Act.
4.a Nursing Facility Services for Individuals 21 Years of Age or Older.

(I) Augmentative communication devices (ACDs) are available to Medicaid-eligible persons residing in a nursing facility when prior authorization is obtained.

(A) To be eligible for reimbursement for an ACD, the nursing facility, prior to purchase of the device, must obtain an evaluation of the resident by a speech-language therapist licensed in the State of Texas. This evaluation must contain all of the following criteria:

i. Diagnosis relevant to the need for an ACD;
ii. Specific ACD being recommended;
iii. Description of how this ACD will meet the specific needs of this individual; and
iv. Description of specific training needs for use of this device to include training needs of the individual, nursing facility staff, and family (when applicable).

(B) The nursing facility must provide a statement of medical necessity for this ACD from the resident’s primary care physician in order to request prior authorization.

(II) Prior authorization must be obtained from the Health and Human Services Commission (HHSC) or its designee before purchase of any ACD. For ACDs costing over $10,000, the prior authorization process will include an independently conducted second speech evaluation facilitated by the Department of Aging and Disability Services (DADS). A nursing facility must submit a copy of the completed initial speech evaluation and physician's attestation of medical necessity to request prior authorization.
4.a Nursing Facility Services for Individuals 21 Years of Age or Older.

(I) Customized Powered Wheel Chairs (CPWCs) are available to Medicaid-eligible persons residing in a nursing facility when prior authorization by HHSC or designee is obtained. The CPWC must be medically necessary, adapted and/or fabricated to meet the individualized needs of the client, and intended for the exclusive and ongoing use of the client.

(A) The nursing facility must provide a statement of medical necessity for a CPWC from the resident’s primary care physician in order to request prior authorization. Medical necessity must be documented in the resident's plan of care.

(B) To be eligible for reimbursement for a CPWC, the nursing facility must obtain an evaluation of the resident by an occupational and/or physical therapist licensed in the State of Texas prior to purchase of the device. This evaluation must contain all of the following criteria:

   i. Diagnosis relevant to the need for a CPWC;
   ii. Specific CPWC being recommended;
   iii. Description of how this CPWC will meet the specific needs of this individual; and
   iv. Description of specific training needs for use of this device to include training needs of the individual, nursing facility staff, and family (when applicable).

(II) Prior authorization must be obtained from the Health and Human Services Commission (HHSC) or its designee before purchase of any CPWC.
4a. Nursing Facility Services for Individuals 21 Years of Age or Older (continued)

Customized adaptive aids are aids that enable an individual to retain or increase the ability to perform activities of daily living or perceive, control, or communicate with the environment in which the individual lives. Customized adaptive aids are intended for use by only the individual for whom the aid is purchased.

Customized adaptive aids are available to individuals with intellectual and developmental disabilities who are receiving services in a nursing facility and have been found through the preadmission screening and resident review process to need a customized adaptive aid. Prior authorization must be obtained from the Health and Human Services Commission before purchase of any customized adaptive aid.

(A) To be eligible for reimbursement for a customized adaptive aid, the nursing facility, prior to the purchase of the aid, must obtain an evaluation of the resident by a physical, occupational, or speech-language therapist licensed in the State of Texas. This evaluation must contain all of the following criteria:

i. Specific item being recommended.

ii. Description of how this item will meet the specific needs of this individual.

iii. Description of specific training needs for use of this device including training needs of the individual, nursing facility staff, and family (when applicable).

(B) The nursing facility must provide a statement of medical necessity for this customized adaptive aid from the resident’s primary care physician in order to obtain prior authorization.

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1 This term has the same meaning as “mental retardation,” defined at 42 C.F.R. § 483.102(b)(3).
4a. Nursing Facility Services for Individuals 21 Years of Age or Older (continued)

Enhanced therapy services are available as a specialized service to individuals with intellectual and developmental disabilities\(^1\) residing in nursing facilities who have been found through the preadmission screening and resident review process to need these services. Physical therapy, occupational therapy, and speech therapy will be provided to eligible individuals as required to maintain the individual's optimum condition.

\(^1\) This term has the same meaning as "mental retardation," defined at 42 C.F.R. § 483.102(b)(3).
4.a Nursing Facility Services for Individuals 21 years or Age or Older (continued)

Specialized Add-on Services for Certain NF Residents

Covered specialized add-on services include habilitative services. Habilitative services are medically necessary services intended to assist the individual in partially or fully attaining, maintaining, or improving developmental-age appropriate skills that were not fully acquired as a result of a congenital, genetic, or early acquired health condition. Specialized add-on services are habilitative services available to individuals residing in a Medicaid-certified nursing facility ("resident"). Preauthorization is required.

Preauthorization is granted when the individual's need for specialized add-on services is identified, recommended by the individual's interdisciplinary team, and included in the resident's habilitative service plan, which is coordinated with the resident's comprehensive care plan and determined to be medically necessary. Specialized add-on services are provided by community-based providers, not the nursing facility. Each allowable specialized add-on service includes transportation between the nursing facility and the service site. HHSC may reimburse a provider agency for delivering specialized add-on services described below, as set out in Attachment 4.19-D, Page 16.

Services will not be paid as specialized add-on services if the services are included in the nursing facility's per diem rate and include expanded interactions, skills training activities, and programs of greater intensity or frequency than provided under the nursing facility's per diem rate.

Allowable specialized add-on services are behavioral support, employment assistance, supported employment, day habilitation, and independent living skills training.

I. Behavioral Support, Employment Assistance, Supported Employment, Day Habilitation, and Independent Living Skills Training

(a) Definitions

(1) Behavioral support - Assistance provided to a resident to increase adaptive behaviors and to replace or modify maladaptive behaviors that prevent or interfere with the resident's interpersonal relationships across all services and social settings delivered by a community-based provider of behavioral support.

Behavioral support consists of:

(A) assessing the behavior(s) to be targeted necessary to design an appropriate behavioral support plan and analyzing those assessment findings;

(B) developing an individualized behavioral support plan that reduces or eliminates the target behaviors, thereby assisting the resident in achieving the outcomes identified in the resident's habilitative service plan;

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4.a Nursing Facility Services for Individuals 21 years of age or Older Specialized Add-On Services (continued)

I. Behavioral Support, Employment Assistance, Supported Employment, Day Habilitation, and Independent Living Skills Training (continued)

(a) Definitions (continued)

(4) Day habilitation - Assistance provided to a resident to acquire, retain, or improve self-help, socialization, and adaptive skills necessary to live successfully and actively participate in all service and social settings. Day habilitation will be delivered by a community-based provider of day habilitation in a setting other than a nursing facility. Service provider qualifications are listed on Appendix 1 to Attachment 3.1-A on page 5j. Day habilitation does not include services provided under the Day Activity and Health Services (DAHS) program. Day habilitation consists of expanded interactions, skills training activities, and programs of greater intensity or frequency beyond those 42 CFR §483.24 requires a nursing facility to provide. Day habilitation services include:

(A) individualized activities consistent with achieving the outcomes identified in a resident's habilitative service plan to attain, learn, maintain, or improve skills;

(B) activities necessary to reinforce therapeutic outcomes targeted by other support providers and other specialized services;

(C) services in a group setting at a location other than a resident's nursing facility for up to five days per week, six hours per day, on a regularly scheduled basis;

(D) personal assistance for a resident who cannot manage personal care needs during the day habilitation activity; and

(E) transportation between the nursing facility and the day habilitation site, as well as during the day habilitation activity necessary for a resident's participation in day habilitation activities.

(5) Independent living skills training - Assistance provided to a resident with a disability, that is consistent with the resident's habilitative service plan and provided in the resident's nursing facility or at community locations by a community-based provider of independent living skills training listed on Appendix 1 to Attachment 3.1-A on page 5h. Service provider qualifications are listed on Appendix 1 to Attachment 3.1-A page 5j. Independent living skills training consists of expanded interactions, skills training activities, and programs of greater intensity or frequency beyond those 42 CFR §483.24 requires a nursing facility to provide. Independent living skills training includes:
4.a. Nursing Facility Services for Individuals 21 years of age or Older Specialized Add-On Services (continued)

I. Behavioral Support, Employment Assistance, Supported Employment, Day Habilitation, and Independent Living Skills Training (continued)

(b) Provider Agency Qualifications- A provider agency of a specialized add-on service is a community-based provider agency with experience in delivering services to individuals with intellectual disabilities or developmental disabilities. The community-based provider agency must be a local intellectual and developmental disability authority or licensed or certified by HHSC to provide specified waiver program services for at least one of the following programs:

(1) Home and Community-based Service (HCS) waiver;
(2) Texas Home Living (TxHmL) waiver;
(3) Community Living Assistance and Support Services (CLASS) waiver; or
(4) Deaf Blind and Multiple Disabilities (DMBD) waiver.

(c) Provider Qualifications for Individual Services

(1) Behavior support- An employee or contractor of a fee-for-service provider agency who provides behavioral support must:

(A) Be licensed as a psychologist in accordance with State law;
(B) Be licensed as a psychological associate in accordance with State law;
(C) Have been issued a provisional license to practice psychology in accordance with State law;
(D) Be licensed as a clinical social worker in accordance with State law;
(E) Be licensed as a professional counselor in accordance with State law; or
(F) Be licensed as a behavior analyst in accordance with State law.
4.a Nursing Facility Services for Individuals 21 Years of Age or Older Specialized Add-On Services (continued)

I. Behavioral Support, Employment Assistance, Supported Employment, Day Habilitation, and Independent Living Skills Training (continued)

(a) Definitions (continued)

(3) Supported employment – Assistance provided to a resident who requires intensive, ongoing support to be self-employed, work from home, or perform in an integrated work setting in the community at which individuals without disabilities are employed, and to sustain competitive employment in an integrated work setting and delivered by a community-based provider of supported employment. Supported employment consists of:

(A) making employment adaptations, supervising, and providing training related to the resident's assessed needs;

(B) transporting the resident between the nursing facility and the site where supported employment services are provided and as necessary to support the person to be self-employed, work from the resident's place of residence, or perform in a work setting; and

(C) participating in habilitative service planning team meetings.

Supported employment add-on services are not available to a resident of a nursing facility through a program funded under the Rehabilitation Act of 1973.
4. a Nursing Facility Services for Individuals 21 Years of Age or Older Specialized Add-On Services (continued)

I. Behavioral Support, Employment Assistance, Supported Employment, Day Habilitation, and Independent Living Skills Training (continued)

(a) Definitions (continued)

(4) Day habilitation – Assistance provided to a resident to acquire, retain, or improve self-help, socialization, and adaptive skills necessary to live successfully and actively participate in all service and social settings. Day habilitation will be delivered by a community-based provider of day habilitation in a setting other than the resident’s nursing facility in a group setting at day habilitation centers owned or under arrangement by the community provider listed on Appendix 1 to Attachment 3.1-A on page 5h. Service provider qualifications are listed on Appendix 1 to Attachment 3.1-A on page 5j. Day habilitation does not include services provided under the Day Activity and Health Services (DAHS) program. Day habilitation consists of expanded interactions, skills training activities, and programs of greater intensity or frequency beyond those 42 CFR §483.24 requires a nursing facility to provide. Day habilitation services include:

(A) individualized activities consistent with achieving the outcomes identified in a resident’s habilitative service plan to attain, learn, maintain, or improve skills;

(B) activities necessary to reinforce therapeutic outcomes targeted by other support providers and other specialized services;

(C) services in a group setting at a location other than a resident’s nursing facility for up to five days per week, six hours per day, on a regularly scheduled basis;

(D) personal assistance for a resident who cannot manage personal care needs during the day habilitation activity; and

(E) transportation between the nursing facility and the day habilitation site, as well as during the day habilitation activity necessary for a resident’s participation in day habilitation activities.

(5) Independent living skills training – Assistance provided to a resident with a disability, that is consistent with the resident’s habilitative service plan and provided in the resident’s nursing facility or at community locations by a community-based provider of independent living skills training listed on Appendix 1 to Attachment 3.1-A on page 5h. Service provider qualifications are listed on Appendix 1 to Attachment 3.1-A on page 5j. Independent living skills training consists of expanded interactions, skills training activities, and programs of greater intensity or frequency beyond those 42 CFR §483.24 requires a nursing facility to provide. Independent living skills training includes:
4.a Nursing Facility Services for Individuals 21 Years of Age or Older Specialized Add-On Services (continued)

I. Behavioral Support, Employment Assistance, Supported Employment, Day Habilitation, and Independent Living Skills Training (continued)

(a) Definitions (continued)

(A) habilitation and support activities that foster improvement of, or facilitate, a resident’s ability to attain, learn, maintain, or improve functional living skills and other daily living activities;

(B) activities that help preserve the resident’s bond with family members, such as educating the family on techniques for teaching the resident appropriate social behaviors and how to effectively respond to the resident’s inappropriate behaviors;

(C) activities that foster inclusion in community activities generally attended by individuals without disabilities; and

(D) transportation to facilitate a resident’s employment opportunities and participation in community activities, and between the resident’s nursing facility and training site.
4.a Nursing Facility Services for Individuals 21 Years of Age or Older Specialized Add-On Services (continued)

I. Behavioral Support, Employment Assistance, Supported Employment, Day Habilitation, and Independent Living Skills Training (continued)

(b) Provider Agency Qualifications - A provider agency of a specialized add-on service is a community-based provider agency with experience in delivering services to individuals with intellectual disabilities or developmental disabilities. The community-based provider agency must be licensed or certified by HHSC to provide program services for at least one of the following programs:

1. Home and Community-based Service (HCS) waiver;
2. Texas Home Living (TxHmL) waiver;
3. Community Living Assistance and Support Services (CLASS) waiver; or
4. Deaf Blind and Multiple Disabilities (DBMD) waiver.

(c) Provider Qualifications for Individual Services

1. Behavioral support – An employee or contractor of a fee-for-service provider agency who provides behavioral support must:

   (A) be licensed as a psychologist in accordance with State law;
   (B) be licensed as a psychological associate in accordance with State law;
   (C) have been issued a provisional license to practice psychology in accordance with State law;
   (D) be certified by HHSC as an authorized provider in accordance with Texas Administrative Code;
   (E) be licensed as a clinical social worker in accordance with State law;
   (F) be licensed as a professional counselor in accordance with State law; or
   (G) be certified as a behavior analyst by the Behavior Analyst Certification Board®, Inc. (BACB®) .
4.a Nursing Facility Services for Individuals 21 Years of Age or Older Specialized Add-On Services (continued)

I. Behavioral Support, Employment Assistance, Supported Employment, Day Habilitation, and Independent Living Skills Training (continued)

(c) Provider Qualifications for Individual Services (continued)

(2) Employment assistance – An employee or contractor of a fee-for-service community-based provider agency who provides employment assistance must:

(A) be at least 18 years of age;

(B) not be the LAR of the resident receiving employment assistance or the spouse of the resident;

(C) have at least one of the following:

(i) a bachelor's degree in rehabilitation, business, marketing, or a related human services field, and at least six months of paid or unpaid experience providing services to people with disabilities;

(ii) an associate's degree in rehabilitation, business, marketing, or a related human services field, and at least one year of paid or unpaid experience providing services to people with disabilities; or

(iii) a high school diploma or a certificate recognized by a state as the equivalent of a high school diploma, and at least two years of paid or unpaid experience providing services to people with disabilities.

(3) Supported employment – An employee or contractor of a fee-for-service community-based provider agency who provides supported employment must:

(A) be at least 18 years of age;

(B) not be the LAR of the resident receiving supported employment or the spouse of the resident;

(C) have at least one of the following:

(i) a bachelor's degree in rehabilitation, business, marketing, or a related human services field, and at least six months of paid or unpaid experience providing services to people with disabilities;

(ii) an associate's degree in rehabilitation, business, marketing, or a related human services field, and at least one year of paid or unpaid experience providing services to people with disabilities; or

(iii) a high school diploma or a certificate recognized by a state as the equivalent of a high school diploma, and at least two years of paid or unpaid experience providing services to people with disabilities.
4.a Nursing Facility Services for Individuals 21 Years of Age or Older
Specialized Add-On Services (continued)

I. Behavioral Support, Employment Assistance, Supported Employment, Day Habilitation, and Independent Living Skills Training (continued)

(c) Provider Qualifications for Individual Services (continued)

(4) Day habilitation and independent living skills training – An employee or contractor of a fee-for-service community-based provider agency who provides day habilitation must

(A) be at least 18 years of age; and

(B) have one of the following:

(i) a high school diploma or a certificate recognized by a state as the equivalent of a high school diploma; or

(ii) documentation of a proficiency evaluation of experience and competence to perform the job tasks that includes:

(I) a written competency-based assessment of the ability to document service delivery and observations of a resident to be served; and

(II) at least three written personal references from persons not related by blood or marriage to the employee or contractor that indicate the employee or contractor has the ability to provide a safe, healthy environment for a resident being served.
4.a Nursing Facility Services for Individuals 21 Years of Age or Older

II. Habilitation Coordination

(a) Definition of Habilitation Service Plan. The habilitative service plan is developed by the interdisciplinary team and includes specialized add-on services and specialized services recommended by PASRR. The habilitative service plan is shared with all community-based providers who deliver specialized add-on services. Implementation of the services identified on the habilitative service plan is monitored by the habilitation coordinator.

(b) Definition of Habilitation Coordination. Assistance for a nursing facility resident with a disability who has chosen to remain in the facility to access appropriate specialized add-on services necessary for the resident to achieve a quality of life and level of community participation acceptable to the resident (and LAR on the resident's behalf). If the resident decides to leave the nursing facility, a service coordinator will be assigned to assist the resident with transitioning into the community. Habilitation coordination consists of:

(1) assessing and periodically reassessing habilitative service needs by gathering information from the resident and other appropriate sources, such as the family members, social workers, and service providers, to determine the resident's habilitative needs and the specialized add-on services that will address those needs;

(2) developing (and periodically revising) an individualized habilitative service plan by identifying with the resident and LAR, if any, desired habilitation outcomes and specifying a course of action to accomplish those outcomes;

(3) assisting the resident to access needed specialized add-on services and other habilitative programs and services that can provide services to address needs and achieve outcomes identified in the habilitative service plan;

(4) monitoring and follow-up activities that consist of ensuring the resident receives needed specialized add-on services, evaluating the effectiveness and adequacy of specialized add-on services, facilitating the coordination of the resident's habilitative service plan and the nursing facility comprehensive care plan, and determining if outcomes identified in the habilitative service plan are being achieved; and

(5) offering educational opportunities and informational activities about community living options, arranging visits to community providers, and addressing concerns about community living.
4.a Nursing Facility Services for Individuals 21 Years of Age or Older

II. Habilitation Coordination

(c) Qualifications of Service Provider of Habilitation Coordination. A service provider of habilitation coordination must:

(1) be an employee of the habilitation coordination provider agency;

(2) have a bachelor's or advanced degree from an accredited college or university with a major in a social, behavioral, or human service field, such as psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human development, gerontology, educational psychology, education, or criminal justice; and,

(3) have at least one year of experience working directly with individuals with intellectual or other developmental disabilities.
4.b. EPSDT Services

EPSDT prior authorization requirement: Prior authorization is required for payment of dental services in excess of the ceiling amount established for initial services or if subsequent appointments and services are required. Also, prior authorization is required for hospitalization expenses in connection with dental services. An orthodontic plan of treatment must be received, authorized, and prepaid while the client is Medicaid eligible and under 21 years of age.

Eligible medical assistance recipients covered under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program are entitled to optometric and eyeglass services as described below and elsewhere in this State Plan, when provided by an appropriate and qualified provider enrolled in the Texas Medical Assistance Program at the time the service(s) is provided.

Each EPSDT recipient is entitled to one eye exam by refraction by an appropriate and qualified provider once every 12 months. An eye exam by refraction may be offered to an EPSDT recipient before 12 months have elapsed since the last such exam if there is a significant change in visual acuity, measured in diopter or axis changes as defined by the single state agency, or if an eye exam by refraction is otherwise medically necessary. The limit of one eye exam by refraction per recipient every 12 months applies to both prosthetic (aphakic) eyewear and non-prosthetic eyewear; the limit of one exam by refraction for either aphakic or non-prosthetic eyewear every 12 months may be waived in either case for a significant change in visual acuity or medical necessity. This limit does not apply to other diagnostic and/or treatment of the eye for medical conditions, other than determination of visual acuity. Diagnostic and treatment services provided by an appropriate and qualified provider are covered by the Texas Medical Assistance Program if the services are (1) within the appropriate and qualified provider's scope of practice, as defined by state law; and (2) reasonable and medically necessary as determined by the single state agency or its designee. Other diagnostic and treatment services provided by a physician are described elsewhere in this State Plan.

Eyewear, including contacts and eyeglasses (lenses and frames), that significantly improves visual acuity or impedes the progression of visual problems is a program benefit. In addition, payment is limited to serviceable and prescription quality eyeglass frames and lenses that meet federal and state requirements, standard prescription requirements, and other specifications as established by the single state agency.

Prosthetic eyewear, including contact lenses and eyeglasses (lenses and frames), is a program benefit provided to an eligible recipient if the eyewear is prescribed for congenital absence of the eye lens, loss of an eye lens because of trauma or post cataract surgery without the placement of an intraocular lens.
4.b. EPSDT Services, continued

Reimbursement is made for as many temporary lenses as are medically necessary during post-surgical cataract convalescence (the four-month period following the date of cataract surgery).

Nonprosthetic eyeglasses or contact lenses are available for lost or destroyed nonprosthetic eyewear or if required because of a change in visual acuity measured in diopter or axis changes as defined by the single state agency.

The repair of prosthetic or non-prosthetic eyeglasses is a benefit when the needed repairs do not exceed the cost of replacement, except that repairs costing less than $2.00 are not reimbursable.
4.b EPSDT Services (Continued)

Repairs to prosthetic eyewear are reimbursable if the cost of materials exceeds $2. Repairs costing less than $2 are not reimbursable by the program and the provider may not bill the recipient for these services.

Nonprosthetic eyewear is available only once every 24 months, unless a recipient's eyes undergo a change in visual acuity of .5 diopters or more, or the eyewear is lost or destroyed. Provisions have been made for the necessary repair or replacement of lost or destroyed nonprosthetic eyewear.

Optometric services provided in skilled or intermediate care facilities are reimbursable by the program if the recipient's attending physician has ordered the service(s) and the order is included in the recipient's medical records at the nursing facility.

EPSDT Expansion under OBRA of 1989 - The single state agency will provide other health care described in Section 1905(a) of the Social Security Act that is found to be medically necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the EPSDT screen, even when such health care is not otherwise covered under the State Plan.

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TN No. 88-21
4b. EPSDT Services (continued)

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SUPERSEDES: TN- 06-08

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Supersedes TN No. 06-08
4.b. EPSDT Services (Continued)

**Audiology and Hearing Services**

**Definition:**
Audiology and hearing services outlined in this section of the state plan are available to Medicaid-eligible recipients under the age of 21 years who are eligible for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services and for whom services are medically necessary.

**Services:**
**Audiology Services**
Pursuant to 42 CFR § 440.110, medically necessary audiology services include, but are not limited to:

1. Identification of children with hearing loss;
2. Determination of the range, nature and degree of hearing loss, including the referral for medical or other professional attention for the amelioration of hearing;
3. Provision of amelioration activities, such as language amelioration, auditory training, speech reading (lip reading), hearing evaluation and speech conversation;
4. Determination of the child's need for group and individual amplification; and
5. Hearing aid services, including necessary equipment and supplies (hearing aid instruments are described under “Prosthetics”).

**Hearing Services**
Hearing aid and audiometric evaluation services for Medicaid clients younger than 21 years of age are reimbursed to willing and qualified Medicaid providers, meeting the qualifications described below.

Audiology and hearing services may be provided in an individual or group setting.

Audiology and hearing services must be prescribed by a physician or by another licensed practitioner within the scope of his or her practice under state law.

**Providers:**
Audiology and hearing services must be provided by a qualified audiologist who meets the requirements of 42 CFR § 440.110(c)(3) and in accordance with applicable state and federal law or regulation.

Services may be provided by:
- A qualified audiologist licensed by the state to furnish audiologist services; or
- A qualified audiology assistant licensed by the state, when the services are provided in a facility setting (such as a comprehensive outpatient rehabilitation facility, an outpatient rehabilitation facility, an outpatient hospital, an inpatient hospital, or a school) and when the assistant is acting.
4.b. EPSDT Services (Continued)

Audiology and Hearing Services (continued)

under the supervision or direction of a qualified audiologist in accordance with 42 CFR § 440.110 and other applicable state and federal law.

Place of Service:
Audiology and hearing services may be delivered in the following places of service: office, home, outpatient setting, or other location, e.g., school.
4b. EPSDT Services (Continued)

Counseling Services

Definition:
Counseling services outlined in this section of the state plan are available to Medicaid-eligible recipients under the age of 21 years, who are eligible for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), and for whom the services are medically necessary.

Services:
Medically necessary EPSDT services are health care, diagnostic services, treatment, and other measures described in section 1905(a) of Title XIX of the Social Security Act that are necessary to correct or ameliorate any defects and physical and mental illnesses and conditions. These services are intended for the exclusive benefit of the Medicaid eligible child and include but are not limited to:

1. Services provided to assist the child and/or parents in understanding the nature of the child's disability;
2. Services provided to assist the child and/or parents in understanding the special needs of the child;
3. Services provided to assist the child and/or parents in understanding the child's development;
4. Health and behavior interventions to identify the psychological, behavioral, emotional, cognitive, and social factors important to the prevention, treatment, or management of physical health problems.
5. Counseling services by providers identified in Appendix 1 to Attachment 3.1-A, Items 6d(5), 6d(6), 6d(7), and 6d(8) of the state plan; and
6. Assessing needs for specific counseling services.

Counseling services may be provided in an individual or group setting.

Providers:
Counseling services must be provided by a qualified counselor who meets the qualification requirements of 42 CFR § 440.60(a) and all other applicable state and federal law or regulation.

Services may be provided by a:

- Licensed Psychologist;
- Provisionally Licensed Psychologist (PLP);
- Licensed Psychological Associate (LPA);
- Licensed Physician;
- Licensed Clinical Social Worker (LCSW);
- Licensed Marriage and Family Therapist (LMFT);
- Licensed Professional Counselor (LPC); or
- Licensed Specialist in School Psychology (LSSP) when the services are provided in a school setting.

State: Texas
Date Received: 9/12/13
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Transmittal Number: TX 13-24

Supersedes TN: 09-07
4.b. EPSDT Services (Continued)

Counseling Services (continued)

Place of Service:

Counseling services may be delivered in the following places of service: office, home, outpatient setting, or other location, e.g., school.
4.b. EPSDT Services (Continued)

Nursing Services

Definition:
Nursing services outlined in this section of the state plan are available to Medicaid-eligible recipients under the age of 21 years, who are eligible for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services and for whom the service is medically necessary.

Services:
Nursing services are defined as the promotion of health, prevention of illness, and the care of ill, disabled and dying people through the provision of services essential to the maintenance and restoration of health.

Nursing services may be provided in an individual or group setting.

Providers:
Nursing services must be provided by a qualified nurse who meets qualification requirements of, and in accordance with, 42 CFR § 440.60 and other applicable state and federal law or regulation, including nursing services delivered by advanced practice nurses (APNs) including nurse practitioners (NPs) and clinical nurse specialists (CNSs), registered nurses (RNs), licensed vocational nurses (LVNs), licensed practical nurses (LPNs).

Nursing services provided on a restorative basis under 42 CFR § 440.130(d), including services delegated in accordance with the Texas Board of Nurse Examiners to individuals who have received appropriate training from a RN.

Place of Service:
Nursing services may be delivered in the following places of service: office, home, outpatient setting, or other location, e.g., school.
4.b. EPSDT Services (Continued)

Occupational Therapy

Definition:
Occupational therapy services outlined in this section of the state plan are available to Medicaid-eligible recipients under the age of 21 years, who are eligible for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services and for whom the services are medically necessary.

Services:
Occupational therapy services must be prescribed by a physician. These services include any necessary supplies and equipment utilized during the therapy session.

Medically necessary EPSDT services are health care, diagnostic services, treatments, and other measures necessary to correct or ameliorate any disability and chronic conditions. These services include but are not limited to:

1. Identification of children with occupational therapy needs;
2. Evaluation for the purpose of determining the nature, extent and degree of the need for occupational therapy services;
3. Improving, developing, or restoring functions impaired or lost through illness, injury, or deprivation;
4. Improving ability to perform tasks for independent functioning when functions are impaired or lost; and
5. Preventing, through early intervention, initial or further impairment or loss of function.

Occupational therapy services may be provided in an individual or group setting.

Providers:
Occupational therapy services must be provided by a qualified occupational therapist who meets the requirements of 42 CFR §440.110(b) and in accordance with applicable state and federal law or regulation.

Services may be provided by:

- A qualified occupational therapist licensed by the state to furnish occupational therapy services; or
- A certified occupational therapy assistant (COTA) when the services are provided in a facility setting (including a comprehensive outpatient rehabilitation facility, an outpatient rehabilitation facility, an outpatient hospital, an inpatient hospital, or a school) and when the assistant is acting under the supervision or direction of a qualified occupational therapist in accordance with 42 CFR § 440.110 and other applicable state and federal law.
4.b. EPSDT Services (Continued)

Occupational Therapy (continued)

Place of Service:
Occupational therapy services may be delivered in the following places of service: office, home, outpatient setting, or other location, e.g., school.
4b. EPSDT Services (Continued)

Personal Care Services

Personal care services are available to Medicaid-eligible clients under the age of 21 years, who are eligible for the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program and for whom services are medically necessary.

Services:
EPSDT services are health care, diagnostic services, treatments, and other measures necessary to correct or ameliorate defects and physical and mental illnesses and conditions.

Personal care services are support services furnished to a client who has physical, cognitive, or behavioral limitations related to the client’s disability or chronic health condition that limit the client’s ability to accomplish activities of daily living (ADLs), instrumental activities of daily living (IADLs), or health-related functions.

Services must be authorized by a physician in accordance with a plan of treatment or (at the State’s option) in accordance with a service plan approved by the State.

Personal care services may be provided in an individual or group setting.

Providers:
Individuals providing personal care services must be a qualified provider in accordance with 42 CFR § 440.167, who is 18 years or older and has been trained to provide the personal care services required by the client. Personal care services will not be reimbursed when delivered by someone who is a legally responsible relative or guardian. Service providers include: individual attendants, attendants employed by agencies that meet the state requirements, attendants employed by agencies contracting with the State, special education teachers, and special education teacher’s aides. Bus monitors/aides may be considered for reimbursement when the personal care services are provided on a specially adapted school bus.

Providers delivering personal care services must be enrolled in the Medicaid program and meet State requirements for a provider of personal care services or meet State contracting requirements for a consumer directed services agency.

Place of Service:
Personal care services are furnished in a home, school, day care facility or other community setting, excluding hospitals, nursing facilities, intermediate care facilities for the mentally retarded, and institutions for mental disease.

SUPERSEDES: TN-07-22
4.b. EPSDT Services (Continued)

Physical Therapy

Definition:
Physical therapy services outlined in this section of the state plan are available to Medicaid-eligible recipients under the age of 21 years, who are eligible for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services and for whom services are medically necessary.

Services:
Physical therapy services must be prescribed by a physician. These services include any necessary supplies and equipment utilized during the therapy session.

Medically necessary EPSDT services are health care, diagnostic services, treatments, and other measures to correct or ameliorate any disability and chronic conditions. These services include but are not limited to:

1. Identification of children with physical therapy needs;
2. Evaluation for the purpose of determining the nature, extent and degree of the need for physical therapy services;
3. Physical therapy services provided for the purpose of preventing or alleviating movement dysfunction and related functional problems; and
4. Obtaining, interpreting, and integrating information appropriate to program planning.

Physical therapy services may be provided in an individual or group setting.

Providers:

Physical therapy services must be provided by a qualified physical therapist who meets the requirements of 42 CFR § 440.110(a) and in accordance with applicable state and federal law or regulation.

Services may be provided by:

- a qualified physical therapist licensed by the state to furnish physical therapy services; or
- a licensed physical therapy assistant (LPTA) when the services are provided in a facility setting (including a comprehensive outpatient rehabilitation facility, an outpatient rehabilitation facility, an outpatient hospital, an inpatient hospital, or a school) and when the assistant is acting under the supervision or direction of a qualified physical therapist in accordance with 42 CFR § 440.110 and other applicable state and federal law.
4.b. EPSDT Services (Continued)

Physical Therapy (continued)

Place of Service:
Physical therapy services may be delivered in the following places of service: office, home, outpatient setting, or other location, e.g., school.
4.b. EPSDT Services (Continued)

Physician Services

Definition:

Physician services outlined in this section of the state plan are available to Medicaid-eligible recipients under the age of 21 years, who are eligible for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services and for whom the service is medically necessary.

Services:

EPSDT medically necessary services are health care, diagnostic services, treatments, and other measures necessary to correct or ameliorate any disability and chronic conditions. These services include but are not limited to:

1. Physician services; and
2. Diagnostic and evaluation services to determine a child’s medically related condition that results in the child’s need for Medicaid services.

Physician services may be provided only in an individual setting.

Providers:

Physician services must be provided by a qualified physician who meets the requirements of, and in accordance with, 42 CFR § 440.50(a) and other applicable state and federal law or regulation.

Place of Service:

Physician services may be delivered in the following places of service: office, home, outpatient setting, or other location, e.g., school.
4b. EPSDT Services (Continued)

Psychological Services

Definition:
Psychology services outlined in this section of the state plan are available to Medicaid-eligible recipients under the age of 21 years, who are eligible for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services, and for whom the services are medically necessary.

Services:
Medically necessary EPSDT services are health care, diagnostic services, treatment, and other measures described in section 1905(a) of Title XIX of the Social Security Act that are necessary to correct or ameliorate any defect and physical and mental illnesses and conditions. These services include but are not limited to:

1. Psychology services as identified in Appendix I to Attachment 3.1A, Item 6d(8), of the state plan;
2. Administering psychological tests and other assessment procedures, and interpreting testing and assessment results;
3. Obtaining, integrating and interpreting information about child behavior and conditions related to learning and functional needs, planning and managing a program of psychological services;
4. Evaluating a Medicaid recipient for the purpose of determining the needs for specific psychological, health or related services; and
5. Assessing the effectiveness of the delivered services on achieving the goals and objectives of the child’s individual educational program (IEP).

Psychological services may be provided in an individual or group setting.

Providers:
Psychological services must be provided by a qualified psychologist who meets the requirements of, and in accordance with, 42 CFR § 440.60 and other applicable state and federal law or regulation.

Services may be provided by:
- A qualified psychologist licensed by the state;
- A qualified psychiatrist licensed by the state;
- Provisionally Licensed Psychologist (PLP);
- Licensed Psychological Associate (LPA);
- A Licensed Specialist in School Psychology (LSSP) when the services are provided in a school setting.

Place of Service:
Psychological services may be delivered in the following places of service: office, home, outpatient setting, or other location, e.g. school.
4.b. EPSDT Services (Continued)

Speech and Language Services

Definition:
Speech and language services outlined in this section of the state plan are available to Medicaid-eligible recipients under the age of 21 years, who are eligible for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services and for whom services are medically necessary.

Services:
Medically necessary EPSDT services are health care, diagnostic services, treatments, and other measures to correct or ameliorate any disability and chronic conditions. These services include but are not limited to:
1. Identification of children with speech or language disorders;
2. Diagnosis and appraisal of specific speech or language disorders;
3. Referral for medical or other professional attention necessary for the habilitation of speech or language disorders; and
4. Provision of speech or language services for the habilitation or prevention of communicative disorders.

Speech and language services must be prescribed by a physician. In a school setting, speech and language services may be prescribed by either a physician or by an other licensed practitioner of the healing arts within the scope of his or her practice under state law in accordance with 42 CFR § 440.110(c).

Speech and language therapy services may be provided in an individual or group setting.

Providers:
Speech and language services must be provided by:
- A qualified speech/language pathologist (SLP) who meets the requirements of, and in accordance with, 42 CFR § 440.110(c), and other applicable state and federal law or regulation;
- American Speech-Language-Hearing Association (ASHA) certified SLP with Texas license and ASHA-equivalent SLP (i.e., SLP with master's degree and Texas license) when the services are provided in a school setting. (Pending equivalency ruling by Texas Attorney General's opinion.);
- A qualified assistant in SLP licensed by the state, when the services are provided in a facility setting (including a comprehensive outpatient rehabilitation facility, an outpatient rehabilitation facility, an outpatient hospital, an inpatient hospital, or a school) and when the assistant is acting under the supervision or direction of a qualified SLP in accordance with 42 CFR § 440.110 and other applicable state and federal law; or
4.b. EPSDT Services (Continued)

Speech and Language Services (continued)

- A provider with a state education agency certification in speech language pathology, a licensed SLP intern, and a grandfathered SLP (has a Texas license and no master's degree) when the services are provided in a school setting and when these providers are acting under the supervision or direction of a qualified SLP in accordance with 42 CFR § 440.110 and other applicable state or federal law.

Place of Service:
Speech and language services may be delivered in the following places of service: office, home, outpatient setting, or other location, e.g., school.
4.b. EPSDT Services (Continued)

Transportation Services in the School Setting

**Definition:**
Transportation services outlined in this section of the state plan are available to Medicaid-eligible recipients under the age of 21 years, who are eligible for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services and for whom the services are medically necessary.

**Services:**
Medically necessary transportation services are provided to all Medicaid-eligible children when the Medicaid-eligible children are receiving school-based services (also known as School Health and Related Services (SHARS)) on the same day. Transportation services are provided on a specially adapted school bus to and/or from the location where the school-based service is provided.

**Providers:**
Transportation services must be provided by a qualified Medicaid provider. Transportation services include direct services personnel, e.g. bus drivers employed by the school districts.
4.b. EPSDT Services (continued)

1) Private Duty Nursing Services:

   a) Private duty nursing (PDN) services are prior authorized and the services must be performed by a licensed registered nurse or a licensed practical nurse. In Texas, licensed practical nurses are referred to as licensed vocational nurses (LVNs). PDN services must be in accordance with 42 CFR § 440.80. PDN services are available to Medicaid recipients eligible for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).

   b) Services:

      i) EPSDT services are screening services, vision services, dental services, and other health care, diagnostic services, treatments, and other measures described in §1905(a) necessary to correct or ameliorate defects and physical and mental illness and conditions. §1905(r); 42CFR §440.40(b)

      ii) PDN is skilled nursing services for EPSDT-eligible recipients who meet the medical necessity criteria for PDN and require individualized, continuous skilled care beyond the level of skilled nursing visits authorized under the Texas Medicaid Home Health Services.

   c) Providers:

      i) PDN services must be provided by a qualified nurse who meets the requirements of applicable state licensing standards, state and federal laws, policy, and in accordance with 42 CFR § 440.80. This requirement applies to nursing services delivered by registered nurses (RNs), licensed vocational nurses (LVNs), and licensed practical nurses (LPNs).

   d) Place of Service:

      i) PDN services may be delivered in the following places of service: home or other location, e.g., school or daycare.
4b. EPSDT Services (Continued)

1) **ESPDT Case Management:**

   a) Children birth through age 20 with a health condition/health risk.

2) **Areas of state in which services will be provided:**

   a) Entire State

3) **Comparability of services:**

   a) Services are not comparable in amount duration and scope. Under section 1915(g) of the Social Security Act, a state may provide services without regard to the comparability requirements of section 1902(a)(10)(B) of the Act.

4) **Definition of services:**

   a) Case management services are services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational, and other services. Case Management includes the following assistance:

      i) Comprehensive face-to-face assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social, or other services required to address short- and long-term health and well being. The frequency of assessment and reassessment is based upon client need and the complexity of the case. Additional follow-up visits can be requested based upon client need. Assessment activities include:

         (1) taking a client’s history;

         (2) identifying the individual’s needs and assessing and addressing family issues that impact the client’s health condition/risk or high-risk condition and completing related documentation; and

         (3) gathering information from other sources, such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.

      ii) Development (and periodic revision) of a specific care plan that:

         (1) is based on the information collected through the face-to-face needs assessment, face-to-face follow-up contacts, or telephone follow up contacts;

         (2) specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
4b. EPSDT Services (Continued)

EPSDT Case Management (Continued)

(3) includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and

(4) identifies a course of action to respond to the assessed needs of the eligible individual, including identifying the individual responsible for contacting the appropriate health and human service providers; and designating the time frame within which the eligible recipient should access services.

iii) Referral and related activities to help an eligible individual obtain needed services, including activities that help link an individual with:

(1) medical, social, and educational providers; and

(2) other programs and services that can provide needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.

iv) Monitoring, follow-up activities, and contacts that are necessary to ensure the care plan is implemented and adequately addresses the individual's needs.

(1) Such activities may be with the individual, family members, providers, or other entities or individuals and conducted as frequently as necessary, and include at least one annual follow-up contact for clients who are eligible for case management for longer than 12 consecutive months, to determine whether the following conditions are met:

(a) services are being furnished in accordance with the individual's care plan;

(b) services in the care plan are adequate; and

(c) the care plan and service arrangement are modified when the individual's needs or status change.

(2) Case management may include contacts with non-eligible individuals that are directly related to identifying the needs and supports for helping the eligible individual access services.

(3) Monitoring includes face-to-face follow-up visits and phone monitoring calls. The frequency of the follow up visits is based upon the complexity of client need. Additional follow-up visits can be requested based upon client need.
4b. EPSDT Services (Continued)

b) Qualifications of providers:

i) Registered nurse (with a bachelor's or advanced degree), registered nurse (without a bachelor's or advanced degree and with two years of experience), or social worker (with bachelor's or advanced degree), currently licensed by the respective Texas licensure board and whose license is not temporary, limited, or provisional in nature; and

ii) Completion of a standardized Department of State Health Services case management training.

5) Freedom of choice:

a) The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a) (23) of the Act.

i) Eligible recipients will have free choice of the providers of case management services within the specified geographic area identified in this plan.

b) Eligible recipients will have free choice of the providers of other medical care under the plan.

6) Access to Services:

a) The State assures that case management services will be provided in a manner consistent with the best interest of the recipient and will not be used to restrict an individual's access to other services under the plan.

b) The State assures that individuals will not be compelled to receive case management services, condition receipt of case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services.

c) The State assures that providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

State: Texas
Date Received: 17 October, 2014
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TN: 14–50 Approval Date: 12–11–14 Effective Date: 10–1–14
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4b. EPSDT Services (Continued)

EPSDT Case Management (Continued)

7) Limitations:
   a) Case Management does not include:
      i) Activities for which third parties are liable to pay;
      ii) Activities not consistent with the definition of case management services under section 6052 of the Deficit Reduction Act, codified at section 1915(g)(2) of the SSA;
      iii) The direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred.

8) Other Limitations:
   a) Case management services are prior authorized by the Department of State Health Services. The number of billable contacts that are prior authorized is based on the client's level of need, level of medical involvement, and complicating psychosocial factors.

9) Payment:
   a) Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

10) Case Records:
   a) For all individuals receiving case management, providers maintain case records that document the following:
      (i) The name of the individual;
      (ii) the dates of the case management services;
      (iii) the name of the provider agency (if relevant) and the person providing the case management service;
      (iv) the nature, content, units of the case management services received and whether goals specified in the care plan have been achieved;
      (v) whether the individual has declined services in the care plan;
      (vi) the need for, and occurrences of, coordination with other case managers;
      (vii) a timeline for obtaining needed services; and
      (viii) a timeline for reevaluation of the plan.
4.b. EPSDT Services (continued)

Diagnostic Services - Environmental Lead Investigation Services

Definition:

Environmental lead investigation services outlined in this section of the state plan are available to Medicaid-eligible recipients under the age of 21 years, who are eligible for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services and for whom the service is medically necessary.

Services:

An environmental lead investigation is an EPSDT medically necessary service when a child has an elevated blood lead level in accordance with federal guidelines and the investigation is recommended by a child’s provider. This service includes a one-time investigation to determine the source of lead at the child’s home or primary residence.

Providers:

In accordance with the regulations at 42 CFR §431.51, all willing and qualified providers may participate in this program. Qualified providers are public health entities. These entities will ensure that all staff and contractors performing environmental lead investigation services are qualified lead risk assessors as stipulated in 40 CFR §745.226.

Place of Service:

Environmental lead investigation services may be delivered at the child’s home or primary residence.
4b. EPSDT Services (continued)

Specialized Rehabilitative Services

Specialized Rehabilitative Services correct deficits in the child’s physical/motor, communication, adaptive, cognitive, social/emotional and sensory skills that are caused by medical, developmental, or other health-related conditions. Services are provided only as part of, or directed exclusively toward, the treatment of the Medicaid-eligible child as part of a specific, goal-oriented plan of care.

Services are:

- Recommended and developed by a multidisciplinary team that includes a physician or licensed practitioner of the healing arts acting within their scope of practice under state law;
- Documented in an Individualized Family Service Plan (IFSP), which serves as the plan of care;
- Monitored at least every six months for their effectiveness in reducing functional limitations and achieving proper growth and development, modified as necessary; and
- Provided by employees or contractors of a qualified Early Childhood Intervention (ECI) agency. Provider qualifications are listed below for each type of service.

A. Specialized Skills Training

Rehabilitation services promote age-appropriate development by providing skills training to correct deficits and teach compensatory skills for deficits that directly result from medical, developmental, or other health-related conditions. Services are provided in the child’s natural environment and include providing information related to the health and development of the child, skills training, and anticipatory guidance for family members, legal guardians, or other significant caregivers to ensure effective treatment of the recipient.

Services may be delivered on an individual or group basis.

Provider Qualifications

A provider of this service is an Early Intervention Specialist who must:

a) Hold an associate’s degree or higher in a relevant field as specified by the Department of Assistive and Rehabilitative Services (DARS);

b) Demonstrate standardized competencies established by DARS;

c) Complete continuing education and ethics training on a schedule identified by DARS; and
4b. EPSDT Services (continued)

Provider Qualifications (continued)

d) Receive routine supervision from a qualified EIS supervisor. A qualified EIS supervisor must have two years of experience providing early childhood intervention services and hold a bachelor's degree from an accredited university either with a specialization in child development, special education, psychology, social work, sociology, nursing, rehabilitation counseling, human development, or related field; or with a specialization in an unrelated field and have at least 18 hours credit in child development.

e) Supervision includes consultation, record review and observation.

B. Speech and Language Therapy

Speech and language therapy includes services designed to promote rehabilitation and remediation of delays or disabilities in language-related symbolic behaviors, communication, language, speech, emergent literacy, and/or feeding and swallowing behavior.

Speech therapy services must be delivered in accordance with 42 CFR 440.110 and §401.001(6) of the Texas Occupations Code.

Licensed speech-language pathologists may perform an evaluation without a physician's order.

A licensed speech-language pathologist may reevaluate the child every 30 days to determine if changes to the plan of care are necessary.

Services must be identified on the IFSP and may be performed without a physician's order.

Services may be delivered on an individual or group basis.

Speech therapy services are provided in the home or other community setting (the child's natural environment).
4b. EPSDT Services (continued)

Speech and Language Therapy (continued)

Provider Qualifications
Speech and language therapy services must be provided by a:
   a) licensed speech language pathologist (SLP) who meets the requirements of 42 CFR 440.110(c), and all other applicable state and federal law or
   b) licensed assistant in SLP when the assistant is acting under the direction of a licensed SLP in accordance with 42 CFR 440.110 or
   c) licensed intern when the intern is acting under the direction of a qualified SLP in accordance with 42 CFR 440.110 and all other applicable state and federal law.

C. Physical Therapy

Physical therapy includes services to address the promotion of sensorimotor function through enhancement of musculoskeletal status, neurobehavioral organization, perceptual and motor development, cardiopulmonary status, and effective environmental adaptation.
Services must be performed in accordance with 42 CFR 440.110.

A licensed physical therapist may perform an evaluation without a physician referral as allowed by 22 TAC 322.1(a)(2)(A).

A licensed physical therapist may reevaluate the child every 30 days to determine if changes to the plan of care are necessary.

Physical therapy services must be identified on the IFSP and prescribed by a physician.

Services may be delivered on an individual or group basis.

Physical therapy services are provided in the home or other community setting (the child's natural environment)

Provider Qualifications
Physical therapy services must be provided by
   a) a licensed physical therapist who meets the requirements of 42 CFR 440.110(a) or
4b. EPSDT Services (continued)

Provider Qualifications (continued)

b) a licensed physical therapy assistant (LPTA) when the assistant is acting under the direction of a licensed physical therapist in accordance with 42 CFR 440.110 and all other applicable state and federal law.

D. Occupational Therapy

Occupational therapy includes services to address the functional needs of a child related to adaptive development, adaptive behavior and play, and sensory, motor, and postural development. These services are designed to improve the child's functional ability to perform tasks in the home and community settings.

Services must be performed in accordance with 42 CFR 440.110

A licensed occupational therapist may perform an evaluation without a physician referral as allowed by §454.213 of the Texas Occupations Code.

A licensed occupational therapist may reevaluate the child every 30 days to determine if changes to the plan of care are necessary.

Occupational therapy services must be identified on the IFSP and prescribed by a physician.

Services may be delivered on an individual or group basis.

Occupational therapy services are provided in a home or other community setting (the child's natural environment).

Provider Qualifications

Occupational therapy services must be provided by
a) a licensed occupational therapist who meets the requirements of 42 CFR 440.110(b) or
b) a certified occupational therapy assistant (COTA) when the assistant is acting under direction of a licensed occupational therapist in accordance with 42 CFR 440.110 and all other applicable state and federal law.
4b. EPSDT Services (continued)

**Enrolled ECI Agency Qualifications**

To be considered a qualified ECI agency the entity must:

a) Contract with the Department of Assistive and Rehabilitative Services for the provision of ECI services;

b) Comply with all applicable federal and state laws and regulations, including provision of a multi-disciplinary team to recommend and oversee the IFSP for each child;

c) Provide supervision from a qualified supervisor according to DARS requirements, and;

d) Provide flexible scheduling to address family needs, including the provision of services outside of normal business hours.

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4b. EPSDT Services (continued)

Prosthetics

a) Definition

Prosthetics outlined in this section of the state plan include orthotic devices and prosthetic devices and are available to Medicaid-eligible recipients under the age of 21 years who are eligible for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services and for whom services are medically necessary.

Orthotic and prosthetic devices are defined as replacement, correction, or support devices prescribed by the physician or other licensed practitioner of the healing arts within the scope of professional practice as defined by Texas law to:

(1) artificially replace a missing portion of the body;
(2) prevent or correct physical deformity or malfunction; or
(3) support a weak or deformed portion of the body.

Hearing aids are considered prosthetic devices and defined as an electronic device that amplifies sound to compensate for impaired hearing.

b) Services

(1) Hearing Aids.

Medical necessity for hearing aids must be determined through an examination conducted by a physician or other licensed practitioner of the healing arts within the scope of his practice as defined by State law.

(2) Prosthetics/Orthotics.

Orthotic and prosthetic devices require prior authorization and must be medically necessary. The services are provided under 42 CFR §§440.120(c) and 440.225 and in accordance with applicable state and federal law and regulation. Orthotic and prosthetic devices are available to Medicaid EPSDT-eligible recipients under the age of 21 years when medically necessary and eligible for federal financial participation.

Other prosthetics, which are not limited to Medicaid EPSDT-eligible recipients, are described in item 12c of this section.
c) Providers

Hearing aids must be furnished by an audiologist or by approved hearing aid fitter and dispenser providers. Providers must meet all federal and state licensing laws and regulations applicable to provision of the service.

Orthotic and prosthetic devices are a benefit of the Texas Medicaid Program when provided by a

- Medicaid-enrolled orthotist, prosthetist, or a prosthetist/orthotist licensed by the state and in accordance with applicable state and federal laws and regulations;
- Physician or other licensed practitioner of the healing arts within the scope of professional practice as defined by Texas law; or
- Medicaid-enrolled provider of durable medical equipment and supplies.

These devices may also be provided by physicians or other licensed practitioners of the healing arts within the scope of professional practice as defined by Texas law.
4b. EPSDT Services (continued)

Prescribed Pediatric Extended Care Center Services

(a) Definition:

Prescribed Pediatric Extended Care Center (PPECC) services are an array of physician-prescribed services designed to meet the medical, social and developmental needs of a child who is medically or technologically dependent and requires ongoing nursing services and other therapeutic interventions. Services are provided under the supervision of a registered nurse licensed by the state of Texas. These services are performed in a Medicaid-enrolled PPECC, which is a community-based non-residential provider licensed by the state, and compliant with state licensing standards. A PPECC serves at least four Medicaid-eligible recipients who are not related by blood, marriage, or adoption.

(b) Eligibility:

This service is available to individuals under the age of 21 based on a determination of medical necessity.

The utilization of PPECC services does not supplant the recipient's choice of private duty nursing, when medically necessary.

(c) Services:

Services are provided in a Medicaid-enrolled PPECC, licensed by the Texas Department of Aging and Disability Services and compliant with state licensing standards. PPECC services require prior authorization.

PPECC services include the development, implementation, and monitoring of a comprehensive plan of care (POC), developed in conjunction with the Medicaid recipient's responsible adult, that specifies the recipient’s medical, nursing, psychosocial, therapeutic, dietary, functional, and developmental service needs, as well as the caregiver training needs of the recipient’s responsible adult(s).

A PPECC must provide the following basic services, prescribed by a physician, in accordance with a recipient's assessment and comprehensive plan of care:
4b. EPSDT Services (continued)

Prescribed Pediatric Extended Care Center Services (continued)

(c) Services: (continued)

(1) Nursing Services–Nursing services provided in accordance with 42 CFR § 440.130(d).

Nursing services must, under state law, be provided by a registered nurse (RN) or licensed vocational nurse (LVN). The provision of nursing services must comply with state licensure requirements related to nursing services and to PPECCs. Direct care staff may perform certain nursing services under the supervision of a RN, as permitted by state regulation related to nurse delegation.

(2) Functional developmental services–Provided in accordance with 42 CFR § 440.130(d). Functional developmental services assist a recipient in maintaining or restoring functional abilities, such as adaptive, motor, and speech. For example, a recipient may receive daily reinforcement through:

- Guided practice in using a utensil during lunch or snack time;
- Guided practice in swallowing;
- Guided use of speech to make a request; or
- Guided physical activities or play that help to restore a motor function.

(A) Functional developmental services are provided by an RN or LVN licensed under state authority or a direct care staff person under the supervision of an RN. Functional developmental services are based on the needs of the recipient, in accordance with the recipient’s plan of care and physician order.

(B) Functional services respond to needs identified in a functional assessment. The functional assessment is part of the comprehensive assessment performed by a RN and includes the following:

(i) measurable goals that maintain or restore independent functioning in daily activities and promote socialization;

(ii) a description of a recipient’s strengths and present performance level with respect to each goal, and;

(iii) planning for specific areas identified as needing restoration.
4b. EPSDT Services (continued)

Prescribed Pediatric Extended Care Center Services (continued)

(c) Services: (continued)

(3) Psychosocial services—Provided in accordance with 42 CFR § 440.130(d).

(A) Psychosocial services are behavioral and cognitive interventions to maintain or restore a recipient's psychosocial wellbeing that has been negatively impacted by medical or technological dependence or other psychosocial stressors. Psychosocial services respond to needs identified in a comprehensive assessment conducted by a RN. Examples of psychosocial services include:

(i) Guided practice to manage or reduce feelings of frustration, anxiety, depression, stress or fear, including:

(I) Using anger or stress management techniques, such as cueing a recipient to count to 10 before responding.

(II) Breathing exercises and other relaxation techniques.

(III) Assistance with breaking tasks into manageable components.

(ii) Redirection strategies to reduce verbal aggressiveness or hostility.

(iii) Providing supportive interventions and positive reinforcement to foster healthy social interactions and interpersonal behaviors.

(iv) Reinforcing age-appropriate assertiveness and decision-making.

(B) Psychosocial services are provided by a physician, RN, or psychologist licensed by the state, consistent with the recipient’s plan of care and physician order. These services may also be rendered by an LVN or direct care staff person under the supervision of the physician, RN, or psychologist.
4b. EPSDT Services (continued)

Prescribed Pediatric Extended Care Center Services (continued)

(c) Services: (continued)

(4) Nutritional Counseling—Provided in accordance with 42 CFR § 440.60.

PPECC services include nutritional counseling provided by a dietitian or RN licensed by the state, in accordance with state law governing scope of practice. These services may also be rendered by an LVN or direct care staff person under the supervision of the dietitian or RN. Nutritional counseling includes advising and assisting a recipient or the recipient’s responsible adult to ensure the recipient’s appropriate nutritional intake.

(5) Responsible adult training and education to facilitate skill development relevant to a recipient’s care are conducted by a physician (per 42 CFR §440.50), RN, or LVN (per 42 CFR §440.60). Direct care staff may perform these services under the supervision of a physician, RN, or LVN.

(6) Personal care services—Provided in accordance with 42 CFR § 440.167.

(A) Personal care services include support services provided to a recipient who meets the definition of medical necessity and requires assistance with activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health-related functions because of a physical, cognitive, or behavioral limitation related to the recipient's disability or chronic health condition.

(B) Personal Care Services will be provided by direct care staff under supervision of the RN in accordance with state PPECC licensure requirements.
4b. EPSDT Services (continued)

Prescribed Pediatric Extended Care Center Services (continued)

(c) Services: (continued)

(7) Transportation—Provided in accordance with 42 CFR § 440.170(a).

(A) Transportation services must be provided either by the PPECC or a contractor of the PPECC, when a recipient has a stated need or physician order. In accordance with state PPECC licensure requirements, the recipient must be accompanied by a PPECC nurse during transport to and from the PPECC.

(B) Transportation to and from the PPECC will be reimbursed on a per case basis (i.e., only when utilized) in accordance with 42 CFR § 440.170(a).

(C) Transportation services are subject to PPECC licensure requirements related to transportation, including the following:

(1) the driver must hold a valid and appropriate Texas driver's license, a copy of which the PPECC must keep on file;

(2) the vehicle used to transport a minor must have a current Texas safety inspection sticker and vehicle registration decal properly affixed to a vehicle;

(3) the PPECC must maintain commercial insurance for the operation of its vehicles, including coverage for minors and staff in the PPECC vehicle in the event of accident or injury; and

(4) the PPECC must maintain documentation of insurance.

(5) PPECC transportation is not provided by the transportation broker.

(6) Recipients have a choice of PPECC providers, who render the transportation services.
4b. EPSDT Services (continued)

Prescribed Pediatric Extended Care Center Services (continued)

(d) Providers and Provider Qualifications:

In accordance with state PPECC licensure standards, the following may render PPECC services:

(1) Medical Director

Medical Director Qualifications. A medical director must:

(A) Hold a valid, unrestricted license to practice medicine or osteopathy in Texas in accordance with state statute; and

(B) Be board-certified in a pediatric specialty recognized by the American Board of Medical Specialties or the American Osteopathic Association.

(C) Meet all requirements as specified in state PPECC licensure regulations.

(2) Administrator and Alternate Administrator

Administrator and Alternate Administrator Qualifications. An administrator and alternate administrator must:

(A) Have at least two years of experience in supervision and management in a pediatric health care setting; and

(B) Meet one of the following criteria:

   (i) be a physician licensed in Texas to practice medicine in accordance with state statute; or

   (ii) be an RN with a master's or baccalaureate degree in nursing and be licensed in accordance with state statute with no disciplinary actions;

(C) Must meet all requirements as specified in state PPECC licensure regulations.
4b. EPSDT Services (continued)

Prescribed Pediatric Extended Care Center Services (continued)

(d) Providers and Provider Qualifications: (continued)

(3) Nursing Director and Alternate Nursing Director

Nursing Director and Alternate Nursing Director Qualifications. A nursing director and alternate nursing director must:

(A) Have a baccalaureate degree in nursing;

(B) Have a valid RN license in accordance with state statute with no disciplinary action;

(C) Have a valid certification in Cardio Pulmonary Resuscitation or Basic Cardiac Life Support; and

(D) Have a minimum of two years of supervision and management in employment in a pediatric setting caring for a medically or technologically dependent minor or at least two years of supervision in one of the following specialty settings:

   (i) pediatric intensive care;
   (ii) neonatal intensive care;
   (iii) pediatric emergency care;
   (iv) center;
   (v) home health or hospice agency specializing in pediatric care;
   (vi) ambulatory surgical center specializing in pediatric care; or (G) have comparable pediatric unit experience in a hospital for two consecutive years before the person applies for the position of nursing director.

(E) Meet all requirements as specified in state PPECC licensing regulations.
4b. EPSDT Services (continued)

Prescribed Pediatric Extended Care Center Services (continued)

(d) Providers and Provider Qualifications: (continued)

(4) Registered Nurse

Registered Nurse Qualifications. An RN must:

(A) Hold a valid RN license in accordance with state statute with no disciplinary action;

(B) Hold valid certifications in Cardio Pulmonary Resuscitation and Basic First Aid; and

(C) Have at least one of the following:

(i) one year of pediatric specialty experience with emphasis on medically and technologically dependent minors, obtained within the previous five years; or

(ii) skills sufficient to meet the competency and training requirements described in subsection (b) of this section.

(D) Meet all requirements as specified in PPECC state licensing regulations.

(5) Licensed Vocational Nurse

Licensed Vocational Nurse Qualifications: An LVN must:

(A) Hold a valid LVN license with no disciplinary action;

(B) Hold valid certifications in Cardio Pulmonary Resuscitation and Basic First Aid; and

(C) Have at least one of the following:

(i) one year of pediatric specialty experience with emphasis on medically and technologically dependent minors obtained within the last consecutive five years; or

(ii) skills sufficient to meet the competency and training requirements described in subsection (b) of this section;

(D) Meet all requirements as specified in state PPECC licensure regulations.
4b. EPSDT Services (continued)

Prescribed Pediatric Extended Care Center Services (continued)

(d) Providers and Provider Qualifications: (continued)

(6) Psychologist

Psychologist Qualifications: Each Psychologist must have a valid Psychologist license in accordance with state statute with no disciplinary action.

(7) Direct Care Staff

Direct Care Staff Qualifications. Each direct care staff member must:

(A) Be 18 years of age or older;

(B) Hold a high school diploma or a general equivalency degree;

(C) Meet at least one of the following:

(i) one year of experience employed in a health care setting providing direct care to minors who are medically or technologically dependent;

(ii) two years of experience employed in a health care, childcare, or school setting providing direct care to minors who are medically or technologically dependent;

(iii) two years of experience employed in a health care setting providing direct care to adults; or

(iv) sufficient skills to meet the competency and training requirements described in subsection (b) of this section; and

(D) Maintain current certification in Pediatric Cardio Pulmonary Resuscitation and basic First Aid.

(E) Meet all requirements as specified in state PPECC licensure regulations.

(F) Direct care staff are supervised by a licensed RN.

(8) Dietician

Dietician Qualifications: A dietician must:

(A) Hold a valid license to use the title of licensed dietitian

(B) Meet all requirements as specified in state PPECC licensure regulations.
4b. EPSDT Services (continued)

Prescribed Pediatric Extended Care Center Services (continued)

(e) Limitations:

1. Services must not exceed 12 hours per day per recipient.

2. Services must be a one-to-one replacement of private duty nursing hours, unless additional hours are medically necessary. While PPECC services do not supplant a recipient's right to private duty nursing services, PPECC services may not be performed or billed during the same hours that a recipient receives private duty nursing services or personal care services from a non-PPECC provider in another setting, such as the home.

3. Medicaid will not reimburse a PPECC for services that are the responsibility of a local school district.

(f) Excluded Benefits:

1. Baby food or formula

2. Durable medical equipment (DME) and medical supplies provided to the recipient by Medicaid's DME and medical supply services

3. Services that are mainly respite care or child care, or that do not directly relate to the recipient's medical needs or disability

4. Services that are primarily the responsibility of a local school district

5. Individualized comprehensive case management beyond required service coordination

6. Services covered separately by Texas Medicaid, such as:

   A. Speech, occupational, physical, respiratory care practitioner services, and early childhood intervention services.

   B. Durable medical equipment (DME), medical supplies, nutritional products provided to the recipient by Medicaid's DME and medical supply service providers.

   C. Private duty nursing, skilled nursing, and home health aide services provided in the home setting. To prevent duplication, these services may be provided before or after PPECC services on a given day when medically necessary, but not at the same time as PPECC services.
4.c. Family Planning Services

1) The Medicaid Program includes those Family Planning Services specified by the single state agency when provided by physicians, advanced nurse practitioners, certified nurse-midwives and certain family planning clinics directed by physicians.

   a) The benefits have been designed to cover expenses by the physician and the advanced nurse practitioners for the usual examinations and laboratory tests needed before starting patients on oral contraceptives or other methods of birth control.

   b) The benefits also include permanent birth control by surgery, when performed within the scope of applicable laws and regulations.

   c) One complete physical examination is allowed per client, per fiscal year, per provider.

2) The State assures that termination of pregnancy (i.e., abortion) is not considered a family planning service and is only covered at the federal medical assistance percentage (FMAP) rate for rape, incest and when, due to a physical condition, the life of the mother would be endangered if the pregnancy went to term.
4d. 1) Face-to-Face Tobacco Cessation Counseling Services provided (by):

☐ (i) By or under supervision of a physician;

☐ (ii) By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services other than tobacco cessation services; * or

☐ (iii) Any other health care professional legally authorized to provide tobacco cessation services under State law and who is specifically designated by the Secretary in regulations. (None are designated at this time)

2) Face-to-Face Tobacco Cessation Counseling Services Benefit Package for Pregnant Women

Provided: ☐ No limitations ☑ With limitations*

*Any benefit package that consists of less than four (4) counseling sessions per quit attempt, with a minimum of two (2) quit attempts per 12 month period (eight (8) per year) should be explained below.

Please describe any limitations: In accordance with the Clinical Practice Guidelines published by the U.S. Public Health Service (PHS) and consistent with U.S. Preventive Services Task Force (USPSTF) grade A recommendation, pregnant women may receive four face-to-face counseling sessions per quit attempt with two quit attempts per year. Pregnant women may receive up to eight counseling sessions from the prenatal through the postpartum period.
5. **Physicians' and Dentists' Services.**

a. Physicians' Services. Services by or under the personal supervision of a physician licensed to practice medicine or osteopathy are covered by the Texas Medical Assistance Program as specified in 42 CFR §440.50.

   (1) **Telemedicine**

   Services provided via telemedicine are a benefit of the Texas Medicaid Program. Telemedicine is defined as the practice of health care delivery by a provider who is located at a site other than the site where the patient is located for the purposes of evaluation, diagnosis, consultation, or treatment that requires the use of advanced telecommunications technology. Chart reviews, electronic mail messages, and facsimile transmissions are not considered telemedicine.

   The distant site provider uses telemedicine to provide a service to the client at the patient site. Qualifying distant site providers are reimbursed in accordance with the standard Medicaid reimbursement methodology. Qualifying patient sites are reimbursed a facility fee.

   (2) **Optometrists' Services**

   Physician services include services of the type which an optometrist is also legally authorized to perform and such services are reimbursed whether furnished by a physician or an optometrist.

   Diagnostic and treatment services provided by an optometrist are covered by the Texas Medical Assistance Program if the services are (1) within the optometrist's scope of practice, as defined by state law and (2) reasonable and medically necessary as determined by the single state agency or its designee.

b. Dentists' Services. Subject to the specifications, conditions and limitations established by the single state agency, services by a Doctor of Dental Surgery or Doctor of Dental Medicine (Dentists' services) are covered by the Texas Medical Assistance Program if the services (1) are within the dentist scope of practice, as defined by law; and (2) would be covered by the Texas Medical Assistance Program when they are provided by a licensed physician (M.D. or D.O.).
5. Physicians' and Dentists' Services.

c. Services provided by Anesthesiologist Assistants

1. Subject to the specifications, conditions, requirements, and limitations established by the single state agency, medically directed anesthesia services provided by an anesthesiologist assistant (AA), as permitted by Texas Occupations Code § 157.001, are covered by the Texas Medical Assistance Program.

2. An AA is a health care professional who works under the direction of an anesthesiologist; is in compliance with all applicable requirements of state law; is a graduate of a medical school-based anesthesiologist's assistant educational program that is accredited by the Commission on Accreditation of Allied Health Education Programs or its predecessor, the Committee on Allied Health Education and Accreditation, and includes approximately two years of specialized basic science and clinical education in anesthesia at a level that builds on a premedical undergraduate science background; and is certified by the National Commission for Certification of Anesthesiologist Assistants. For services to be payable to these professionals, the professional must comply with all applicable federal and state laws governing the service provided; be enrolled in, and approved for participation in, the Texas Medical Assistance Program; sign a written agreement with the single state agency or its designee; comply with the terms of the provider agreement and all requirements of the Texas Medical Assistance Program, including federal and state regulations, rules, handbooks, standards, and guidelines published by the single state agency or its designee; and bill for services covered by the Texas Medical Assistance Program in the manner and format prescribed by the single state agency or its designee.

3. The Texas Medical Assistance Program will not reimburse the AA for equipment or supplies. Equipment and supplies are the responsibility of the facility in which the AA services are provided. If the equipment and supplies are covered and reimbursable by the Texas Medical Assistance Program, payment may be made to the facility if the facility is approved for participation in the Texas Medical Assistance Program. The basis and amount of reimbursement depends on the reimbursement methodology utilized by the Texas Medical Assistance Program for the services and providers involved.
6.a. Podiatrists' Services

Services include those provided by a licensed podiatrist, that are within the scope of practice of the profession as defined by state law and are covered by Medicare.
6.b. Optometric Services

Eligible medical assistance recipients covered under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program receive optometric and eyeglasses services through the EPSDT program as described elsewhere in this State Plan.

Optometric services provided in skilled or intermediate care facilities are reimbursable by the program if the recipient’s attending physician has ordered the service(s) and the order is included in the recipient’s medical records at the nursing facility.

Coverage of chiropractic services is limited to services that consist of medically necessary treatment or correction by means of manual manipulation of the spine, by use of hands only, to correct a subluxation demonstrated by x-ray to exist to the same extent that such benefits are provided under Medicare Part B. The x-ray must be done prior to such treatment. The chiropractor must be licensed to practice when and where the services are performed and must meet the uniform minimum standards promulgated by the Secretary of the Department of Health and Human Services under Title XVIII of the Social Security Act.

Coverage for such treatment is limited to no more than 12 visits per recipient in each 12 consecutive month period. A 12 consecutive month period begins with the first month in which services are provided.

Documenting x-rays will be kept on file and are subject to utilization review and audit procedures. Coverage of chiropractic services will be determined by the single state agency or its designated agent in accordance with the regulations, rules and procedures governing chiropractic services under Part B of Title XVIII of the Social Security Act. Coverage does not extend to the diagnostic, therapeutic services or adjunctive therapies furnished by a chiropractor or by others under his or her orders or direction. This exclusion applies to the x-ray taken for the purpose of determining the existence of a subluxation of the spine. Additionally, braces or supports, even though ordered by a physician (M.D. or D.O.) and supplied by a chiropractor, are not reimbursable items.
6.d. **Other Practitioners' Services**
6.d.(3) Certified Registered Nurse Anesthetists' Services. Subject to the specifications, conditions, requirements, and limitations established by the single state agency, anesthesia services provided by a certified registered nurse anesthetist (CRNA) are covered by the Texas Medical Assistance Program. A CRNA is defined as a registered nurse who is approved as an advanced nurse practitioner by the state in which he or she practices and who is currently certified by either the Council on Certification of Nurse Anesthetists or the Council on Recertification of Nurse Anesthetists.

Covered services must be provided by a CRNA enrolled and approved for participation in the Texas Medical Assistance Program. The CRNA must sign a written provider agreement with the single state agency. By signing the agreement, the CRNA agrees to comply with the terms of the agreement and all requirements of the Texas Medical Assistance Program, including regulations, rules, handbooks, standards, and guidelines published by the single state agency or its designee. The CRNA must bill for services covered by the Texas Medical Assistance Program in the manner and format prescribed by the single state agency or its designee.

The Texas Medical Assistance Program will not reimburse the CRNA for equipment or supplies. Equipment and supplies are the responsibility of the facility in which the CRNA services are provided. If the equipment and supplies are covered and reimbursable by the Texas Medical Assistance Program, payment may be made to the facility if the facility is approved for participation in the Texas Medical Assistance Program. The basis and amount of reimbursement depends on the reimbursement methodology utilized by the Texas Medical Assistance Program for the services and providers involved.
6.d.(4) Other Categories of Advanced Nurse Practitioner Services

Advanced nurse practitioner--A registered professional nurse, currently licensed in the State of Texas, who is prepared for advanced nursing practice by virtue of knowledge and skills obtained through a post-basic or advanced educational program of study acceptable to the Board of Nurse Examiners for the State of Texas. The advanced nurse practitioner is prepared to practice in an expanded role to provide health care to individuals, families, and/or groups in a variety of settings. The advanced nurse practitioner functions in a collegial relationship with other health care professionals making independent decisions about nursing needs and interdependent decisions with health care professionals regarding health regimens.

In addition to coverage of services performed by certified nurse midwives, certified registered nurse anesthetists, certified pediatric nurse practitioners, and certified family nurse practitioners described elsewhere in this state plan and subject to the specification, conditions, requirements, and limitations established by the Single State Agency or its designee, services performed by advanced nurse practitioners are covered if the services: 1) are within the scope of practice for advanced nurse practitioners, as defined by state law; 2) are consistent with rules and regulations promulgated by the Board of Nurse Examiners for the State of Texas or other appropriate state licensing authority; and 3) would be covered by the Texas Medical Assistance Program if provided by a licensed physician (M.D. or D.O.).

To be payable, services must be reasonable and medically necessary as determined by the Single State Agency or its designee.

The advanced nurse practitioner must comply with all applicable federal and state laws and regulations governing the services provided; be enrolled and approved for participation in the Texas Medical Assistance Program; sign a written provider agreement with the Single State Agency or its designee; comply with the terms of the provider agreement and all requirements of the Texas Medical Assistance Program, including regulations, rules, handbooks, standards, and guidelines published by the Single State Agency or its designee; and bill for services covered by the Texas Medical Assistance Program in the manner and format prescribed by the Single State Agency or its designee.

Advanced nurse practitioners who are employed or remunerated by a physician, hospital, facility, or other provider must not bill the Texas Medical Assistance Program directly for their services if that billing would result in duplicate payment for the same services. If the services are coverable and reimbursable by the program, payment may be made to the physician, hospital, or other provider (if the provider is approved for participation in the Texas Medical Assistance Program) who employs or reimburses advanced nurse practitioners. The basis and amount of Medicaid reimbursement depend on the services actually provided, who provided the services, and the reimbursement methodology determined by the Texas Medical Assistance Program as appropriate for the services and the providers involved.

Mental health counseling services for emotional disorders or conditions provided to Medicaid eligible clients by a licensed clinical social worker (LCSW) are covered services. Services provided by an LCSW are available to Medicaid eligible recipients. To be payable, the services must be reasonable and medically necessary as determined by the single state agency or its designee.

To be considered for reimbursement by the Texas Medical Assistance Program, LCSWs must be licensed as a master social worker and be recognized as being qualified for the practice of clinical social work by the Texas State Board of Social Worker Examiners. These providers must comply with all federal and state laws and regulations governing the services provided.

Participating LCSWs must be enrolled in the Texas Medical Assistance Program and comply with all of the terms of the provider agreement and all of the regulatory provisions published by the single state agency or its designee.

LCSWs who are employed or remunerated by another provider may not bill the Texas Medical Assistance Program directly for counseling services if that billing would result in the duplicate payment for the same services.

6.d.(6) Licensed Professional Counselor (LPC).

Mental health counseling services for emotional disorders or conditions provided to Medicaid eligible recipients by a licensed professional counselor (LPC) are covered services. Services provided by an LPC are available to Medicaid eligible recipients. To be payable, the services must be reasonable and medically necessary as determined by the single state agency or its designee.

To be considered for reimbursement by the Texas Medical Assistance Program, LPCs must be licensed by the Texas Board of Examiners of Professional Counselors in accordance with the Texas Licensed Professional Counselor Act. These providers must comply with all federal and state laws and regulations governing the service provided. Participating LPCs must be enrolled in the Texas Medical Assistance Program and comply with all the terms of the provider agreement and all of the regulatory provisions published by the single state agency or its designee.

LPCs who are employed or remunerated by another provider may not bill the Texas Medical Assistance Program directly for counseling services if that billing would result in the duplicate payment for the same services.
6.d. (7) Licensed Marriage and Family Therapist (LMFT). Mental health counseling services for emotional disorders or conditions provided to Medicaid eligible clients by a licensed marriage and family therapist (LMFT) are covered services. Services provided by an LMFT are available to Medicaid eligible recipients. To be payable, the services must be reasonable and medically necessary as determined by the single state agency or its designee.

To be considered for reimbursement by the Texas Medical Assistance Program, LMFTs must be licensed by the Texas Board of Examiners of Marriage and Family Therapists in accordance with the Texas Licensed Marriage and Family Therapist Act. These providers must comply with all federal and state laws and regulations governing the service provided.

Participating LMFTs must be enrolled in the Texas Medical Assistance Program and comply with all the terms of the provider agreement and all of the regulatory provisions published by the single state agency or its designee.

LMFTs who are employed or remunerated by another provider may not bill the Texas Medical Assistance Program directly for counseling services if that billing would result in duplicate payment for the same services.
6d(8) Psychologists' Services

Services provided by a licensed psychologist are available to Medicaid-eligible recipients. Psychological counseling and services provided by a licensed psychologist are covered if the services (1) are within the psychologist's scope of practice, as defined by state law; and (2) would be covered by the Texas Medical Assistance Program when they are provided by a licensed physician (M.D. or D.O.).

Psychologists' services must be provided by a licensed psychologist enrolled in and approved for participation in the Texas Medical Assistance Program. A psychologist is defined as a person who is licensed to practice as a psychologist in the state in which the service is performed.

Services performed by a provisionally licensed psychologist (PLP) or a licensed psychological associate (LPA) are a benefit of the Texas Medical Assistance Program only when the services are provided within the PLP's or LPA's scope of practice and under the direct supervision of a licensed psychologist.

A licensed psychologist who is employed by or remunerated by a physician, hospital, facility, or other provider may not bill the Texas Medical Assistance Program directly for psychologist's services if that billing would result in duplicate payment for the same services. If the services are covered and reimbursable by the program, payment may be made to the physician, hospital, or other provider (if approved for participation and who is enrolled in the Texas Medical Assistance Program) who employs or reimburses the licensed psychologist. The basis and amount of Medicaid reimbursement depends on the service actually provided, who provided the service, and the reimbursement methodology used by the Texas Medical Assistance Program as appropriate for the service and provider(s) involved.
6.d.(9). **Services provided by Physician Assistants.**

(a) Services performed by physician assistants are covered if the services are within the scope of practice for physician assistants, as defined by state law; are consistent with rules and regulations promulgated by the Texas Physician Assistant Board or other appropriate state licensing authority; and are covered services under the Texas Medical Assistance Program.

(b) Physician Assistants are health care professionals who are licensed by the state to practice as physician assistants, who have met and maintained the eligibility requirements set forth in the law (such as successful completion of an educational program accredited by the Accreditation Review Commission on Education for the Physician Assistant for the training of physician assistants and certification as such by the National Commission on Certification of Physician Assistants). For services to be payable to these professionals, the professional must be licensed as a Physician Assistant; comply with all applicable federal and state laws governing the service provided; be enrolled in, and approved for participation in, the Texas Medical Assistance Program; must sign a written agreement with the single state agency or its designee; must comply with the terms of the provider agreement and all requirements of the Texas Medical Assistance Program, including federal and state regulations, rules, handbooks, standards, and guidelines published by the single state agency or its designee; and bill for services covered by the Texas Medical Assistance Program in the manner and format prescribed by the single state agency or its designee.

(c) Physician Assistants who are employed or remunerated by a physician may bill the Texas Medical Assistance Program and be paid directly for their services. (Both the physician assistant and the employing/contracting entity may not bill services if that billing would result in duplicate payment for the same services.) If the services are reimbursable by the program, payment may be made to the entity (if approved for participation in the Texas Medical Assistance Program) that employs or reimburses the Physician Assistant. The basis and amount of Medicaid reimbursement depends on the services actually provided, who provided the service, and the reimbursement methodology utilized by the Texas Medical Assistance Program as appropriate for the services and provider(s) involved.
Other Practitioners’ Services (continued)

6.d (10). Licensed Midwife

Birthing services provided in a Medicaid certified freestanding birthing center by a licensed direct-entry midwife are covered services. Services provided by a licensed direct-entry midwife are available to Medicaid beneficiaries. Services provided by a licensed direct-entry midwife must be reasonable and medically necessary as determined by the single state agency or its designee.

To be considered for Medicaid reimbursement, licensed direct-entry midwives must be licensed by the Texas Midwifery Board at the Department of State Health Services in accordance with the Texas Midwifery Act. These providers must comply with all federal and state laws and regulations governing the service provided. Participating licensed direct-entry midwives must be enrolled in the Texas Medical Assistance Program and comply with all the terms of the provider agreement and all the regulatory provisions published by the single state agency or its designee.
6.d (11). **Pharmacist.**

a. Administration Services

1. Certain injectable drugs and vaccines administered by a participating pharmacy are covered services. Administration services do not require prior authorization.

2. HHSC lists the injectable drugs and vaccines that may be provided by a participating pharmacy on its Internet website.

3. Participating pharmacies are licensed pharmacies enrolled as Title XIX providers with the Vendor Drug Program.

4. Administering pharmacists are health care professionals who are licensed by the Texas State Board of Pharmacy to practice as a pharmacist, who have met and maintained the eligibility requirements set forth in law, and who have been certified by the State Board of Pharmacy to administer injectable drugs and vaccines. Administering pharmacists are under the supervision of a physician in accordance with Texas law. Pharmacists are employed and remunerated by a pharmacy for their services. If the services are covered and reimbursable by the program, payment may be made to the pharmacy who employs the licensed pharmacist.

b. Vaccine Services

1. Certain vaccines may be provided by a participating pharmacy. Coverage of vaccines do not require a prescription for Medicaid-eligible clients age seven and older. Vaccines do not require prior authorization.

2. HHSC lists the vaccines that may be provided by a participating pharmacy on its Internet website.

3. Participating pharmacies are licensed pharmacies enrolled as Title XIX providers with the Vendor Drug Program.
4. Administering Pharmacists are health care professionals who are licensed by the Texas State Board of Pharmacy to practice as a pharmacist, who have met and maintained the eligibility requirements set forth in law, and who have been certified by the State Board of Pharmacy to administer vaccines. Administering pharmacists are under the supervision of a physician in accordance with Texas law. Pharmacists may administer immunizations or vaccinations only under a physician’s written protocol authorizing the administration. Pharmacists are employed and remunerated by a pharmacy for their services. If the services are covered and reimbursable by the program, payment may be made to the pharmacy who employs the licensed pharmacist.
6.d. Other Practitioners’ Services

(12) Licensed Behavior Analysts

a. To the extent required by EPSDT, a licensed behavior analyst (LBA) operating within the LBA’s state scope of practice and licensure requirements may provide applied behavior analysis (ABA) evaluation and treatment services to children under 21 who have a diagnosis of autism spectrum disorder (ASD) when the services are delivered in accordance with state licensure requirements.

LBAs must provide direct supervision to licensed assistant behavior analysts (LaBAs) and behavior technicians (BTs), if LaBAs or BTs are utilized to deliver covered ABA services. LBAs shall assume professional responsibility for and ensure the quality of ABA services rendered by the LaBAs and BTs under the LBA’s direct supervision. The supervision of an LaBA and BT is within state scope of practice for the LBA. The supervision of a BT by an LaBA who is supervised by an LBA is within state scope of practice for the LBA and LaBA.

b. Provider Qualifications

1. LBAs must:
   a. Be licensed by the Texas Department of Licensing and Regulation (TDLR);
   b. Have a current certification of Board-Certified Behavior Analyst-Doctoral (BCBA-D) or Board-Certified Behavior Analyst (BCBA) by the Behavior Analyst Certification Board (BACB) or other certification as required by TDLR;
   c. Have no active, disqualifying sanctions or disciplinary actions; and
   d. Have a completed criminal background check according to the State's requirements.

2. LaBAs must:
   a. Be licensed by the TDLR;
   b. Have a current certification of Board-Certified assistant Behavior Analyst (BCaBA) by the BACB or other certification as required by TDLR;
   c. Have no active, disqualifying sanctions or disciplinary actions;
   d. Have a completed criminal background check according to the State's requirements;
   e. Work under the direct supervision of an LBA; and
   f. Have the supervisory relationship documented in writing.
3. BTs must:
   a. Be 18 years old or older;
   b. Be currently registered by the BACB or another national body that is accredited by the American National Standards Institute (ANSI) or National Commission for Certifying Agencies (NCCA) and that certifies BTs specializing in ABA or autism spectrum disorder;
   c. Have a high school diploma or national equivalent;
   d. Have a completed criminal background check that meets the certifying body’s requirements;
   e. Work under the direct supervision of an LBA or an LaBA, who is supervised by an LBA; and
   f. Have the supervisory relationship documented in writing.
7. **Home Health Care Services**

In accordance with the provisions or specifications established by the single state agency, home health care services are as follows:

A. Authorized services, supplies, equipment, or appliances must be suitable for treatment and/or related to the medical condition of the recipient. The services provided through home health are intended for the recipient and must be related to the medical condition, rather than primarily for the convenience of the recipient, caregiver/guardian, or the provider. The service, supply, equipment, or appliance must be provided to an eligible recipient in his or her place of residence. The recipient's place of residence does not include a hospital, nursing facility, or intermediate care facility for the mentally retarded. The only exception for services provided in an intermediate care facility for the mentally retarded occurs when the facility is not required to provide services as defined in Subpart I of 42 CFR Part 483. All home health services are provided in accordance with 42 CFR 440.70.

B. The recipient for whom home health care services are authorized must be under the continuing care and supervision of a licensed physician or allowed practitioner. An allowed practitioner is a licensed physician assistant (PA) or an advanced practice registered nurse, who is licensed as a certified nurse practitioner (CNP) or clinical nurse specialist (CNS). Allowed practitioners, (PAs, CNPs, and CNSs) must maintain a valid and registered prescriptive authority agreement in accordance with state law. Medical necessity criteria include supporting documentation of the medical need and the appropriateness of the equipment, service, or supply prescribed by the physician or allowed practitioner for the treatment of the individual recipient.

C. Services, supplies, equipment, or appliances must be prescribed by a physician or allowed practitioner as medically necessary and appropriate and documented as part of the physician's or allowed practitioner's plan of treatment for the recipient in the written, dated, and signed plan of care and/or order form.

D. All home health benefits require prior authorization for payment, unless otherwise specified by the Title XIX single state agency and must be furnished by a home health agency or a durable medical equipment/supplier enrolled to provide Title XIX home health services. Insulin syringes and needles are obtained with a physician's or allowed practitioner's prescription from a participating pharmacy and do not require prior authorization.

E. To become enrolled as a Title XIX home health agency or home health durable medical equipment supplier, the home health agency or durable medical equipment supplier must be approved as a Title XVIII (Medicare) home health services provider or durable medical equipment/supplier and must be enrolled with the Title XIX single state agency.
7 Home Health Care Services (continued)

F. Services are limited to:

(i) Part-time or intermittent professional nursing services provided by a registered nurse or licensed vocational nurse with appropriate supervision furnished through a Title XIX home health agency or by a registered nurse when no home health agency exists in the area.

(ii) Services of a home health aide who has been assigned by a professional registered nurse and who is under the supervision of a professional registered nurse.

(iii) Visits by either a nurse or a home health aide as defined under this program.

(iv) Certain medical supplies, equipment, and appliances suitable for use in the recipient's place of residence.

(v) Physical therapy services, provided by a physical therapist meeting the criteria defined in §440.110, are available only for treatment of acute musculoskeletal or neuromuscular conditions or acute exacerbations of a chronic musculoskeletal or neuromuscular condition.

(vi) Occupational therapy services, provided by an occupational therapist meeting the criteria defined in §440.110, are available for the evaluation and function-oriented treatment of individuals whose ability to function in life roles is impaired by recent or current physical illness, injury, or condition. There must be specific goals to achieve a functional level within a reasonable amount of time based on the therapist's evaluation and the physician's or allowed practitioner's assessment and plan of care.

G. Medicare must be utilized as a primary resource for payment of home health benefits for those persons who are enrolled in Medicare.
7. Home Health Care Services
(cont.)

**In-Home Services for Total Parenteral Nutrition (TPN)**

a) **Definition:** In-home Total Parenteral Nutrition (TPN)/Hyperalimentation activities outlined in this section of the State plan are available to Medicaid eligible recipients for the treatment of conditions which require long-term nutritional support. TPN/Hyperalimentation is not available when oral/enteral intake will maintain adequate nutrition.

b) **Services:** Home health services, including in-home Total Parenteral Nutrition (TPN)/hyperalimentation activities, are provided to a recipient on his or her physician's or allowed practitioner’s orders as part of a written plan of care that the physician or allowed practitioner reviews every 60 days.

Medically necessary TPN/hyperalimentation services include:

i) **Medical Supplies** in accordance with 42 C.F.R. § 440.70(b)(3) including:

   (A) TPN/Hyperalimentation solutions and additives as ordered by the client's physician or allowed practitioner.
   (B) Supplies and equipment that are required for the administration of prescribed solutions and additives.
   (C) Enteral supplies, nutritional products, and equipment, if medically necessary, in conjunction with TPN/hyperalimentation.

ii) **Nursing Services** in accordance with 42 C.F.R. § 440.70(b)(1):

   (A) Visits by a registered nurse appropriately trained in the administration of TPN/Hyperalimentation.
   (B) Education of the client and/or caregivers regarding the administration of in-home TPN/Hyperalimentation before the service begins. Education also must include the use and maintenance of required supplies and equipment.

c) **Providers:** In-home TPN/hyperalimentation equipment and supplies must be provided by an enrolled Medicaid durable medical equipment supplier or a medical supply provider who meets the requirements of, and provides the services in accordance with, 42 C.F.R. § 440.70 and other applicable state and federal laws and regulations. Nursing services are delivered by Home Health Agencies meeting requirements for participation in Medicare and requirements at 42 CFR §440.70(d).

d) **Place of Service:** In home TPN/hyperalimentation services must be delivered in the recipient's place of residence as defined in 42 C.F.R. § 440.70.

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TN: 21-0043  Supersedes TN: 07-18  Approval Date: 03-15-22  Effective Date: 10-01-21
7. **Home Health Care Services (continued)**

**Home Health Supplies Provided by a Pharmacy**

(a) Certain home health supplies that may be provided by a participating pharmacy are specified by the Title XIX single state agency and require a physician's or allowed practitioner's prescription. These supplies do not require prior authorization unless otherwise specified.

(b) HHSC lists home health supplies that may be provided by a participating pharmacy on its website. This list includes the insulin syringes and needles referenced on Page 14 of this Appendix.

(c) Participating pharmacies are licensed pharmacies enrolled as Title XIX providers with the Vendor Drug Program.

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7. **Home Health Care Services (continued)**

**Home Telemonitoring Services**

(a) Home telemonitoring services are a benefit of the Texas Medicaid Program as provided in this section, are based on medical necessity, and are subject to the specifications, conditions, limitations, and requirements established by the Texas Health and Human Services Commission (HHSC) or its designee.

(b) Home telemonitoring services require scheduled remote monitoring of data related to a patient's health and transmission of the data to a licensed home health agency or a hospital.

(c) Home telemonitoring service providers must:

1. comply with all applicable federal, state, and local laws and regulations;
2. be enrolled and approved for participation in the Texas Medicaid Program as home telemonitoring service providers;
3. bill for services covered under the Texas Medicaid Program in the manner and format prescribed by HHSC;
4. share clinical information gathered while providing home telemonitoring services with the patient's physician or allowed practitioner; and
5. not duplicate disease management program services provided by the Texas Medicaid Wellness Program.

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1) Private Duty Nursing Services are available to Medicaid recipients under the age of 21 years through EPSDT (Early and Periodic, Screening, Diagnosis and Treatment). Refer to Appendix I to Attachment 3.1-A, Item 4.b.

2) Reserved
9. Clinic Services.

Maternity Clinic Services.

Subject to the specifications, conditions, limitations and requirements established by the single state agency, payment will be made for maternity clinic services as defined at 42 CFR 440.90 and elsewhere when provided to eligible recipients by approved providers.

A. Covered maternity clinic services include but are not necessarily limited to risk assessment, medical services, laboratory/screening services, case coordination/outreach, nutritional counseling, psychosocial counseling, family planning counseling and patient education regarding maternal and child health.

B. As a condition for receiving payment for maternity clinic services, the services must be determined by a licensed physician (MD or DO) to be reasonable and medically necessary for the care of an eligible pregnant woman (patient) during the patient's prenatal period and subsequent 60 day post partum period.

C. The physician prescribing the services must be directly affiliated with the clinic either by employment or by a contractual agreement/formal arrangement with the clinic to assume professional responsibility for services provided to the clinic patients.

D. The physician must see each patient and prescribe each patient's plan of care.

E. The plan of care must be based on a risk assessment. The risk assessment must be based on findings obtained from a health history, laboratory/screening services and a physical examination. Criteria for assessing the patient's risk is established by the single state agency.

F. The level of services provided to the patient must be commensurate with the risk assessment and be available to patients experiencing a normal or high risk pregnancy.

G. Covered services must be provided to outpatients by the physician or by licensed, professional clinic staff under the direction of the physician. The physician and professional clinic staff must be licensed by the state in which the services are provided. Services provided by the professional clinic staff must be within the staffs' scope of practice as defined by state law.

H. Although the physician does not have to be present in the clinic during all hours covered services are provided, the physician must assume professional responsibility for the services provided in the clinic and must ensure these services are medically appropriate and
in conformance with the plan of care. The physician must spend as much
time in the clinic as is necessary to assure that patients are
receiving services in a safe and efficient manner in accordance with
accepted standards of medical practice.

I. Clinics must have arrangements for referral of non-stress test (NST),
sonography, and amniocentesis for high-risk patients.

J. A provider of maternity clinic services must:
1. Be a facility that is not an administrative, organizational or
financial part of a hospital.
2. Be organized and operated to provide maternity clinic services to
outpatients.
3. Comply with all applicable federal, state and local laws and
regulations.
4. Employ or have a contractual agreement/formal arrangement with a
licensed physician(s) (MD or DO) who assumes professional
responsibility for the services provided to the clinic's
patients.
5. Adhere to the Bureau of Maternal and Child Health Maternity
Guidelines, dated June 20, 1988, and subsequent revisions issued
by the Texas Department of Health, unless otherwise specified by
the single state agency.
6. Ensure that services provided to each patient are commensurate
with the patient's medical needs based on the patient's risk
assessment, plan of care and physician direction and are
documented in the patient's medical records.
7. Be enrolled and approved for participation in the Texas Medical
Assistance Program.
8. Sign a written provider agreement with the single state agency or
its designee. By signing the agreement, the maternity clinic
agrees to comply with the terms of the agreement and all
requirements of the Texas Medical Assistance Program including
regulations, rules, handbooks, standards, and guidelines published
by the single state agency or its designee, and
9. Bill for services covered by the Texas Medical Assistance Program
in the manner and format prescribed by the single state agency or
its designee.
K. As a condition for receiving payment for services other than maternity clinic services which are covered under the Texas Medical Assistance Program, a maternity clinic, as the provider, must meet the same conditions of participation as any other provider of the same services(s) and is subject to the qualifications, limitations and exclusions in the amount, duration and scope of benefits and all other provisions specified in this state plan and elsewhere.
9. Clinic Services (Continued).

Tuberculosis (TB) Clinic Services

Subject to the specifications, conditions, limitations, and requirements established by the single state agency or its designee, payment will be made for TB clinic services to eligible recipients by approved providers.

A. TB Clinic Services include:

1. Directly Observed Therapy (DOT) – Includes the delivery of prescribed anti-tuberculosis medication, direct observation of the patient swallowing the medication, monitoring for side effects, and documentation of the provision of DOT.

2. Nursing Assessment – Includes conducting a brief mental and physical assessment, referral for social or other medical services, and other assessments per protocol.

B. Provider Qualifications:

1. Must be a facility that is not an administrative, organizational, or financial part of a hospital;

2. Must be organized and operated to provide TB-related services;

3. Must be a local health department or certified by the Texas Department of State Health Services as a provider of TB clinic services; and

4. Must employ or have a formal arrangement with a licensed physician(s) (M.D. or D.O.) who assumes professional responsibility for the services provided to the clinic’s patients.
9. Clinic Services (continued)

Renal Dialysis Facility Services

Subject to the specifications, conditions and limitations established by the single state agency, renal dialysis facility services are covered as follows:

a) Renal dialysis facility services must be provided in a "renal dialysis facility" as defined by 42 CFR §405.2102 and other applicable federal and state laws, rules, and regulations.

b) Covered renal dialysis facility services include outpatient dialysis and home dialysis services defined by 42 CFR §405.2102 and other applicable federal and state laws, rules, and regulations.

c) Renal dialysis facilities must be certified by and participating in Medicare (Title XVIII of the Social Security Act) and be approved by the single state agency or its designated agent and have a written provider agreement with the single state agency.

d) Renal dialysis facility services are furnished on an outpatient basis.
9. Clinic Services (Continued)

Ambulatory Surgical Center Services.

Subject to the specifications, conditions and limitations established by the single state agency, ambulatory surgical center services are covered as follows:

a) Ambulatory surgical procedures provided in ambulatory surgical center facilities are limited to those approved by CMS for Medicare, unless otherwise specified by the single state agency.

b) Ambulatory surgical center services must be provided in an "Ambulatory Surgical Center" or "ASC" as defined by 42 CFR 416 and other applicable federal and state laws, rules, and regulations.

c) Ambulatory surgical centers must meet applicable state laws, rules, regulations, and licensure requirements.

d) Ambulatory surgical center facilities or entities must be approved for and participating in Medicare (Title XVIII of the Social Security Act) and be approved by the single state agency or its designated agent and have a written provider agreement with the single state agency.

e) Ambulatory surgical center facility services are limited to those services furnished in connection with or directly related to a covered surgical procedure approved by CMS for Medicare unless otherwise specified by the single state agency.
State of Texas

10. Dental Services.
   Not provided.

Subject to the specifications, conditions, requirements, and limitations established by the Single State Agency, physical therapy services, which include necessary equipment and supplies, provided by a licensed physical therapist are covered by the Texas Medical Assistance Program. A licensed physical therapist is an individual who is a graduate of a program of physical therapy approved by the Commission on Accreditation in Physical Therapy Education, and who is licensed by the Texas State Board of Physical Therapy Examiners or other appropriate state licensing authority.

To be payable, services must be within the physical therapist's scope of practice, as defined by state law; and be reasonable and medically necessary, as determined by the Single State Agency or its designee. Therapy must be prescribed by a licensed physician (M.D. or D.O.) and performed under a plan of care developed by the physician and/or physical therapist. Covered services also include the services of a physical therapist assistant when the services are provided under the direction of and billed by the licensed physical therapist. Therapy to maintain function once maximum benefit has been reached, or to promote general fitness or well-being is not a benefit of the program.

Licensed physical therapists who are employed by or remunerated by a physician, hospital, facility, or other provider may not bill the Texas Medical Assistance Program directly for physical therapy services if that billing would result in duplicate payment for the same services. If the services are covered and reimbursable by the Texas Medical Assistance Program, payment may be made to the physician, hospital, or other provider (if approved for participation in the Texas Medical Assistance Program) who employs or reimburses the licensed physical therapist. The basis and amount of Medicaid reimbursement depends on the services actually provided, who provided the services, and the reimbursement methodology utilized by the Texas Medical Assistance Program as appropriate for the services and provider(s) involved.
11.b. Occupational Therapy.

Not provided.
11.c. Services for individuals with speech, hearing or language disorders (provided by or under the supervision of a speech pathologist or audiologist).

a) Services

Services are limited to a hearing evaluation.

b) Providers

A hearing evaluation must be provided by a qualified audiologist who meets the requirements of CFR § 440.110(c)(3) and in accordance with applicable state and federal law or regulation.

Providers must meet all federal and state licensing laws and regulations applicable to provision of the service.
12a. Prescribed Drugs

Prescribed drugs are limited as follows:

(a) **Number of Prescriptions:** Each eligible recipient is entitled to a basic number of prescriptions each month.

(b) **Number of Refills:** As many as 11 refills may be authorized by the prescriber, but the total number authorized must be dispensed within 12 months of the date of the original prescription subject to state and federal laws for controlled substance drugs.

(c) **Coverage of Drugs in the Texas Drug Code Index (TCDI):** The state will reimburse only for the drugs of pharmaceutical manufacturers who have entered into and have in effect a rebate agreement in compliance with Section 1927 of the Social Security Act, unless the exceptions in Section 1902(a)(54), 1927(a)(3) or 1927(d) apply. The state permits coverage of participating manufacturers’ drugs, even though it may be using other restrictions. The prior authorization program provides for a 24-hour turnaround from receipt of the request for prior authorization. The prior authorization program also provides for a 72-hour supply of drugs in emergency situations.

(d) **Prior Authorization Procedures:** A health care practitioner who prescribes a drug that is not included on the Preferred Drug List (PDL) for a Medicaid recipient must request prior authorization of the drug to the state agency or its designee. Specific procedures for the submission of requests for prior authorization will be available both on the Health and Human Services Commission’s (HHSC) Internet website and in printed form. A health care practitioner may request a printed copy of the procedures and forms from HHSC. This prior authorization requirement does not apply to a newly enrolled Medicaid recipient until the 31st calendar day after the date of the determination of the recipient's Medicaid eligibility.

(e) **Preferred Drug List:** The state agency will consider a drug listed on the TCDI for inclusion in the PDL based on the following factors:

(1) The recommendations of the Drug Utilization Review Board (DUR) Board;

(2) The clinical efficacy of the drug consistent with the determination of the Food and Drug Administration and the recommendations of the DUR Board;

(3) Comparison of the price of the drug and the price of competing drugs to the Texas Medicaid outpatient drug program;

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Supersedes TN: 09-0039
12a. Prescribed Drugs

(4) A program benefit offered by the manufacturer or labeler of the drug partially or wholly in lieu of a supplemental rebate and accepted by the state; and

(5) Written evidence offered by a manufacturer or labeler supporting the inclusion of a product on the PDL.

The state will examine information from any or all of these sources when considering the drugs to be included in the PDL.

The state will only include on the PDL drugs provided by a manufacturer or labeler that: (1) has reached an agreement with the state for supplemental rebates for drugs provided to Medicaid recipients; or (2) has not reached an agreement for supplemental rebates, if the state determines that inclusion of the drug on the PDL will have no negative cost impact. Manufacturers or labelers that offer a program benefit must first have a supplemental rebate agreement.

(f) Supplemental Medicaid Drug Rebate Agreement: Pursuant to Section 1927 of the Act, the state has the following policies for Medicaid supplemental rebates and program benefits:

(1) A model agreement between the state and a drug manufacturer for drugs provided to the Medicaid population, effective February 15, 2018, and entitled "Texas Health and Human Services Commission, Title XIX Vendor Drug Program, Supplemental Rebate Agreement," has been authorized by CMS.

(2) Supplemental rebates received by the state in excess of those required under the national drug rebate agreement will be shared with the federal government on the same percentage basis as applied under the national rebate agreement.

(3) A model program benefit agreement between the state and the drug manufacturer for program benefits provided to the Medicaid program, submitted to CMS on September 14, 2004 and entitled "Texas Health and Human Services Commission Title XIX Vendor Drug Program Benefit Agreement" has been authorized by CMS.

(4) Program benefits will consist of benefits, services, or expenditures that the state would otherwise bear under its state plan as medical or administrative expense.
12a. Prescribed Drugs, continued

(5) For program benefits, only the direct costs associated with the Program Benefit investment, including non-monetary benefits such as in-kind goods and services, in the program by the manufacturer or labeler will count as reducing the amount of the supplemental rebate owed. The savings or reduced claim experience that may result from the investment does not reduce the amount of the supplemental rebate owed.

(6) Program benefits received by the State will be treated as supplemental rebates and will be shared with the Federal government on the same percentage basis as applied under the national rebate agreement. For those manufacturers who have a Program Benefit Agreement, the State will determine the amount of supplemental rebate owed by the manufacturer at the end of a year. This amount represents 1) the potential total amount of Program Benefit investment by the manufacturer for the year, and 2) the basis for determining the amount of supplemental rebate that will be shared with the Federal government. For the CMS-64, the State will reduce its other Federal claims by the amount of the Federal share of the entire supplemental rebate owed at the end of the “Texas Health and Human Services Commission Title XIX Vendor Drug Program Supplemental Rebate Agreement” term.

(7) Where the program benefit amount is less than the supplemental rebate amount, the program benefit amount plus the difference between the full supplemental rebate amount and the program benefit amount will be shared with the Federal government on the same percentage basis as applied under the national rebate agreement.

(g) Drug Utilization Review Board (DUR Board): The DUR Board is established in accordance with Section 531.0736 of the Texas Government Code, and Section 1927 (g)(3) of the Social Security Act. The DUR Board is appointed by the executive commissioner of HHSC.

(1) The DUR Board consists of at least 17 physicians and pharmacists of whom two are nonvoting managed care organization members. In addition to these 17 members, the DUR Board will include one consumer advocate who represents Medicaid recipients.

(2) The DUR Board shall develop recommendation for preferred PDLs to be adopted by the State Agency, suggest to the State Agency restrictions or prior authorization requirements on prescription drugs, recommend to the State Agency educational interventions for Medicaid providers, review drug utilization across Medicaid, and perform other duties that may be specified by law and otherwise make recommendations to the State Agency.
12a. **Prescribed Drugs, continued**

(3) The DUR Board shall meet at least quarterly to consider products in PDL categories, and other clinical topics the State Agency recommends for consideration. In developing its recommendations for a PDL, the DUR Board shall consider, for each product included in a category of products, the clinical efficacy, safety, cost-effectiveness and any program benefit associated with the product. The DUR Board shall inform the State Agency of its reasons of recommending drugs for the PDL. The DUR Board shall maintain confidentiality of information used in considering their recommendations including any information deemed confidential by law.

(h) Public Notice: The State Agency will publish notice of the meetings of the DUR Board. The notices will include the topics to be considered at the upcoming meeting and instructions concerning filing of written comments and application to provide public testimony before the committee. The PDL will be published on the HHSC website. Within 10 days following the State Agency’s decision on the recommendations of the DUR Board, the Agency will publish revisions to the PDL on the HHSC website.

(i) No payment will be made for drugs in hospitals, nursing facilities and other institutions where those drugs are included in the reimbursement formula and vendor payments to the institution.

(j) Expanded pharmacy benefits under EPSDT will end on the last day of the month in which the individuals has his or her 21st birthday.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency Texas

MEDICAID PROGRAM: REQUIREMENTS RELATING TO COVERED OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY

<table>
<thead>
<tr>
<th>Citation(s)</th>
<th>Provision(s)</th>
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<tbody>
<tr>
<td>12.a.1 1935(d)(1)</td>
<td>Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.</td>
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Supersedes Approval Date 5-23-06 Effective Date 1-1-06

TN No. 05-20

STATE: Texas
DATE REC'D: 11-10-05
DATE APV'D: 5-23-06
DATE EFF: 1-1-06
HCFA 179 Code: 05-20

SUPERSEDES: NONE - NEW PAGE
(k). **Value-Based Agreement**

The State may enter into value-based contracts with manufacturers on a voluntary basis.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency: Texas

MEDICAID PROGRAM: REQUIREMENTS RELATING TO PAYMENT FOR COVERED OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY

Citation(s): 1927(d)(2) and 1935(d)(2)

Provision(s):

1. The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit – Part D.

- The following excluded drugs are covered:
  - (a) agents when used for anorexia, weight loss, weight gain (see specific drug categories below)
  - (b) agents when used to promote fertility (see specific drug categories below)
  - (c) agents when used for cosmetic purposes or hair growth (see specific drug categories below)
  - (d) agents when used for the symptomatic relief of cough and colds (see specific drug categories below)
  - (e) prescription vitamins and mineral products, except prenatal vitamins and fluoride (see specific drug categories below)
  - (f) non-prescription drugs (see specific drug categories below)
  - (g) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee (see specific drug categories below)

- No excluded drugs are covered

(a) Agents when used for anorexia, weight loss, weight gain: Appetite stimulants, anorexic agents, and fat absorption-decreasing agents.
(b) Agents when used for symptomatic relief of cough and colds: Antihistamines, antitussives, decongestants, and expectorants.
(c) Prescription vitamins and mineral products: Single and multiple vitamins and minerals and combinations.
(f) Non-prescription drugs: Coverage for the following categories when a non-prescription drug is an economical and therapeutic alternative to a prescription drug item: analgesics; anti-emetics; anti-inflammatory agents; antiparasitics; dermatological agents; enzyme replacements; gastrointestinal agents including H-2 antagonists, proton pump inhibitors, laxatives, and antacids; insulin, ophthalmic agents; otic agents; and respiratory agents.
12.b. Dentures.

Not provided.
12.c. Prosthetics

a) Definition

Prosthetics outlined in this section of the state plan include orthotic devices and prosthetic devices.

Orthotic and prosthetic devices are defined as replacement, correction, or support devices prescribed by the physician or other licensed practitioner of the healing arts within the scope of professional practice as defined by Texas law to:

(1) artificially replace a missing portion of the body;

(2) prevent or correct physical deformity or malfunction; or

(3) support a weak or deformed portion of the body.

Hearing aids are considered prosthetic devices and defined as an electronic device that amplifies sound to compensate for impaired hearing.

External breast prosthesis is defined as an external prosthetic device that is used to replace breast tissue and to produce a symmetrical appearance of the breasts.

b) Services

(1) Hearing Aids.

Medical necessity for a hearing aid must be determined through an examination conducted by a physician or other licensed practitioner of the healing arts within the scope of his practice as defined by State law. Coverage for eligible recipients age 21 and older who have hearing loss in both ears is limited to one hearing aid. Coverage is not available for recipients age 21 and older who have hearing loss in only one ear.

(2) External Breast Prostheses.

External breast prostheses are a benefit for all Medicaid eligible recipients with a history of medically necessary mastectomy procedure(s). This benefit includes external breast prostheses for the breast(s) on which medically necessary mastectomy procedure(s) have been performed. Medical necessity for an external breast prosthesis must be determined through an examination, conducted by a physician licensed to practice medicine or osteopathy in the state where and when the service is performed.
12.c. Prosthetics, continued

c) Providers

Hearing aids must be furnished by an audiologist or by approved hearing aid fitter and dispenser providers. Providers must meet all federal and state licensing laws and regulations applicable to provision of the service.

External breast prostheses are a benefit of the Texas Medicaid Program when provided by a licensed prosthetist or prosthetist/orthotist licensed by the state and in accordance with applicable state and federal laws and regulations.

These devices may also be provided by physicians or other licensed practitioners of the healing arts within the scope of professional practice as defined by Texas law.
12.d. **Eyeglasses**

Eyeglasses are a benefit for eligible recipients of the medical assistance program.

Non-prosthetic eyewear includes contact lenses and lenses and frames. Prosthetic eyewear includes contact lenses and lenses and frames. The eyewear must be medically necessary to be reimbursable.
Diagnostic Services

Diagnostic Services for Persons with a potential of Mental Retardation

Not Provided
State of Texas

13.b. Screening Services.
Not Provided.
13.c. Preventive Services

Preventive services provided under this section are provided by practitioners who meet individual practitioner certification standards according to federal and state law. Each provider must be approved for participation in the Texas Medical Assistance Program by the Texas Health and Human Services Commission.

Preventive services include services to:

a) prevent disease, disability and other health conditions or their progression,

b) prolong life, and

c) promote physical and mental health and efficiency

Eligible recipients, other than EPSDT recipients, are entitled to one comprehensive preventive exam per year. The preventive services must be provided in accordance with the United States Preventive Services Task Force (USPSTF).

Optometric Services

Eligible recipients, other than EPSDT recipients, are entitled to one eye exam by refraction every 24 months performed by a provider qualified to provide optometric services under the Texas Medical Assistance Program. Adults may also be offered an eye exam by refraction before the 24 month period has elapsed if there is a significant change in visual acuity, measured in diopter or axis changes. Payment will be made by the Texas Medical Assistance Program for one eye examination with refraction per recipient every 24 months. This limit applies only to determinations of visual acuity, not to other diagnostic services or to treatment of the eye for medical conditions.
13.d. Rehabilitative Services

Day Activities and Health Services.

Day Activities and Health Services are a component of the Rehabilitative Services defined at 42 CFR 440.130(d). The single state agency will pay for Day Activities and Health Services when provided to eligible recipients in accordance with state agency established conditions, specifications and limitations by providers who are approved by and under contract with the single state agency.

A. Day Activities and Health Services must be prescribed by a physician and provided under the supervision of a nurse licensed in the State of Texas.

B. An individual must have a need because of a chronic medical condition and be able to benefit therapeutically from Day Activities and Health Services. Potential for receiving therapeutic benefit from Day Activities and Health Services will be established by an assessment of the recipient’s medical needs. Reassessment of this need and authorization for continued Day Activities and Health Services is required at least every twelve months.

C. A recipient of Day Activities and Health Services must establish and maintain a living arrangement in the community outside of the Day Activities and Health Services facility.

D. Day Activities and Health Services are limited to no more than 10 hours per day and 230 hours per month for each eligible recipient.*

E. Facilities providing Day Activities and Health Services must meet any licensing requirement imposed by the Texas Department of Health and must meet all other qualifications established by the

* Durational, dollar, and quantity limits are waived for recipients of EPSDT services. Services allowable under Medicaid laws and regulations may be covered when medically necessary for these recipients.

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13. d Rehabilitative Services (Continued).

   Single state agency.

   F. The provider must maintain records and submit reports and other information specified by the single state agency.

Chemical Dependency Treatment Facility Services. (See EPSDT item 4.b)

A. Mental Health Rehabilitative Services – Definition and Authorization Process

Mental Health Rehabilitative Services are those age appropriate services determined via a uniform assessment protocol and recommended by a licensed practitioner of the healing arts as medically necessary to reduce an individual’s disability resulting from severe mental illness for adults, or serious emotional, behavioral, or mental disorders for children; and to restore an individual to his/her best possible functioning level in the community. Services that provide assistance in maintaining functioning may be considered rehabilitative when necessary to help an individual achieve a rehabilitation goal as defined in the rehabilitation plan. In addition to a determination of need based on the uniform assessment protocol, eligible individuals residing in a nursing facility (NFs) must have been determined through PASARR to require specialized services.

The treatment planning process for Mental Health Rehabilitative Services requires the active participation of the Medicaid eligible individual (or their legally authorized representative when necessary due to the individual’s age or legal status). Treatment plans are based on a comprehensive assessment and must address the individual’s strengths, areas of need, the individual’s preferences, and descriptions of the individual’s recovery goals.

1. Authorization of Services

Each person determined to need Mental Health Rehabilitative Services must have a plan of care developed by the Medicaid enrolled provider of Rehabilitative services that describes in writing the type, amount and duration of Mental Health Rehabilitative Services determined to be medically necessary to meet the needs of the person. The plan of care must be recommended by a Licensed Practitioner of the Healing Arts (LPHA) and must be consistent with the State uniform utilization guidelines or include documentation providing clinical justification for the exceptions. The plan of care must be authorized by the state operating agency or its designee. The plan of care will be reviewed by the Medicaid provider on a regular basis and modified as necessary to meet the needs of the person. Changes to the plan of care with regard to type, amount, or duration must be approved by a licensed practitioner of the healing arts practicing within the scope of his/her licensure. All plans of care are subject to review and approval by the state operating agency or its designee.

2. Mental Health Rehabilitative Services – Service Definitions:

Mental Health Rehabilitative Services are age-appropriate, individualized, and designed to ameliorate mental and functional disabilities that negatively affect community integration, community tenure, and/or behaviors resulting from serious mental illness or emotional disturbance that interfere with an individual's ability to obtain or retain employment or to function in other non-work, role appropriate settings. Day programming for acute needs is provided on a large group basis and is site-based. All other services are provided on a one-to-one or small group basis, either on-site or in the community. Mental health rehabilitative services include:

a. Medication training and support – curriculum-based training and guidance that serves as an initial orientation for the individual in understanding the nature of their mental illnesses or emotional disturbances and the role of medications in ensuring symptom reduction and increased tenure in the community. This service includes: assisting the individual to develop correct procedures for following a prescription medication regimen; strategies to manage symptomology and maximize functioning; developing an understanding of the relationship between mental illness and the medications prescribed to treat the illness; the interaction of medication with other medications, diet, and mood altering substances; the identification and management of potential side effects; and the necessity of taking medications as prescribed and following doctor's orders.

Providers of medication training and support must be certified as at least one of the following:
1) Qualified Mental Health Professional - Community Services (QMHP-CS)
2) Community Services Specialist (CSSP)
3) Peer Provider
4) Licensed medical personnel
5) Family Partner

b. Psychosocial rehabilitation service – social, educational, vocational, behavioral, and/or cognitive interventions to improve a client's potential for social relationships, occupational or educational achievement, and living skills development. This service is provided by members of a therapeutic team. When appropriate, the provision of services will address the impact of co-occurring disorders upon the individual's ability to decrease symptomology and increase community tenure. This service includes:

(1) Independent living – skills training and/or supportive interventions that focus on the improvement of communication skills, appropriate interpersonal behaviors, and other skills necessary for independent living or, when age appropriate, functioning effectively with family, peers and teachers. Training for independent living includes: skills related to personal hygiene; transportation utilization; money management; the development of natural supports; access to needed services in the community, e.g., medical care, substance abuse services, legal services, living accommodations; and social skills, e.g., communicating one's needs to strangers and making appropriate choices for the use of leisure time. Individuals receiving psychosocial rehabilitation service are not eligible to simultaneously receive skills training and development.
13. d Rehabilitative Services (Continued).

(2) Coordination – skills training and/or supportive interventions to assist the individual in improving their ability to gain and coordinate access to necessary care and services. Training for coordination skills includes instruction and guidance in such areas as: identifying areas of need across all life domains, prioritizing needs and setting goals, identifying potential service providers and support systems, initiating contact with providers and support systems, participating in the development and subsequent revisions of their plan of care, coordinating their services and supports, and advocating for necessary changes and improvements to ensure that they obtain maximum benefit from their services and supports. Individuals receiving Psychosocial Rehabilitation Service are not eligible to simultaneously receive Medicaid Targeted Case Management Services.

(3) Employment related service – training and supports that are not job specific and have as their focus the development of skills to reduce or overcome the symptoms of mental illness that interfere with the individual’s ability to make vocational choices, attain or retain employment. Included are activities such as: skills training related to task focus, task completion, planning and managing activities to achieve outcomes, personal hygiene, grooming and communication, and skills training related to securing appropriate clothing, developing natural supports, and arranging transportation. Also included are supportive contacts related to the school or work-site situation to reduce or manage behaviors or symptoms related to the individual’s mental illness or emotional disturbance that interfere with job performance or progress toward the development of skills that would enable the individual to obtain or retain employment.

(4) Housing related service - training and supports that focus on the development of skills to reduce or overcome the symptoms of mental illness that interfere with the individual’s ability to obtain or maintain tenure in independent integrated housing. Included are activities such as: skills training related to home maintenance and cleanliness, problem solving with landlord and other residents, and maintaining appropriate interpersonal boundaries. Also included are supportive contacts related to the housing situation to reduce or manage behaviors or symptoms related to the individual’s mental illness or emotional disturbance that interfere with maintaining independent integrated housing.

(5) Medication related service – Training and supportive interventions that focus on individual-specific needs and goals regarding the administration of medication, monitoring efficacy and side-effects of medication, and other nursing services that enable the individual to attain or maintain an optimal level of functioning. Medication related service does not include services or activities that are incidental to physician services provided during a clinical appointment.

Providers of Psychosocial Rehabilitation Services that address independent living, coordination, employment-related issues, and housing-related issues must be certified as at least one of the following:
1) QMHP-CS
2) CSSP
3) Peer Provider

Providers of Psychosocial Rehabilitation Services that address medication issues must be certified as licensed medical personnel.
   Service Definitions (continued).

c. Skills training and development – skills training and/or supportive interventions that focus on the improvement of communication skills, appropriate interpersonal behaviors, and other skills necessary for independent living or, when age appropriate, functioning effectively with family, peers and teachers. Skills training and development may include: skills related to personal hygiene; transportation utilization; money management; the development of natural supports; access to needed services in the community, e.g., medical care, substance abuse services, legal services, living accommodations; and social skills (e.g. communicating one’s needs to strangers and making appropriate choices for the use of leisure time). Individuals receiving skills training and development are not eligible to simultaneously receive psychosocial rehabilitation service.

   Providers of skills training and development must be certified as at least one of the following:
   1) QMHP-CS
   2) CSSP
   3) Peer Provider
   4) Family Partner

d. Crisis intervention – intensive community-based one-to-one service provided to individuals who require services in order to control acute symptoms that place the individual at immediate risk of hospitalization, incarceration, or placement in a more restrictive treatment setting. This service focuses on behavioral skills training for stress and symptom management, problem solving and reality orientation to help the individual identify and manage their symptoms of mental illness, supportive counseling, and training to adapt to and cope with stressors. Also included is the assessment of dangerousness and, when appropriate, coordination of emergency services.

   Providers of crisis intervention must be certified as a QMHP-CS.

e. Day program for acute needs – short-term, intensive, site-based treatment in a group modality to an individual who requires multidisciplinary treatment in order to stabilize acute psychiatric symptoms or prevent admission to a more restrictive setting or reduce the amount of time spent in the more restrictive setting. Day programs for acute needs are goal-oriented, provided in a highly structured and safe environment with constant supervision, and ensure an opportunity for frequent interaction between client and staff. Day programs for acute needs must at all times have sufficient staff to ensure safety and program adequacy according to an established staffing ratio and staff response times. This service focuses on intensive, medically-orientated, multidisciplinary interventions such as behavior skills training, crisis management and nursing services that are designed to stabilize acute psychiatric symptoms. These services may be provided in a residential facility; however, none of the residential facilities are greater than 16 beds.

   Providers of day program activities that address symptom management and functioning skills must be certified as at least one of the following:
   1) QMHP-CS
   2) CSSP
   3) Peer Provider

   Providers of day program activities that address pharmacology issues must be certified as licensed medical personnel. Providers of psychiatric nursing services must be a registered nurse (RN).
3. Providers and Qualifications

a. QMHP-CS
The credentialing requirement minimums for a QMHP-CS are as follows:
- Demonstrated competency in the work to be performed, and
- Bachelor's degree from an accredited college or university with a minimum number of hours that is equivalent to a major in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education, or early childhood intervention, or
- RN.

An individual who possesses any of the following licenses is automatically certified as a QMHP-CS:
- Advanced Practice nurse (APN) - Tex.Occ.Code, Chapter 301
- Licensed Psychologist - Tex.Occ.Code, Chapter 501
- Licensed Clinical Social Worker (LCSW) - Tex.Occ.Code, Chapter 505
- Licensed Marriage and Family Therapist (LMFT) - Tex.Occ.Code, Chapter 502
- Licensed Professional Counselor (LPC) - Tex.Occ.Code, Chapter 503.

A QMHP-CS must be clinically supervised by at least another QMHP-CS. If a QMHP-CS is clinically supervised by another QMHP-CS, the supervising QMHP-CS must be clinically supervised by a LPHA.

b. CSSP
The credentialing requirement minimums for a CSSP are as follows:
- High school diploma or high school equivalency,
- Three continuous years of documented full-time experience in the provision of mental health rehabilitative services as of August 30, 2004, and
- Demonstrated competency in the provision and documentation of mental health rehabilitative services.

A CSSP must be clinically supervised by at least a QMHP-CS.

c. Peer Provider
The credentialing requirement minimums for a Peer Provider are as follows:
- High school diploma or high school equivalency, and
- One cumulative year of receiving mental health services.

A Peer Provider must be clinically supervised by an LPHA.

A Peer Provider must satisfy all staff credentialing, competency, training and clinical supervision requirements as stipulated in 13.d.B.2. Services provided by a Peer Provider must be included in the treatment plan as described in 13.d.A.

d. Licensed medical personnel
The credentialing requirement minimum for licensed medical personnel is licensure as at least one of the following:
- Physician - Tex.Occ.Code, Chapter 151
- APN - Tex.Occ.Code, Chapter 301
- Physician Assistant (PA) - Tex.Occ.Code, Chapter 204
- RN - Tex.Occ.Code, Chapter 301
- Licensed Vocational Nurse (LVN) - Tex.Occ.Code, Chapter 301

SUPERSEDES: NONE - NEW PAGE
   Providers and Qualifications (continued).

   e. Family Partner
      The credentialing requirements for a family partner are as follows:
      - High school diploma or high school equivalency and
      - One cumulative year of participating in mental health services as the parent or legally
        authorized representative (LAR) of a child receiving mental health services.

      A family partner must be supervised by at least a QMHP.

      A family partner must satisfy all staff credentialing, competency, training, and clinical
      supervision requirements as stipulated in 13.d.B.2. Services provided by a family partner
      must be included in the treatment plan as described in 13.d.A.

      Family partners must be credentialed as a certified family partner within one year of their hire
      date. The State or its contractor manages the state certification process for family partners
      and will make all necessary education and training modules relevant to the certification
      process available to all family partners. The State or its contractor will administer and
      oversee the testing protocol for certified family partners.

      The family partner service is provided to parents or LARs for the benefit of the Medicaid
      eligible child.

4. Mental Health Rehabilitative Services do not include any of the following:

   a. services to inmates in public institutions as defined in 42 CFR § 435.1009;
   b. services to individuals under 65 years of age residing in institutions for mental diseases as described
      in 42 CFR § 435.1009;
   c. job task specific vocational services;
   d. educational services;
   e. room and board residential costs;
   f. services that are an integral and inseparable part of another Medicaid-reimbursable service, including
      targeted case management services, residential rehabilitative behavioral health services, institutional
      and waiver services;
   g. services that are covered elsewhere in the state Medicaid plan;
   h. services to individuals with a single diagnosis of mental retardation or other developmental disability
      or disorder and who do not have a co-occurring diagnosis of mental illness in adults or serious
      emotional disturbance in children;
   i. inpatient hospital services;
   j. respite services; or
   k. family support services.
13. d Rehabilitative Services (Continued).

B. Provider Qualifications – To enroll as a provider of Mental Health Rehabilitative Services and to maintain active provider status, an applicant/enrolled provider agency must:

1. Demonstrate a history of providing to adults and children, as well as a capacity to continue to provide to adults and children, a readily accessible, comprehensive, integrated, and well-coordinated system of services and supports, beneficial to adults and children who have been determined to need Mental Health Rehabilitative Services, that includes all of the Mental Health Rehabilitative Services reimbursable under this plan, and be either:

   a. a governmental or non-governmental entity designated as a community mental health center or community mental health and mental retardation center in accordance with §534.001f of the Texas Health and Safety Code that is in compliance with and maintains on-going compliance with the Texas Department of Mental Health and Mental Retardation’s Community Mental Health Standards (25 TAC 412 Subchapter G); or

   b. a corporation authorized to do business in the State of Texas that demonstrates, through the implementation of written and readily available policies, procedures, and practices and on-site confirmation thereof, compliance with standards of care promulgated by the single state agency or its designee with the approval of the single state agency, that are comparable to those required of providers qualifying under 13d(B) (1) (a) and assure:

      (1) The safety, health, rights, privacy and dignity of persons receiving Mental Health Rehabilitative Services.

      (2) Access to emergency services, including a 24-hour-a-day, 365-day-a-year staffed telephone screening and crisis response system, immediate access to emergency medical and psychiatric services, and immediate face-to-face assessment by qualified mental health professional staff, including physicians.

      (3) Competency of staff (including volunteers, interns, and students), appropriate to job duty, including licensure commensurate with state law, and sufficient numbers of staff ensure safety and adequacy of programming, including emergency responses within programming.

      (4) Physical separation of children and adults in residential and other program settings.

      (5) Compliance with the most recent edition of the National Fire Protection Association’s Life Safety Code and certification, registration, or licensure, as applicable for all inpatient
13. d Rehabilitative Services (Continued).

and residential facilities utilized for services provided directly or under arrangement.

(6) Communication with recipients in a language and format understandable to the recipient through the provision of interpretive services; translated materials; and use of native language and staff.

(7) The use of a record system that ensures the integrity of the individual record; provides for organization of content and storage of records; is administered by an appropriately trained and credentialed individual; and is consistent with all federal, state, and local laws and regulations pertaining to storage of records.

(8) A quality improvement process, that includes a plan and an annual self-evaluation of performance, that is based on valid data-driven decisions including both clinical and non-clinical aspects of care.

(9) An infection control plan approved by a physician which includes prevention, education, management, and monitoring of significant infections.

(10) A peer review process that promotes sound clinical practice, professional growth, and credentialing within the provider agency, and that abides by generally accepted guidelines and applicable laws, including necessary investigatory processes to comply with licensing requirement.

(11) A utilization management program which utilizes a formal assessment of medical necessity, efficiency and/or clinical appropriateness of services and treatment plans on a prospective and concurrent basis, reviews services using established protocols, and allows for an objective appeal process.

2. Assure that covered services are provided to recipients by staff who meet credentialing, competency, and/or training requirements promulgated by the single state agency or its designee, with the approval of the single state agency. Credentialing is to be performed by the provider. All staff, including Peer Providers, must demonstrate competency to perform their job duties (e.g., written exam, role play, mentorship) on an ongoing basis as determined by the provider. All staff, including Peer Providers, must receive training on: the nature of mental illness and serious emotional disturbance, client rights, cultural sensitivity, client abuse and neglect, the uniform assessment protocol, the uniform utilization guidelines, treatment plan development, crisis management, skill training techniques, treatment of co-occurring psychiatric and substance use disorders, availability of community resources, and effective advocacy. Staff, including Peer Providers, must receive ongoing and "refresher" training as required by the provider (e.g., CPR every 3 years, treatment plan development in response to job performance deficit). Staff, including Peer Providers, must receive clinical supervision as required by the single state agency or its designee. Oversight of the credentialing, competency, training and clinical supervision processes is provided by the single state agency or its designee.
13. d  Rehabilitative Services (Continued).

3. Comply with all federal, state, and local laws and regulations applicable to Mental Health Rehabilitative Services and the Texas Medical Assistance Program.

4. Sign a written provider agreement with the single state agency or its designee. By signing the agreement, the provider of mental health rehabilitative services agrees to comply with the terms of the agreement and all requirements of the Texas Medical Assistance Program, including regulations, rules, provider manuals, standards, policy clarification statements, and guidelines published by the single state agency or its designee.

5. Document and bill for services covered by the Texas Medical Assistance Program in the manner and format prescribed by the single state agency or its designee.

6. Allow access by the single state agency or its designee to recipient and the recipient’s records when necessary to carry out the single state agency’s responsibilities.

7. Demonstrate a history of providing, as well as the capacity to continue to provide comprehensive system of services and supports required by 13d(B) (1) to, and as needed by individuals required to submit to mental health treatment under the Texas Code of Criminal Procedure, Article 17.032 (relating to Release on Personal Bond of Certain Mentally Ill Defendants), or Article 42.12, Section 5(a) or Section 11(d) (relating to Community Supervision); and to, and as needed by, individuals required to submit to mental health treatment due to involuntary commitment for outpatient treatment under the Texas Health and Safety Code, Chapter 573 (relating to Emergency Detention) and Chapter 574 (relating to Court Ordered Mental Health Services).
13. d Rehabilitative Services (Continued).

8. Request criminal history record information on all employees and applicants whom an offer of employment or volunteer status is made, as authorized in the Texas Health and Safety Code §411.115 and ensure that no volunteer or employee of the enrolled provider, contracted employee of the enrolled provider, or employee or volunteer of a provider delivering rehabilitative services under arrangement who has a criminal history is allowed to provide services to or interact with persons receiving Mental Health Rehabilitative Services.

9. Comply with state policies and procedures pertaining to financial audits and cost reports as determined by the state auditor and/or the single state agency or its designee, with approval of the single state agency.

10. Ensure that when services are provided under arrangement the provider delivering those services under arrangement:

   a. Complies with all applicable federal, state, and local laws and regulations pertaining to mental health rehabilitative services.

   b. Has in effect an agreement with the enrolled provider agency stipulating that the provider delivering services under arrangement complies with all requirements of the Texas Medical Assistance Program, including regulations, rules, provider manuals, standards, policy clarification statements, and guidelines.

   c. Is in compliance with all standards applicable to the provision of the Mental Health Rehabilitative Services, as promulgated by the single state agency or its designee, with approval by the single state agency, through rules, regulations, provider manuals, policy clarifications, guidelines, and other documents.

11. Retain responsibility for Mental Health Rehabilitative Services provided directly or under arrangement.
13.d. Rehabilitative Services (continued)

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13.d. Rehabilitative Services (continued)

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Supersedes TN 00-18
13.d. Rehabilitative Services (continued)

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13.d  Speech Therapy Evaluation

I. One speech evaluation for the purpose of determining the medical need for speech therapy services does not require prior authorization.

II. Speech Therapy that exceeds one speech evaluation must be prior authorized. Prior authorization of speech therapy requires a statement of medical necessity from the Medicaid recipient’s physician.

III. Speech therapy services for persons residing in nursing homes are included in the nursing facility rate described in Attachment 4.19-D (NF).
13.d Rehabilitative Services, continued

Substance Abuse and Dependency Treatment Services

Substance abuse and dependency services are those age-appropriate treatment services determined via a nationally-recognized screening and assessment protocol, recommended by a licensed practitioner of the healing arts as medically necessary, and appropriate to treat a substance abuse and dependency disorder and restore an individual to his or her best possible functional level. Rehabilitative services, when provided to maintain function, may be considered when medically necessary to assist an individual in achieving a rehabilitative goal, as defined in the rehabilitative treatment plan.

Substance abuse and dependency treatment services include a set of rehabilitative clinical interventions approved under a goal-oriented written treatment plan, designed to promote treatment and recovery and prevent relapse. The treatment plan [or plan of care] includes medical and/or psychotherapeutic modalities aimed at treating substance abuse and dependency disorders, as defined by the current Diagnostic and Statistical Manual of Mental Disorders.

Substance abuse and dependency treatment services include:

1) Screening and Assessment
   a) Provided by a licensed practitioner of the healing arts using a nationally-recognized screening and assessment tool.
   b) The purpose of the screening and assessment is to identify the individual's level of addiction and treatment needs.
   c) Providers of Screening and Assessment must be certified as a Qualified Credentialed Counselor (QCC)

2) Substance abuse detoxification treatment services
   a) Provided by:
      i) Licensed hospitals; or
      ii) Facilities that are licensed and regulated by the Department of State Health Services to provide substance abuse and dependency treatment services, including detoxification.
13.d Rehabilitative Services, continued

Substance Abuse and Dependency Treatment Services, Continued

2) b) Description of services:
   i. Evaluation to determine the level of intoxication or withdrawal potential and determine the client's treatment plan;
   ii. Monitoring mental status, vital signs, and complications;
   iii. Medication therapy to manage the client’s immediate withdrawal symptoms; and
   iv. Counseling regarding the client’s illness that is designed to:
      (1) assess the client's readiness for change;
      (2) offer general and individualized information on substance abuse and dependency;
      (3) enhance client motivation;
      (4) engage the client in treatment; and
      (5) include a detoxification plan that contains the goals of successful and safe detoxification as well as transfer to another treatment program.

c) Providers of evaluation, monitoring, and medication therapy must be licensed medical personnel. Providers of counseling must be certified as a QCC.

3) Treatment services

a) Provided by facilities that are licensed and regulated by the Department of State Health Services to provide substance abuse and dependency treatment services.

b) Description of services:
Services include appropriate counseling and psycho-educational modalities designed to promote treatment and recovery and prevent relapse. Treatment services include:
(1) Evaluation using a nationally-recognized tool to identify the medically appropriate duration of service based on medical need and severity of addiction;
(2) Development of a goal-oriented written plan of care designed to promote treatment and recovery and prevent relapse, and that is recommended by a licensed practitioner of the healing arts;

SUPERSEDES: NONE - NEW PAGE
13.d Rehabilitative Services, continued

Substance Abuse and Dependency Treatment Services, continued

3) b) (3) Therapeutic modalities including: motivational interviewing; and individual, group and family counseling focused on the individual eligible for Medicaid;
(4) Psycho-education aimed at providing education on the effects of substance use;
(6) Medication management; and
(7) Relapse prevention.

c) Providers of evaluation, development of plan of care, therapeutic modalities, psycho-education, and relapse prevention must be certified as a QCC. Providers of medication management must be licensed medical personnel.

4) Providers and Qualifications
a) Licensed medical personnel
The credentialing requirement minimums for licensed medical personnel is licensure as at least one of the following:
• Physician – Texas Occupations Code (Tex Occ. Code), Chapter 155
• Advanced Practice Nurse (APN) – Tex. Occ. Code, Chapter 301
• Physician Assistant (PA), Tex. Occ. Code, Chapter 204
• Registered Nurse (RN) – Tex. Occ. Code, Chapter 301
• Licensed Vocational Nurse (LVN) – Tex. Occ. Code, Chapter 301

b) Qualified Credentialed Counselor
The credentialing requirement minimums for qualified credentialed counselor is as at least one of the following:
• Licensed Chemical Dependency Counselor (LCDC) – Tex. Occ. Code
• Licensed Professional Counselor (LPC) – Tex. Occ. Code. Chapter 503
• Licensed Clinical Social Worker (LCSW) – Tex. Occ. Code, Chapter 505
• Licensed Marriage and Family Therapist (LMFT) – Tex. Code, Chapter 502
• Licensed Psychologist – Tex. Occ. Code, Chapter 501
• Licensed Physician – Tex. Occ. Code, Chapter 155
• Licensed Physician Assistant – Tex. Occ. Code, Chapter 204
• Certified Addictions Registered Nurse (CARN) – Tex Occ. Code, Chapter 504
• Advanced practice nurse practitioner - clinical nurse specialist or nurse practitioner with a specialty in psych-mental health – Tex. Occ. Code, Chapter 301.
13.d  Rehabilitative Services, continued

Peer Specialist Services

(a) Definition:

Peer specialist services are provided under 42 CFR 440.130(d) as a rehabilitative services benefit. Peer specialist services are recovery-oriented, person-centered, relationship-focused, and trauma-informed.

These non-clinical services are based on a relationship between the peer specialist and the Medicaid-eligible individual. A peer specialist uses his or her lived experience to assist an individual in developing skills, problem solving strategies, and coping mechanisms for stressors and barriers encountered when recovering from a mental health condition or a substance use disorder as well as achieving goals and objectives in the individual's person-centered recovery plan, which serves as the plan of care.

Peer specialist services are designed to improve quality of life for the individual, help the individual avoid more restrictive levels of care such as psychiatric inpatient hospitalization, and help the individual achieve long-term recovery from symptoms related to the individual's mental health condition and/or substance use disorder.

(b) Services:

Peer specialist services (provided individually or in a group setting) may include:

1. Recovery and wellness support, which includes providing information on, support with, and assistance planning for recovery;
2. Mentoring, which includes serving as a role model and providing assistance in finding needed community resources and services; and
3. Advocacy, which includes providing support in stressful or urgent situations, and helping to ensure that the recipient's rights are respected. Advocacy may also include encouraging the recipient to advocate for him or herself to obtain services.

Peer specialists who are employed by Medicaid-enrolled providers delivering behavioral health services may deliver peer specialist services. A peer specialist may not practice psychotherapy, create plans of care, or engage in any service that requires a license.
13.d  Rehabilitative Services, continued

Peer Specialist Services, Continued

(c) Eligibility to Receive Services:

Peer specialist services are available to individuals 21 years of age or older who have a mental health condition and/or substance use disorder and who have peer specialist services included as a component of their person-centered recovery plan, which serves as the plan of care.

(d) Care Coordination:

Peer specialists who are employed by Medicaid-enrolled providers delivering behavioral health services must deliver peer specialist services as part of a coordinated, comprehensive, and individualized approach to treating an individual’s mental health and/or substance use condition. Providers of peer specialist services shall coordinate with all behavioral health service providers involved in the individual’s care, and utilize a person-centered approach to treatment planning and service delivery, in collaboration with the individual.

(e) Exclusions:

The following services are not billable as peer specialist services:

1) Record keeping or documentation activities;
2) Peer specialist services delivered in the course of delivery of other behavioral health services; and
3) Services provided without the individual present.
13.d  Rehabilitative Services, continued

Peer Specialist Services, Continued

(f) Peer Specialist Qualifications:

A peer specialist must:

1) be at least 18 years of age;
2) have lived experience with a mental health condition, substance use disorder, or both;
3) have a high school diploma or General Equivalency Diploma (GED);
4) be willing to appropriately share his or her own recovery story with clients;
5) be able to demonstrate current self-directed recovery;
6) pass criminal history and registry checks as described in state regulations governing certification for peer specialists; and
7) Demonstrate the ability to support the recovery of others from mental illness and/or substance use disorder.

A peer specialist must complete all required training and be certified before providing services, and fulfill ongoing education requirements.
13.d Rehabilitative Services, continued

Peer Specialist Services, Continued

(g) Peer Specialist Certification:

In order to deliver peer specialist services, an individual must first complete required orientation and self-assessment activities as outlined in state regulations governing certification for peer specialists and then complete a core training delivered by a certified training entity.

Upon completion of the core training, supplemental training as either a mental health peer specialist or a recovery support peer specialist must be completed. Upon completion of the core and supplemental training, a person may apply for initial certification to an approved certification body.

- A knowledge assessment is required to complete both the core and supplemental trainings.

A peer specialist who has received initial certification may begin delivering Medicaid-billable services while participating in a supervised internship at the peer specialist's place of employment.

- The internship consists of 250 hours of supervised work experience that should be completed within a six-month period.

After completing the required internship hours, peer specialists may apply for renewed certification through the certification body.

- Certification must then be renewed every two years, including any required continuing education hours.
- Peer specialists may only deliver services within their specialty area.
- Certification must be maintained in good standing with the certification body.
13.d  Rehabilitative Services, continued

Peer Specialist Services, Continued

(h) Peer Specialist Supervision:

An organization in which peer specialists deliver services must provide supervision for peer specialists.

Peer specialist supervision must be provided by a:

1. Qualified Credentialed Counselor (QCC);
2. Licensed Practitioner of the Healing Arts (LPHA);
3. Qualified Mental Health Practitioner-Community Services (QMHP-CS), with a QCC or LPHA supervising the QMHP-CS; or
4. Qualified Peer Supervisor (QPS), with a QCC or LPHA supervising the QPS.

Peer specialist supervision must focus on a peer specialist’s provision of services, including review of cases and activities, skill building, problem resolution, and professional growth. Supervision may also include aspects specific to the organization, such as following organizational policy or other administrative matters.

Peer specialist supervision must occur at least once weekly for a peer specialist with an initial certification, at least once monthly for a peer specialist with a two-year certification, or more frequently at the request of the peer specialist. Peer specialist supervisors must document all supervisory sessions and maintain records in the peer specialist’s employee personnel file.

A QCC or LPHA supervising a QMHP-CS or QPS must provide individual or group supervision at least once monthly, and conduct an observation of the QMHP-CS or QPS conducting peer specialist supervision at a frequency determined by the LPHA or QCC based on the QMHP-CS’s or QPS’s skill level.
14.a Services for individuals age 65 or older in Institutions for Mental diseases - Inpatient Hospital Services.

1) Eligible population. Inpatient hospital services in an institution for mental disease are limited to individuals:
A. who 65 years old or older;
B. who have one or more mental diseases;
C. who have no acceptable alternative treatment;
D. for whom the single state agency or its designee has determined inpatient hospital services in an institution for mental disease to be reasonable and medically necessary.

2) Definition of services. Inpatient services in an institution for mental disease include but are not limited to:
A. initiation, titration and/or change in medication;
B. monitoring and assessing by qualified mental health professionals;
C. suicide precautions;
D. redirection of inappropriate behaviors and/or reinforcement of appropriate behaviors;
E. group and individual therapies;
F. structured skills training activities;
G. room and board; and
H. nursing services.

3) Provider qualifications. All providers seeking to provide inpatient hospital services in an institution of mental disease must:
A. submit an approved application for enrollment through means established by the single state agency or its designee;
B. meet the Medicare conditions of participation specified in 42 CFR 482.60;
C. be accredited by the Joint Commission on Accreditation of Healthcare Organizations;
D. if applicable, be licensed as a psychiatric hospital under the provision of the Health and Safety Code, Chapter 577;
E. meet the requirements of 42 CFR 440.140(a) pertaining to providers of inpatient hospital services in institutions for mental disease;
F. be in compliance with applicable standards promulgated by the state mental health authority as provisions of the Texas Administrative Code, Title 25, Part II, Chapters 401, 402, 403, 404, 405, and 408, relating to patient care and treatment in inpatient mental health facilities;
3) Provider Qualifications. (Continued)

G. be serving a patient population in which more than 50 percent currently require institutionalization because of mental disease;

H. have a consistent historical pattern of accepting involuntary admissions;

I. assure, within a written provider agreement the capacity to: admit, readmit from alternative care, and treat both eligible persons voluntarily seeking services under the provision of the Health and Safety Code, Chapter 572 and persons lawfully compelled to accept inpatient mental health treatment under the provisions of the Health and Safety Code, Chapters 573 and 574;

J. ensure that inpatient hospital care will maintain the patient at, or restore the patient to, the greatest possible degree of health and independent functioning; and

K. allow access by the single state agency or its designee to the institution, the patient, and the patient's records when necessary to carry out the agency's responsibilities and provide access to records in accordance with the provisions of Title 42 Code of Federal Regulations §431.107.
14.b. Services for Individuals Age 65 or Older in Institutions for Mental Diseases - Skilled Nursing Facility Services.

Not provided.
14.c. Services for Individuals Age 65 or Older in Institutions for Mental Diseases - Intermediate Care Facility Services.

Not provided.
15.6. Intermediate Care Facility Services in a Public Institution (or Distinct Part Thereof) for the Mentally Retarded or Persons With Related Conditions.

Intermediate care facilities services (other than such services in an institution for mental diseases) are limited by:

The attending physician's prescription of a level of care setting and the single state agency's level of care determination for which vendor payments will be made.
15.b. Intermediate Care Facility Services in a Public Institution (or Distinct Part Thereof) for the Mentally Retarded or Persons With Related Conditions. (Continued)

Reimbursement methodology for ICF-MR dental services is described in 4.19-B, Item 24, page 17, and such dental services are limited to ICF-MR residents.
15c. Intermediate Care Facility Services.

(I) Augmentative communication devices (ACDs) are available to Medicaid-eligible individuals residing in Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) when prior authorization is obtained.

(A) To be eligible for reimbursement for an ACD, the ICF/MR, prior to purchase of the device, must obtain an evaluation of the individual by a speech language therapist licensed in the State of Texas. This evaluation must contain all of the following criteria:

i. Diagnosis relevant to the need for an ACD;
ii. Specific ACD being recommended;
iii. Description of how this ACD will meet the specific needs of this individual; and
iv. Description of specific training needs for use of this device to include training needs of the individual, ICF/MR staff, and family (when applicable).

(B) The ICF/MR must provide a statement of medical necessity for this ACD from the individual's primary care physician in order to request prior authorization.

(II) Prior authorization must be obtained from the Health and Human Services Commission (HHSC) or its designee before purchase of any ACD. For ACDs costing over $10,000, the prior authorization process will include an independently conducted second speech evaluation facilitated by the Department of Aging and Disability Services (DADS). An ICF/MR must submit a copy of the completed initial speech evaluation and physician's attestation of medical necessity to request prior authorization.
16. Inpatient Psychiatric Facility Services for Individuals Under 21 Years of Age.

Inpatient psychiatric facility services for individuals under 21 years of age are prior authorized. Reimbursement is subject to the requirements set out in 42 CFR 441.
17. Nurse-Midwife Services

(a) In addition to the specifications, conditions, requirements, and limitations established by the single state agency or its designee, which are applicable generally to all Medicaid providers in accordance with Federal law, rules and regulations, the following provisions are applicable to Nurse-Midwife Services for purposes of the Texas Medical Assistance Program:

(1) Nurse-Midwife services must be provided by a Certified Nurse-Midwife (CNM), enrolled and approved for participation in the Texas Medical Assistance Program. A certified Nurse-Midwife is defined as a licensed registered nurse approved by the State Board of Nursing as an advanced practice nurse in midwifery, and who is also certified by the American College of Nurse-Midwives.

(2) To the extent and under the circumstances authorized under State laws, rules and regulations, and in the case of services furnished in an institution, hospital or other facility to the extent permitted by the institution, hospital or facility, Nurse-Midwife services are covered if the services:
   (A) are within the scope of practice for Certified Nurse Midwives, as defined by State law;
   (B) are consistent with rules and regulations promulgated by the Board of Nursing or other appropriate state licensing authority; and
   (C) would be covered by the Texas Medical Assistance Program if provided by a licensed physician (M.D. or D.O.).

(3) Home deliveries performed by a Certified Nurse-Midwife are covered when the single state agency or its designee has prior authorized the home delivery.

(4) Certified Nurse-Midwives who manage the medical aspects of a case under the control and supervision of a physician in accordance with the rules of the State Board of Nursing and the Texas Nursing Practice Act will only be directly reimbursed by the Texas Medical Assistance Program for such services to the extent that they are performed under the written protocols required by the Board of Nursing and are not duplicative of other charges to the Medicaid program.

(5) For services other than Nurse-Midwife Services, other applicable provisions of this Title XIX State Plan and the Texas Medical Assistance Program will apply.

(6) Child birth education classes are not reimbursable.
17. **Nurse-Midwife Services (continued)**

(7) For purposes of coverage and reimbursement by the Texas Medical Assistance Program, deliveries by a Certified Nurse-Midwife, that are performed in a general or acute care hospital or a special hospital or facility such as a birthing center, must be done in a hospital or facility licensed and approved by the appropriate state licensing authority for the operation of maternity and newborn services and approved by the single state agency for participation in the Texas Medical Assistance Program.

(8) To participate in the Texas Medical Assistance program, a Certified Nurse-Midwife must identify the licensed physician or group of physicians with whom an arrangement has been made for referral and consultation in the event of medical complications. If the collaborating physician or group is not a participating provider in the Texas Medical Assistance Program, the Nurse-Midwife must inform recipients of their potential financial responsibility in accordance with requirements of the Texas Medical Assistance Program applicable to all Medicaid providers. If and when the physician or group with whom an arrangement has been made for referral and consultation in the event of medical complications is changed or cancelled, the CNM must notify the single state agency or its designee in writing of the identity of the new physician or group within two weeks after the cancellation or change.
18. Hospice Care.

The Texas Department of Aging and Disability Services (DADS) administers the Texas Medicaid Hospice Program through provider enrollment contracts with hospice agencies. These agencies must be licensed by the DADS and be Medicare certified as hospice agencies by the Centers for Medicare and Medicaid Services (CMS), Department of Health and Human Services. Coverage of services in the Texas Medicaid Hospice Program follows the amount, duration, and scope of services specified in the Medicare Hospice Program, with the following three exceptions:

1. The Texas Medicaid Hospice Program has unlimited benefit periods of unlimited duration.
2. The Texas Medicaid Hospice Program does not have a maximum number of days for which a recipient can receive hospice services under Medicaid.
3. The Texas Medicaid Hospice Program does not allow cost sharing to be imposed on Medicaid recipients for hospice services rendered to Medicaid recipients.

The recipient must file a Medicaid election statement with a particular Medicaid hospice provider. In doing so, the recipient waives rights to other Medicaid services that are related to the treatment of his or her terminal illness(es) with the exception of individuals less than 21 years of age. Individuals less than 21 years of age may receive concurrent hospice and acute care treatment. The recipient has the right to cancel the election at any time without forfeiting additional Medicaid hospice coverage at a later time. The recipient does not waive rights to Medicaid services for conditions not related to the terminal condition. Dually eligible (Medicare and Medicaid) recipients must participate in the Medicare and Medicaid hospice programs simultaneously in order to receive Medicaid hospice services.

HHSC meets the requirements of section 1905(o) of the Social Security Act and section 4305-4308 of the State Medicaid manual.

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State of Texas

Appendix 1 to Attachment 3.1-A
page 41

19. Case Management Services - Chronically Mentally Ill

See Supplement 1 to Attachment 3.1-A, page 1A
19. Case Management Services - Mentally Retarded or Related Conditions

See Supplement 1 to Attachment 3.1-A, page 1B
19. Case Management Services - Blind and Visually Impaired Children was deleted in SPA 17-0001:

Page 41b (TN-92-32)
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Appendix 1 to Attachment 3.1-A
page 41c

19. Case Management Services - High-Risk Pregnant Women

See Supplement 1 to Attachment 3.1-A, page 1D
State Plan Amendment /TN 07-016, approved in April 2009, deleted page 41d (TN 92-32)

See Supplement 1 to Attachment 3.1-A, page 1 F.
20.a. Extended Services To Pregnant Women - Pregnancy-related and Postpartum Services for 60 Days after the Pregnancy Ends.

Services within the amount, duration and scope of the Texas Medical Assistance Program contained in this state plan are available as pregnancy-related services, postpartum services, or services for any other medical condition that may complicate pregnancy when medically necessary and provided by a participating provider.
20.b. Extended Services To Pregnant Women - Services For Any Other Medical Conditions That May Complicate Pregnancy.

Services within the amount, duration and scope of the Texas Medical Assistance Program contained in this state plan are available as pregnancy-related services, postpartum services, or services for any other medical condition that may complicate pregnancy when medically necessary and provided by a participating provider.
21. Ambulatory Prenatal Care for Pregnant Women Furnished During a Presumptive Eligibility Period by a Provider (In Accordance With Section 1920 of The Act).

Provided with no limitations.
22. **Respiratory Care services.**

(a) In-Home Respiratory Therapy services are available through Medicaid in accordance with 42 CFR §440.185. Services are provided to Medicaid eligible recipients who:

1. are ventilator-dependent for life support at least six hours per day;
2. have been ventilator dependent for at least 30 consecutive days as an inpatient in one or more hospitals, skilled nursing facilities (SNF), or intermediate care facilities (ICF);
3. but for the availability of these respiratory care services at home, would require respiratory care as an inpatient in a hospital, SNF, or ICF; and would be eligible to have payment made for such inpatient care under the state Medicaid plan;
4. have adequate social support services to be cared for at home;
5. wish to be cared for at home; and
6. receive services under the direction of a physician who is familiar with the recipient's medical history and care, and who has medically determined that in-home care is safe and feasible for the individual.

(b) **Services:**

1. Medically necessary In-Home Respiratory Therapy services include:
   - (A) Respiratory therapy services and treatments prescribed by the recipient's physician.
   - (B) Education of the recipient and/or appropriate family members/support persons regarding the in-home respiratory care. Education must include the use and maintenance of required supplies, equipment, and techniques appropriate to the situation.
2. Disposable respiratory supplies are a benefit through Home Health and are not reimbursed to the certified respiratory therapist.

(c) **Providers:** In-Home Respiratory Therapy services must be provided by a Certified Respiratory Care Practitioner who is certified by the Department of State Health Services (DSHS) to practice under Texas Occupations Code § 604.051.

(d) **Place of Service:** In-Home Respiratory Therapy services must be delivered in the home setting.
23. **Services by Certified Family and Pediatric Practitioners.**

(a) Services performed by Certified Family and Pediatric Practitioners are covered if the services are within the scope of practice for an advanced practice nurse, as defined by state law; are consistent with rules and regulations promulgated by the Texas State Board of Nursing or other appropriate state licensing authority; and are covered services under the Texas Medical Assistance Program.

(b) Certified Family and Pediatric Practitioners are defined as registered nurses who are approved by the State Board of Nursing to practice as nurse practitioners and clinical nurse specialists as a result of graduation from an accredited program for the training of nurse practitioners and clinical nurse specialists. For services to be payable to these practitioners, the practitioner must be enrolled in and approved for participation in the Texas Medical Assistance Program; must sign a written agreement with the single state agency or its designee; must comply with the terms of the provider agreement and all regulations, rules, handbooks, standards, and guidelines published by the single state agency or its designee; and must bill for services covered by the Texas Medical Assistance Program in the manner and format prescribed by the single state agency or its designee.

(c) Certified Family and Pediatric Practitioners who are employed or remunerated by a physician may bill the Texas Medical Assistance Program and be paid directly for their services. (For the physician to bill, the practitioner must agree that charges for his or her services may be included in the other entity’s billing.) Services may not be billed by both the practitioner and the employing/contracting entity if that billing would result in duplicate payment for the same services. If the services are reimbursable by the program, payment may be made to the entity (if approved for participation in the Texas Medical Assistance Program) who employs or reimburses the practitioner. The basis and amount of Medicaid reimbursement depends on the services actually provided, who provided the service, and the reimbursement methodology utilized by the Texas Medical Assistance Program as appropriate for the services and provider(s) involved.
24.a. Transportation

Payment will be made for ambulance services, provided the following conditions are met and the services are provided in accordance with laws, regulations and guidelines governing ambulance services under Part B of Medicare.

A. To be covered, ambulance services must be medically necessary and reasonable. Medical necessity is established when the recipient's condition is such that use of any other method of transportation is contraindicated and no other suitable transportation is available. For a recipient receiving ambulance services, when some means of transportation other than ambulance could be used without endangering the recipient's health, no payment may be made for ambulance services.

B. Any recipient whose condition is such that use of any other method of transportation is contraindicated will be transported to and from the provider of his choice who is generally available and used by other residents of the community for any appropriate medical care included under the state agency's Title XIX plan. The transport must be prior authorized by the state agency or its designee.

If no participating provider of the appropriate care is available within the community, transportation will be to and from the nearest participating provider who can provide appropriate medical care included under the state agency's Title XIX plan.

Any recipient whose condition is such that use of any other method of transportation is not contraindicated will be transported to the nearest hospital, skilled nursing facility or other destination that would ordinarily be expected to have the appropriate facilities for the treatment of the injury or illness involved. Ambulance services from a hospital or skilled nursing facility to such recipient's home is covered if the recipient's home is within the locality of the hospital or skilled nursing facility or if the recipient's home is outside of the locality but such hospital or skilled nursing facility is the nearest one with appropriate facilities.
24.a. Transportation (Continued)

(Continued) The term "locality," with respect to ambulance service for recipient's whose condition is such that use of any other method of transportation is not contraindicated, means the service area surrounding the hospital or skilled nursing facility from which individuals normally come or are expected to come for hospital or skilled nursing services. The term "appropriate facilities," with respect to ambulance service for recipients whose condition is such that use of any other method of transportation is not contraindicated, means that the facility is generally equipped to provide the needed care for the illness or injury involved. It is the institution, its equipment, its personnel and its capability to provide the services necessary to support the required medical care that determine whether it has appropriate facilities.

C. The ambulance services must be provided by an ambulance service supplier and the ambulance must be equipped as an ambulance and operated by trained personnel in accordance with state laws, and under the appropriate rules, licensing, or regulations of the area in which the ambulance is operated.

In addition to limitations specified above, medical transportation is limited as follows:

- The use of medical transportation must be for health-related purposes.
- Reimbursement will not be made to Title XIX recipients.
- Payment for medical transportation to and/or from providers of covered Title XIX services on behalf of eligible recipients will be made only where transportation is not otherwise available through the individual recipient's family, friends or community resources who will provide the services free or transportation of any means other than ambulance is contraindicated and no other suitable transportation is available.
- Payment will only be made to approved medical transportation providers.
24.a. Transportation (Continued)

- Exceptions to the transportation provisions contained in this plan may be authorized by the Health and Human Services Commission or its designee when, in the opinion of the commission, circumstances of medical necessity warrant such exceptions.
- In order to be a covered benefit for which reimbursement may be made, the transportation provided must be appropriate to each eligible recipient’s particular combination of physical limitations, geographic location, and available source of care.
- Transportation for full benefit dual eligible recipients to obtain prescription medications covered under the Medicare Part D benefit will be provided at the same level of service, and under the same restrictions, as is offered to all Medicaid recipients.
24.b. Services provided in Religious Nonmedical Health Care Institutions.

Christian Science Sanatoria Services for which payment will be made are nursing facility services (as defined at 42 CFR 440.155) considered appropriate by the single state agency, which are provided to eligible recipients in Christian Science Sanatoriums that are operated by, or listed and certified by the First Church of Christ Scientists, Boston, Massachusetts.
State of Texas

24.c. Reserved
24.d Nursing Facility Services for Individuals Under 21 Years of Age.

Nursing facility services (other than services in an institution for mental disease) provided in a Title XIX nursing facility approved by the single state agency to eligible individuals are limited by a requirement for a medical necessity determination. The treating physician prescribes the nursing facility setting, and the state agency provides the medical necessity determination for which payment will be made.

Nursing facility services includes drugs that are reimbursed through the Vendor Drug Program. This encompasses all drugs contained in the resident's plan of care, subject to the drug rebate provision of Section 1927 of the Social Security Act.
Payment for emergency hospital services is limited to hospitals approved for Title XIX participation by the single state agency.
25. Birthing Center Facility Services.

1) Licensed or Otherwise State-Approved Freestanding Birth Centers

Provided:  ☐ No limitations  ☑ With limitations

Please describe any limitations:

Subject to the specifications, conditions, requirements, and limitations established by the single state agency or its designee, birthing center facility services under this State Plan are limited to birthing centers licensed by the State of Texas pursuant to the Texas Birthing Center Licensing Act (Texas Health & Safety Code Chapter 244) or other legally authorized licensing authority under applicable state laws to provide a level of service commensurate with the professional skills of a physician (M.D. or D.O.), a certified nurse-midwife (CNM), or licensed midwife (LM) who acts as the birth attendant. The center, the physician, CNM, and LM must be licensed at the time and place the services are provided. The birthing center must be enrolled and approved by the state agency or its designee to participate in the Texas Medical Assistance Program.

Coverage of birthing center facility services is limited to certain birthing services provided by the center and determined by the attending physician, CNM, or LM to be necessary for the care of the mother and live newborn child following the mother's normal, uncomplicated pregnancy. Reimbursable services are limited to facility services provided during the labor, delivery, and postpartum periods. Birthing center facility services furnished prior to or after the above described period are not considered birthing center facility services and are not covered or reimbursed as such under this State Plan. Services provided by a physician, CNM, or LM are not considered to be birthing center facility services. For services other than birthing center facility services, other applicable provisions of this Title XIX State Plan and the Texas Medical Assistance Program will apply.

2) Licensed or Otherwise State-Recognized covered professionals providing services in the Freestanding Birth Center

Provided:  ☐ No limitations  ☑ With limitations (please describe below)

☐ Not applicable (there are no licensed or State-approved freestanding birth centers)

Please describe any limitations:

Subject to the specifications, conditions, requirements, and limitations established by the single state agency or its designee, the State will reimburse an LM for a service in accordance with provisions of the State Plan only if the LM is licensed by the State of Texas pursuant to the Texas Midwifery Act or other legally authorized licensing authority under applicable state laws to provide...
25. Birthing Center Facility Services (continued).

services consistent with rules and protocols promulgated by the Texas Midwifery Board or other appropriate state licensing authority that are provided in a freestanding birthing center. The services must be within the LM's scope of practice, as defined by state law and permitted by the freestanding birthing center, and must be one of the following: prenatal care; labor and delivery; postpartum care immediately following delivery and until discharge or transfer from the freestanding birthing center; or newborn care immediately following delivery and until discharge or transfer from the freestanding birthing center.

Please check all that apply:

☒ (a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan (i.e., physicians and certified nurse midwives).

☒ (b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife). *

☐ (c) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.).*

*For (b) and (c) above, please list and identify below each type of professional who will be providing birth center services:

Licensed midwives who are licensed by the State of Texas.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State: _____ TEXAS _____

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26. Personal Care Services

Subject to the specifications, conditions, and limitations established by the Texas Department of Aging and Disability Services, payments will be made for Personal Care Services as defined at 42 CFR 440.167 when provided to eligible recipients by providers who are approved by and under contract with the Texas Department of Aging and Disability Services.

A. Prior approval to provide services is required in all cases.

B. Providers of Personal Care Services must meet qualifications established by the Texas Department of Aging and Disability Services.

C. Services are limited to the lesser of:
   - no more than fifty (50) hours per week per recipient,
   - the number of hours per week per recipient that may be provided within the limit of the cost of the average Medicaid nursing facility rate for recipients whose assessed medical needs can be met by long-term, non-technical medical observation and authorized assistance with the activities of daily living that are necessary because of a chronic medical condition complicated by functional limitations. *

D. As a condition for payment, Personal Care Services must be the primary need and may not be substituted for services needed to bring about improvement of an acute medical condition.

E. The range of Personal Care Services to be provided is established by an assessment of the recipient's medical and functional needs. Reassessment of the functional need and authorization for continued Personal Care Services are required at least every twelve months.

F. A recipient's home is the recipient's full time abode but does not include a hospital, nursing facility, intermediate care facility for the mentally retarded, institution for mental disease, or any other setting in which Personal Care Services are already available or could be made available by family members or sources outside the Personal Care Program. Personal care services may be provided in alternate locations outside the home.

* Durational, dollar, and quantity limits are waived for recipients of EPSDT services. Personal Care Services allowable under the title XIX of the Social Security Act and its implementing regulations may be covered when medically necessary for these recipients.

SUPERSEDES: TN. 02-01
26. Personal Care Services (Continued).

G. A family member is defined as an individual with a duty under the Texas Family Code, Sections 2.501 and 151.001, to support the recipient, i.e., spouse for spouse and parent for minor child.

H. The provider must maintain records and submit reports and other information specified by the Texas Department of Aging and Disability Services.

I. Personal care services are supervised by an employee designated as "supervisor" when provided by an agency under contract with the Texas Department of Aging and Disability Services to provide personal care services.
28. Any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary (in accordance with section 1905(a)(29) of the Social Security Act and 42 C.F.R. § 440.170)

a. Transportation (provided in accordance with 42 C.F.R. § 440.170) excluding "school-based" transportation

☐ Not provided
☒ Provided without a broker as an optional medical service

☐ Non-emergency transportation is provided through a brokerage program as an optional medical service in accordance with 1902(a)(70) of the Social Security Act and 42 C.F.R. § 440.170(a)(4).
28. Any other medical care (continued)
   a. Transportation (continued)

   As an optional service, the following nonemergency medical transportation (NEMT) services meet the definition outlined in the Medicaid regulations (at 42 CFR 440.170(a)) and all other requirements relating to Medicaid services. These services include:

   (i) **Demand response transportation services.** Curb to curb transportation that involves using a transportation provider, including a transportation network company, who dispatches vehicles in response to requests for individual or shared one-way trips. Demand response transportation services are provided when fixed route services are either unavailable or do not meet the health care needs of clients. Services must be timely and provided by licensed, qualified, courteous, knowledgeable, and trained personnel.

   (ii) **Mass transit.** Transportation by bus, rail, air, ferry, or intra-city bus, either publicly or privately owned, which provides to the public general or special service on a regular and continuing basis. Mass transit is intercity or intra-city transportation. Mass transit also involves using commercial air service to transport an eligible Medicaid recipient to an authorized covered Medicaid service.

   The single state agency purchases tickets from intra-city and intercity mass transit providers (e.g., bus, rail, air) with state funds as an administratively efficient way to assure the availability of NEMT service by participating mass transit providers for eligible recipients whose medical conditions allow. The claim for FFP will not be made until an eligible recipient uses the ticket to obtain transportation for a necessary medical service.

   (iii) **Individual Transportation Participant.** Transportation by an individual transportation participant (ITP) who is approved for mileage reimbursement at a prescribed rate to provide transportation for a prior authorized MTP client to a prior authorized health care service.

   **Exclusion:** Mileage reimbursement made directly to a Medicaid beneficiary or to a beneficiary’s immediate family member (ITP-Self) does not qualify for the federal medical assistance percentage (FMAP) match.

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28. Any other medical care (continued)
   a. Transportation (continued)

   (iv) **Lodging.** Transportation-related services authorized by the single state agency to provide overnight lodging for eligible recipients in conjunction with a healthcare service. Lodging services are arranged through a lodging establishment (e.g., hotel, motel, charitable home, or hospital that provides overnight lodging), that has agreed to provide lodging paid by the single state agency. Direct payment is made to a lodging establishment either as a reimbursement or direct bill or up front utilizing the State credit card.

   **Exclusion:** Reimbursement of eligible lodging expenses directly to a Medicaid beneficiary or to a beneficiary’s immediate family member is not eligible for FMAP.

   (v) **Meals.** Transportation-related services authorized by the single state agency for the purpose of funding meals for eligible recipients during an extended stay away from the recipient’s residence.

   **Exclusion:** Reimbursement of eligible meal expenses directly to a Medicaid beneficiary or to a beneficiary’s immediate family member is not eligible for FMAP.

   (vi) **Advanced Funds.** Transportation-related services authorized by the single state agency and provided in advance and disbursed by the financial services vendor to a recipient, responsible party, or Individual Transportation Participant (ITP) for the purpose of funding transportation or transportation-related services (e.g., gasoline, meals and/or lodging, etc.). The state’s claim for FFP in these expenditures will not be made until after the recipient has received the medical care for which the expenditures were necessary.

   (vii) **Attendant.** Cost to transport parent, responsible party, or services animal who accompanies a recipient for the purpose of providing necessary mobility or personal or language assistance to the recipient during the time that transportation and healthcare services are provided. Additionally, if a services animal is authorized to accompany a beneficiary, the state reimburses the provider for the space occupied by the services animal at the rate established in the services area for an adult attendant.
28. Any other medical care (continued)
   a. Transportation (continued)

Exclusion of Transportation by a Prescribed Pediatric Extended Care Center (PPECC)

Transportation provided by a prescribed pediatric extended care center (PPECC) is not included as a non-emergency transportation service.
AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

General exclusions and limitations applicable to the amount, duration, and scope of medical and remedial care and services provided under this State Plan.

On behalf of the categorically needy, only reasonable costs or reasonable charges as applicable for medical or remedial care will be paid when the items of care furnished are medically necessary for diagnosis, treatment, or both, subject to exclusions and limitations applicable to specific services and third party liability. These exclusions and limitations do not apply to the services covered by the Texas Health Steps Comprehensive Care Program.

The benefits of this program do not include:

1. Services provided to any individual who is an inmate in a public institution (except as a patient in a medical institution approved for participation in the Medicaid program), or is a patient in:
   (A) the hospital or nursing sections of institutions for individuals with intellectual disabilities, or
   (B) an institution for mental disease if the patient is between the ages of 22 and 64;

2. Special shoes or other supportive devices for the feet and ambulation aids (except as provided for in the home health services program);

3. Any services provided by military medical facilities, except:
   (A) military hospitals enrolled to provide inpatient emergency services,
   (B) Veterans Administration facilities, or
   (C) United States Public Health Service hospitals;

4. Care and treatment related to any condition covered by workmen's compensation laws;

5. Care, treatment or other services by a doctor of dentistry unless:
   (A) the recipient's dental diagnosis is causally related to a life-threatening medical condition; or
   (B) the treatment is specifically authorized by the Health and Human Services Commission (HHSC) or its designee;

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Supersedes TN: 09-09
AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORYCALLY NEEDY

6. Any care or services to the extent that a benefit is paid or payable under Medicare;

7. Any services or supplies provided to an individual before the effective date of designation by HHSC as an eligible recipient or after the effective date of denial as an eligible recipient except orthodontic services that are authorized and initiated while the recipient is eligible for Medicaid may be continued for 36 months after a recipient is no longer Medicaid eligible;

8. Any services or supplies provided in connection with cosmetic surgery except as required for the prompt repair of accidental injury or for improvement of the functioning of a malformed body member or as required by federal law;

9. Immunizations specifically for travel to or from foreign countries. Immunizations included on the immunization schedule approved by the Advisory Committee on Immunization Practices (ACIP) are a benefit unless an immunization is specifically excluded by HHSC;

10. Any services provided by an immediate relative of the eligible recipient or member of the eligible recipient’s household except for personal care services;

11. Custodial care;

12. Any services or supplies provided outside of the United States, except for deductible and co-insurance portions of Medicare benefits as provided for in this plan;

13. Any service or supplies not provided for in this plan;

14. Any services or supplies to the extent that benefits are available for such services or supplies under any other contract or policy of insurance, or would have been so available in the absence of this contract.

15. Any services or supplies not provided for in this plan for:

   (A) the treatment of flat foot conditions and the prescription of supportive devices therefor;

   (B) the treatment of subluxations of the foot; or

   (C) routine foot care (including the cutting or removal of corns, warts, or calluses, the trimming of nails, and other routine hygiene care);

TN No. 09-09 Approval Date 3-4-10 Effective Date 1-1-10

Supersedes TN No. 94-10
16. Any services or supplies that are experimental or investigational;

17. Outpatient behavioral health benefits to an individual for the diagnosis or treatment of mental disease, psychoneurotic, and personality disorders while not confined as an inpatient in a hospital which exceed 30 visits to enrolled practitioners per calendar year. This utilization control limitation may be exceeded when prior authorized on a case by case basis;

18. Services provided by ineligible or suspended providers;

19. Any service or supplies for which claims were not submitted within the filing deadline.

20. Institutional Care, separate payments are not made for services and supplies in an institution where the reimbursement formula and vendor payment include such services or supplies as a part of the institutional care.
1915(j) Self-Directed Personal Assistance Services State Plan Amendment Pre-Print

Citation

3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)

1915(j) ☑ Self-Directed Personal Assistance Services, as described and limited in Appendix 3 to Attachment 3.1-A.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy.

SUPERSEDES: NONE - NEW PAGE

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1024. The time required to complete this information collection is estimated to average 20 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
State of Texas

1915(j) Self-Directed Personal Assistance Services State Plan Amendment Pre-Print

Amount, Duration, and Scope of Medical and Remedial Care Services Provided To the Categorically Needy

- Self-Directed Personal Assistance Services, as described in Appendix 3 to Attachment 3.1-A.

  - Election of Self-Directed Personal Assistance Services: By virtue of this submittal, the State elects Self-Directed Personal Assistance Services as a State Plan service delivery option.

  - No election of Self-Directed Personal Assistance Services: By virtue of this submittal, the State elects not to add Self-Directed Personal Assistance Services as a State Plan service delivery option.
Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation.

State of Texas
1915(j) Self-Directed Personal Assistance Services State Plan Amendment Pre-Print

i. Eligibility

The State determines eligibility for Self-Directed Personal Assistance Services:

A. ☑ In the same manner as eligibility is determined for traditional State Plan personal care services, described in Item 4b page 7f, Item 25, and Item 26 of the Medicaid State Plan.

B. ☐ In the same manner as eligibility is determined for services provided through a 1915(c) Home and Community-Based Services Waiver.

ii. Service Package

The State elects to have the following included as Self-Directed Personal Assistance Services:

A. ☑ State Plan Personal Care and Related Services, to be self-directed by individuals eligible under the State Plan.

B. ☐ Services included in the following section 1915(c) Home and Community-Based Services waiver(s) to be self-directed by individuals eligible under the waiver(s). The State assures that all services in the impacted waiver(s) will continue to be provided regardless of service delivery model. Please list waiver names and services to be included.

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TN No. 09-36 Approval Date 7-29-09 Effective Date 11-3-08

Supersedes TN No. SUPERSEDES: NONE - NEW PAGE
iii. Payment Methodology

A. [ ] The State will use the same payment methodology for individuals self-directing their PAS under section 1915(j) than that approved for State plan personal care or for section 1915(c) Home and Community-Based waiver services.

B. [x] The State will use a different payment methodology for individuals self-directing their PAS under section 1915(j) than that approved for State plan personal care services or for section 1915(c) Home and Community-Based waiver services.

iv. Use of Cash

A. [ ] The State elects to disburse cash prospectively to participants self-directing personal assistance services. The State assures that all Internal Revenue Service (IRS) requirements regarding payroll/tax filing functions will be followed, including when participants perform the payroll/tax filing functions themselves.

B. [x] The State elects not to disburse cash prospectively to participants self-directing personal assistance services.

v. Voluntary Disenrollment

The State will have the following safeguards in place to ensure continuity of services and assure participant health and welfare during the period of transition between self-directed and traditional service delivery models.

An individual may voluntarily terminate participation in the consumer-directed services (CDS) option at any time by notifying the individual's case manager/service coordinator. Within 14 calendar days of the individual's request, the case manager will:

1. provide the individual with a choice of possible agency providers;
2. notify the agency provider of the individual’s choice; and
3. negotiate an end date for the CDS option and a start date for the agency option with no break in service.

The individual's case manager/service coordinator assists the individual to ensure continuity of PAS services through the traditional agency service delivery option (provider-managed service delivery) and maintenance of the individual's health and welfare during the transition from the CDS option.
The following is a discussion of the general roles and responsibilities of case management, support consultation, and financial management services.

**Case management**
Case management is provided by case managers/service coordinators and focuses on service planning. Service planning is conducted in the same manner for those who are self-directing and for those who are using traditional provider-managed personal assistance services.

Case Manager/Service Coordinator responsibilities include:

- presenting the CDS option when individuals enroll and at the annual review;
- working through consumer self-assessment to determine if the persons interested in using the CDS option would benefit from a Designated Representative or a Support Advisor;
- determining, along with individual, the need for services, including Support Consultation, service unit levels, the tasks to be performed, and the goals of the service;
- developing the service plan;
- determining the need for a back-up service plan;
- approving service back-up plans;
- facilitating transfer to the CDS option by sending the referral form, the service plan, the back-up plan, and the consumer self-assessment to the Consumer Directed Services Agency (CDSA) of the person’s choosing;
- approving corrective action plans;
- receiving and reviewing quarterly reports from the CDSA;
- initiating a corrective action plan, if needed;
- conducting monitoring visits;
- approving termination from the CDS option; and
- facilitating voluntary and involuntary disenrollment from the CDSA option.

**Support Consultation**
Support consultation, provided by Support Advisors, is a service available exclusively to those who use self-direction and focuses on supporting the individual as employer in carrying out the employer functions. Support consultation is an optional service available to all individuals who choose to direct their own services.
Support Advisor responsibilities include:
• assisting, as needed, with developing the risk-planning checklist and CDS Support plan, including the service back-up plan and identified needs of additional coaching and support;
• assisting, as necessary, with the implementation of the CDS Support plan;
• providing coaching and mentoring related to being an employer; and
• assisting with completion of forms related to the hiring process.

Support Advisors do not play a role in voluntary disenrollment. Support Advisors will not monitor health and welfare, which is the responsibility of the case managers/service coordinators. However, Support Advisors are required to inform case managers/service coordinators of any health or safety issues. A Support Advisor must notify the individual’s case manager or service coordinator:

(1) when service goals have been met;
(2) if the person receiving support consultation is unable or unwilling to cooperate with service delivery; or
(3) of the progress and status of the service required by the individual’s program.

Financial Management Services
Financial Management Services are provided by Consumer Directed Services Agencies (CDSA) to individuals who serve as the common law employer of their providers.

CDSA functions include:
• providing the consumer with an initial orientation to CDS, which includes a review of rules and requirements as well as roles and responsibilities;
• providing ongoing training and support to the consumer;
• assisting with conducting required criminal history checks and other required checks, such as the Nurse Aide Registry and Employee Misconduct Registry;
• verifying citizenship status and qualifications of employees and applicants for employment;
• maintaining documentation of the appointment of a designated representative;
• approving and monitoring budgets;
• providing assistance in determining staff wages and benefits subject to State limits;
• monitoring continued eligibility of employees;
• preparing and filing applicable tax forms and reports;
• assisting with budget development;
• approving in writing budgets and budget revisions;
• paying allowable expenses incurred by the consumer;
• preparing a quarterly budget status report;
• acting as employer-agent for the consumer by handling payroll withholdings, tax deposits, reporting, timesheets, receipts and invoices and paying service providers;
• retaining copies of consumer back-up plans;
• conducting an annual satisfaction survey with the consumer;
• reporting consumer noncompliance to the state-employed caseworker;
• initiating interventions and corrective action plans; and
• recommending termination of the CDS option for consumer noncompliance.

When an individual voluntarily leaves the CDS option, the CDSA closes the employer’s payroll and payable accounts and completes all deposits and filings of required reports with governmental agencies on behalf of the individual.

After 90 days, the individual may choose to re-enroll in the CDS option.

vi. Involuntary Disenrollment

A. The circumstances under which a participant may be involuntarily disenrolled from self-directing personal assistance services, and returned to the traditional service delivery model are noted below.

Involuntary termination of the CDS option may occur when either:

(1) the individual’s case manager/service coordinator, in consultation with the Support Advisor if the individual is utilizing that support service, and the CDSA, determine that continued participation in the CDS option would not permit the individual’s health and welfare to be met; or

(2) the individual’s case manager/service coordinator, in consultation with the CDSA or DADS staff, determines that the individual or the
individual's representative, when provided with additional support from the CDSA or Support Advisor, has not carried out employer responsibilities in accordance with requirements of the option.

Within 14 calendar days, or earlier if based on health and welfare concerns, the case manager will coordinate the transfer to the traditional provider-delivered services, as long as the individual remains eligible to receive State Plan Personal Care benefit. The case manager/service coordinator will:

1. inform the individual of the reason for terminating the CDS option;
2. inform the individual of his or her right to a fair hearing;
3. provide the individual with a choice of possible agency providers;
4. notify the provider of the individual’s choice;
5. negotiate an end date for the CDS option and a start date for the agency option with no break in service; and
6. if the individual appeals, and if the decision for termination is upheld following the fair hearing process, the case manager coordinates the termination of services.

B. The State will provide the following safeguards in place to ensure continuity of services and assure participant health and welfare during the period of transition between self-directed and traditional service delivery models.

The individual’s case manager assists the individual with changing from CDS to the traditional agency service delivery option (provider-managed service delivery) to ensure no break in service in order to maintain the individual’s health and welfare.

For individuals whose health and welfare are at risk, the case manager will facilitate an immediate transfer to a provider and ensure that CDS back-up plans are utilized until the transfer date to the agency option. If necessary, the case manager may utilize other resources to ensure health and welfare.

The CDSA closes the employer’s payroll and payable accounts and completes all deposits and filings of required reports with governmental agencies on behalf of the individual.
vii. Participant Living Arrangement

Any additional restrictions on participant living arrangements, other than homes or property owned, operated, or controlled by a provider of services, not related by blood or marriage to the participant are noted below.

**The State has no additional restrictions on the individual's living arrangement.**

viii. Geographic Limitations and Comparability

A. ☑ The State elects to provide self-directed personal assistance services on a statewide basis.

B. ☐ The State elects to provide self-directed personal assistance services on a targeted geographic basis. Please describe:

C. ☑ The State elects to provide self-directed personal assistance services to all eligible populations.

D. ☐ The State elects to provide self-directed personal assistance services to targeted populations. Please describe:

E. ☑ The State elects to provide self-directed personal assistance services to an unlimited number of participants.

F. ☐ The State elects to provide self-directed personal assistance services to _______ (insert number of) participants, at any given time.

ix. Assurances

A. The State assures that there are traditional services, comparable in amount, duration, and scope, to self-directed personal assistance services.

B. The State assures that there are necessary safeguards in place to protect the health and welfare of individuals provided services under this State Plan Option, and to assure financial accountability for funds expended for self-directed personal assistance services.

**SUPERSEDES: NONE - NEW PAGE**
C. The State assures that an evaluation will be performed of participants’ need for personal assistance services for individuals who meet the following requirements:
   i. Are entitled to medical assistance for personal care services under the Medicaid State Plan; or
   ii. Are entitled to and are receiving home and community-based services under a section 1915(c) waiver; or
   iii. May require self-directed personal assistance services; or
   iv. May be eligible for self-directed personal assistance services.

D. The State assures that individuals are informed of all options for receiving self-directed and/or traditional State Plan personal care services or personal assistance services provided under a section 1915(c) waiver, including information about self-direction opportunities that is sufficient to inform decision-making about the election of self-direction and provided on a timely basis to individuals or their representatives.

E. The State assures that individuals will be provided with a support system meeting the following criteria:
   i. Appropriately assesses and counsels individuals prior to enrollment;
   ii. Provides appropriate counseling, information, training, and assistance to ensure that participants are able to manage their services and budgets;
   iii. Offers additional counseling, information, training, or assistance, including financial management services:
   iv. At the request of the participant for any reason; or
   v. When the State has determined the participant is not effectively managing their services identified in their service plans or budgets.

F. The State assures that an annual report will be provided to CMS on the number of individuals served through this State Plan Option and total expenditures on their behalf, in the aggregate.

G. The State assures that an evaluation will be provided to CMS every 3 years, describing the overall impact of this State Plan Option on the health and welfare of participating individuals, compared to individuals not self-directing their personal assistance services.

H. The State assures that the provisions of section 1902(a)(27) of the Social Security Act, and Federal regulations 42 CFR 431.107, governing provider agreements, are met.
I. The State assures that a service plan and service budget will be developed for each individual receiving self-directed PAS. These are developed based on the assessment of needs.

J. The State assures that the methodology used to establish service budgets will meet the following criteria:
   i. Objective and evidence based, utilizing valid, reliable cost data.
   ii. Applied consistently to participants.
   iii. Open for public inspection.
   iv. Includes a calculation of the expected cost of the self-directed PAS and supports if those services and supports were not self-directed.
   v. Includes a process for any limits placed on self-directed services and supports and the basis/bases for the limits.
   vi. Includes any adjustments that will be allowed and the basis/bases for the adjustments.
   vii. Includes procedures to safeguard participants when the amount of the limit on services is insufficient to meet a participant’s needs.
   viii. Includes a method of notifying participants of the amount of any limit that applies to a participant’s self-directed PAS and supports.
   ix. Does not restrict access to other medically necessary care and services furnished under the plan and approved by the State but not included in the budget.

x. Service Plan

The State has the following safeguards in place, to permit entities providing other Medicaid State Plan services to be responsible for developing the self-directed personal assistance services service plan, to assure that the service provider’s influence on the planning process is fully disclosed to the participant and that procedures are in place to mitigate that influence.

The State does not permit entities providing other Medicaid State Plan services to be responsible for developing the individual’s self-directed personal assistance service plan.

xi. Quality Assurance and Improvement Plan

The State’s quality assurance and improvement plan is described below, including:

i. How it will conduct activities of discovery, remediation, and quality improvement in order to ascertain whether the program meets assurances, corrects shortcomings, and pursues opportunities for improvement; and
ii. The system performance measures, outcome measures, and satisfaction measures that the State will monitor and evaluate.

Consumer Directed Services are monitored for quality assurance and improvement under the authority of the Texas Health and Human Services Commission (HHSC), the State Medicaid agency, under the auspices of its operating agency, the Texas Department of Aging and Disability Services (DADS).

The State seeks to discover areas of non-compliance related to health and welfare or financial accountability and remediate any identified issues in order to improve services. The State wants to evaluate whether:

- a participant-driven approach is used;
- choice in service delivery models is available; and
- supports for participant direction are in place and are effective for participants.

Activities of discovery, remediation, and quality improvement:
HHSC adopted rules (40 Tex. Admin. Code, Ch. 41, effective January 1, 2007) governing the CDS option. These rules define a comprehensive program to assure appropriate and effective support and oversight for individuals who choose Self-Directed Personal Assistance Services through the State’s CDS option. Adherence to and enforcement of these rules, and the documentation required, provide the basis for activities of discovery, remediation, and quality improvement for system performance measures, outcome measures, and satisfaction measures. The rules address the following areas:

- enrollment and service planning;
- responsibilities of employers and designated representatives;
- enrollment and responsibilities of CDSAs;
- enrollment process, transfer, suspension, and termination;
- budgets;
- support consultation services and Support Advisor responsibilities;
- reporting allegations; and
- oversight.
Methods of discovery:
On-site monitoring of the CDSAs is conducted by the DADS contracting unit every other year. The analysis is based on a sample of 30 cases. Monitoring focuses on ensuring financial accountability and participant health and welfare and involves verification of the following:

- polices and procedures are in place and are working as they are supposed to;
- criminal background checks are completed;
- a CDSA Orientation is completed in person with each participant;
- the consumer budget was developed on the DADS-approved budget workbook;
- payroll and tax functions are carried out;
- individuals were informed of the complaint procedure and how to report abuse, neglect, and exploitation (ANE); and
- all billing can be supported with documentation.

The information obtained from the monitoring reviews is recorded and tracked using a data base.

The Participant Experience Survey (PES) is a survey instrument designed for older adults and adults with physical disabilities. The Quality Assurance and Improvement (QAI) unit at DADS uses the PES instrument every year as part of the Long Term Services (LTS) and Supports Quality Review process. Each year, QAI selects a subset of DADS programs for review through a rotating schedule of all programs. The State Plan Personal Care Services benefit will be included in reviews in even numbered years (e.g. 2010, 2112) as part of the review process. The findings are shared with program staff to determine areas for quality improvement. The results are compiled into a report that is posted on the agency’s website:

State law (Government Code, Section 2114.002) requires that Texas state agencies biennially submit to the Governor’s Office of Budget Planning and Policy (GOBPP) and the Legislative Budget Board (LBB) information gathered from customers on the quality of agency services. In 2006, the Texas Health and Human Services Commission (HHSC) contracted with the Survey Research Center at the University of North Texas (UNT) to conduct a mail survey of a random sample of individuals from six programs within the Texas Health and Human Services (HHS) system. The purpose of the survey is to obtain customer opinions of their interactions with Texas Health and
Human Services departments, including DADS’ community Medicaid entitlement programs. The 2006 report is available at http://www.hhsc.state.tx.us/reports/Customer_Service.pdf.

Up to this point, questions on the CDS option have not been included in the survey. While the survey is administered to DADS consumers, there has been no specific sampling methodology to target those who use the CDS option. The State will be redesigning the survey and the sampling approach by the end of 2011 and plans to include a focus on CDS.

Each CDSA is required to assess consumer satisfaction with Financial Management Services (FMS) annually, when participants transfer away from the CDSA, or when participants terminate the CDS option. DADS reviews these satisfaction surveys during on-site monitoring reviews.

DADS tracks complaints from participants, family members and interested other parties that come into the complaint hotline related to the CDS option. These complaints are logged in a data base.

Activities of remediation:
Each complaint is addressed by DADS staff by talking with the participant or family member and, if necessary, directly with the Consumer Directed Services Agencies (CDSA) as a follow up to the initial complaint.

Activities of quality improvement:
- follow up on corrective action plans;
- follow up on contract sanctions;
- enhance training and improve technical support;
- require additional training;
- enact policy modifications in response to consumer satisfaction surveys; and
- implement recommendations from the Consumer Direction Workgroup.

The State provides the CDSAs and Support Advisors with additional training if monitoring results indicate problems with billing, producing quarterly reports for consumer and case manager or service coordinators, criminal history check(s) were not completed, or a back-up plan was not in place. The expectation from the training of the CDSAs and Support Advisors is that they would be better able to educate and support consumers. DADS holds quarterly conference calls with the CDSAs to discuss any implementation issues.
System Performance Measures will be reviewed every other year by DADS contract monitoring staff. Measures include:

- 100 percent of CDSA reviews show compliance with the requirement to perform criminal history, Nurse Aide Registry, and Employee Misconduct Registry checks before hiring a non-licensed provider;
- 100 percent of CDSA reviews show compliance with the requirement to inform the individual and/or the designated representative about how to report allegations of abuse, neglect or exploitation;
- 100 percent of CDSA reviews indicate that participants have been informed of the complaint procedures;
- 100 percent of on-site CDSA reviews show compliance with the requirement that service providers are qualified and trained as required;
- 100 percent of CDSA reviews show that the requirement for a service back-up plan is in place;
- 100 percent of on-site CDSA reviews include evidence that quarterly budget reports were sent to individual employers and case managers or service coordinators;
- 100 percent of on-site CDSA reviews show evidence that CDSAs provided individual employers with copies of their CDS budgets; and
- 100 percent of on-site CDSA reviews show evidence that service plans were followed, time sheets were processed correctly, the employment taxes were filed and paid, and invoices were paid.

Outcome Measures will be collected and analyzed every other year through contract monitoring and the Participant Experience Survey (PES). Outcome measures include the following:

- 90 percent of participants have maximum control in selecting, managing and supervising their personal assistance services;
- 90 percent of participants have the amount of support they desire to self-direct services;
- 100 percent of participants’ health and safety is not adversely affected; and
- 2 percent or fewer participants are involuntarily terminated from the CDS option.
Satisfaction Measures will be collected and analyzed annually from information collected by the CDSAs. Measures include:

- 90 percent of participants are satisfied with their choice and flexibility in managing their services;
- 90 percent of participants are satisfied with their FMS provider; and
- 90 percent of participants are satisfied with their Support Advisor.

DADS defines critical events under the CDS option as those events that:
1. occur because of the individual's participation in the CDS option, and
2. jeopardize the individual's health or welfare.

Complaints filed with Consumer Rights and Services, a department within the Department of Aging and Disability Services (DADS) are tracked, investigated and resolved as soon as possible. Complaint intake has an automated system for keeping track of complaints.

Complaints include any dissatisfaction expressed by a person, orally or in writing, to the DADS Consumer Rights and Services Department about any matter related to a program service. Subjects of complaints specifically related to the CDS option include:
1. the quality of Financial Management Services (FMS) provided;
2. failure of a CDS employer to follow CDS option rules;
3. alleged abuse, neglect or exploitation of an individual using the CDS option by the service provider hired by the CDS employer; and
4. failure by the provider hired by the CDS employer to respect the individual's rights.

Case managers/service coordinators have the primary responsibility for monitoring the health and welfare of all participants—those who use the CDS option and those who use traditional provider-managed services. However, Support Advisors are required to inform case managers of any health or safety issues. A Support Advisor must notify the individual's case manager or service coordinator:
1. when service goals have been met;
2. if the person receiving support consultation is unable or unwilling to cooperate with service delivery; or
3. of the progress and status of the service required by the individual's program, including not meeting service goals.

The CDSAs are required to send the consumer and the case manager or service coordinator a quarterly report. This report indicates any under-
utilization or over-utilization of services by showing the amount of funds expended to date for each service category versus the projected spending amount. CDSAs also include in this report, if warranted, information about issues or concerns related to the individual’s participation in the CDS option. The quarterly reporting is the minimum requirement. Employers, Designated Representatives or case managers/service coordinators may request the report more frequently, as needed.

The CDSAs can also ask the consumer to complete a corrective action plan if the employer: hires an ineligible service provider; submits incomplete, inaccurate, or late documentation of service delivery; does not follow the budget; does not comply with program requirements related to the CDS option; does not meet service plan outcomes; or does not meet other employer responsibilities.

If requested by the case manager/service coordinator or CDSA, the participant must develop a corrective action plan, which must be approved by the case manager/service coordinator. The participant may request assistance from the Support Advisor to develop and implement the corrective action plan. If the participant has not implemented the corrective action plan, or if the corrective action plan is not working, the case manager can involuntarily terminate the participant from the CDS option. If the participant’s health and safety is in immediate jeopardy, he or she may be asked to return to the agency option for at least 90 days.

xii. Risk Management

A. The risk assessment methods used to identify potential risks to participants are described below.

As part of the initial CDS decision-making process, individuals or their legally authorized representative are required to complete a Consumer Self-Assessment, which asks the individual to identify areas related to recruiting, hiring and supervising attendants in which they may need additional support. If the individual or legally authorized representative cannot complete the assessment and chooses to use the CDS option, a designated representative, selected by the consumer or legally authorized representative, must complete the assessment and assist with employer tasks.
B. The tools or instruments used to mitigate identified risks are described below.

**Risk-Planning Checklist.** At the first meeting with the CDSA, individuals will be given the Risk-Planning Checklist to discuss with their Support Advisor. This instrument lists many common risk factors, ranging from physical to cognitive disabilities, and social issues such as social isolation.

**CDS Support Plan.** This plan includes risks that the individual will assume and strategies to mitigate any risks identified based on the Risk-Planning Checklist.

C. The State’s process for ensuring that each service plan reflects the risks that an individual is willing and able to assume, and the plan for how identified risks will be mitigated, is described below.

**Information from Consumer Self-assessment Tool,** in conjunction with discussion with the consumer or legally authorized representative, will be used to determine if the individual would benefit from Support Consultation and, if so, the number of hours to be authorized on the individual’s service plan. In addition, the Support Advisor uses this self-assessment as a guide to provide education and coaching to the individuals while they are using the CDS option.

**CDSA orientation**

Once an individual or legally authorized representative has selected the CDS option, he or she must select a CDSA that will provide financial management services such as registering as the individual’s employer-agent with the IRS and conducting payroll and tax functions. The CDSA is required to provide an in-person orientation before the individual can begin to use the CDS option. At the orientation, the CDSA explains the roles and responsibilities of using the CDS option, assists with developing the consumer budget, and reviews the requisite forms to be completed during the hiring process. Individuals may also use a designated representative (DR) to carry out employer functions. If the individual decides to use a designated representative, the individual will work with the CDSA to determine which specific employer tasks the DR will assume. To prevent over- and under-utilization, CDSAs are required to send to the individual and the case manager a quarterly report summarizing the amount of funds expended and the number of hours used.
Support Advisor training and on-going support

All individuals will have access to Support Consultation. The individual either elects to use a Support Advisor provided by the CDSA or has the opportunity to use a Support Advisor from the list of certified Support Advisors provided by the State. After meeting with the CDSA, the individual can begin to use the Support Advisor. The Support Advisor and the individual review and discuss the Risk-Planning Checklist and Consumer Self-Assessment tool to complete the CDS Support Plan, which identifies the risks the individual will assume and any needed areas of coaching and assistance. A copy of the CDS Support Plan is sent to the CDSA and the case manager/service coordinator.

Service back-up plan

In addition, individuals using the CDS option must complete a service back-up plan. This plan includes reasons for implementing the back-up plan, multiple back-up plan strategies (including informal supports), specific actions to be taken in the absence of service delivery, and contact information for each back-up strategy. Support Advisors can assist employers with the development of the back-up plan.

D. The State’s process for ensuring that the risk management plan is the result of discussion and negotiation among the persons designated by the State to develop the service plan, the participant, the participant’s representative, if any, and others from whom the participant may seek guidance, is described below.

Under the CDS option, the individual is the key driver in the development of the service plan, the CDS Support Plan and the back-up plan. The individual is responsible for completing the CDS Support Plan and the back-up plan with the assistance of the Support Advisor and approval by the case manager. The individual is responsible for ensuring that the CDSA and the case manager/service coordinator has a copy of the CDS Support Plan.
xiii. Qualifications of Providers of Personal Assistance

A. ☐ The State elects to permit participants to hire legally liable relatives as paid providers of the personal assistance services identified in the service plan and budget.

B. ☒ The State elects not to permit participants to hire legally liable relatives, as paid providers of the personal assistance services identified in the service plan and budget.

xiv. Use of a Representative

A. ☒ The State elects to permit participants to appoint a representative to direct the provision of self-directed personal assistance services on their behalf.

i. ☐ The State elects to include, as a type of representative, a State-mandated representative. Please indicate the criteria to be applied.

B. ☐ The State elects not to permit participants to appoint a representative to direct the provision of self-directed personal assistance services on their behalf.

xv. Permissible Purchases

A. ☐ The State elects to permit participants to use their service budgets to pay for items that increase a participant's independence or substitute for a participant's dependence on human assistance.

B. ☒ The State elects not to permit participants to use their service budgets to pay for items that increase a participant's independence or substitute for a participant's dependence on human assistance.

xvi. Financial Management Services

A. ☒ The State elects to employ a Financial Management Entity to provide financial management services to participants self-directing personal assistance services, with the exception of those participants utilizing the cash option and performing those functions themselves.

i. ☐ The State elects to provide financial management services through a reporting or subagent through its fiscal
intermediary in accordance with section 3504 of the IRS Code and Revenue Procedure 80-4 and Notice 2003-70; or

ii. ☒ The State elects to provide financial management services through vendor organizations that have the capabilities to perform the required tasks in accordance with section 3504 of the IRS Code and Revenue Procedure 70-6. (When private entities furnish financial management services, the procurement method must meet the requirements set forth Federal regulations in 45 CFR section 74.40 – section 74.48.)

iii. ☐ The State elects to provide financial management services using “agency with choice” organizations that have the capabilities to perform the required tasks in accordance with the principles of self-direction and with Federal and State Medicaid rules.

B. ☐ The State elects to directly perform financial management services on behalf of participants self-directing personal assistance services, with the exception of those participants utilizing the cash option and performing those functions themselves.
State/Territory: Texas

**AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED**

**MEDICALLY NEEDIT GROUP(S):** Pregnant Women, Children, Caretaker Relatives

The following ambulatory services are provided.

Ambulatory services are provided to the medically needy in the same scope as those provided to categorically eligible individuals as listed in the plan.

*Description provided on attachment.*

<table>
<thead>
<tr>
<th>State</th>
<th>TX</th>
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<tr>
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*Supersedes: 85-1*
State/Territory: Texas

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED TO MEDICALLY NEEDY
GROUP(S): Pregnant Women, Children, Caretaker Relative

1. Inpatient hospital services other than those provided in an institution for mental diseases.
   ☒ Provided ☐ No limitations ☒ With limitations*

2.a. Outpatient hospital services.
   ☒ Provided ☐ No limitations ☒ With limitations*

b. Rural health clinic services and other ambulatory services furnished by a rural health clinic
   covered under the Plan.
   ☒ Provided ☐ No limitations ☒ With limitations*

c. Federally qualified health center (FQHC) services and other ambulatory services that are
   covered under the Plan and furnished by an FQHC in accordance with section 4231 of the
   State Medicaid Manual (HCFA-Pub. 45-4)
   ☒ Provided ☐ No limitations ☒ With limitations*

3. Other laboratory and X-ray services.
   ☒ Provided ☒ No limitations ☒ With limitations*

4.a. Nursing facility services (other than services in an institution for mental diseases) for
   individuals 21 years of age or older.
   ☒ Provided ☐ No limitations ☒ With limitations*

b. Early and periodic screening, diagnostic and treatment services for individuals under 21
   years of age, and treatment of conditions found.
   ☒ Provided ☐ Not provided

c. Family planning services and supplies for individuals of childbearing age.
   ☒ Provided ☐ No limitations ☒ With limitations*

d. Tobacco cessation counseling services for pregnant women
   ☒ Provided ☐ No limitations ☒ With limitations*

*Description provided on attachment.

STATE Texas
DATE REC'D 3-26-12
DATE APPV'D 6-07-12
DATE EFF 1-1-12

TN: 12-07 Approval Date: 6-07-12 Effective Date: 1-1-12
Supersedes TN: 92-05
State/Territory: Texas

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED MEDICALLY NEEDY GROUP(s): Pregnant Women, Children, Caretaker Relative

5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a nursing facility, or elsewhere.

Provided: ___ No limitations XXX With limitations*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

Provided: ___ No limitations XX With limitations:

*Description provided on attachment.
6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.
   a. Podiatrists' Services
      /X/ Provided  // No limitation  /X/ With limitations*
   b. Optometrists' Services
      /X/ Provided  // No limitation  /X/ With limitations*
   c. Chiropractors Services
      /X/ Provided  // No limitation  /X/ With limitations*
   d. Other Practitioners Services
      /X/ Provided  // No limitation  /X/ With limitations*

7. Home Health Services
   a. Intermittent or part-time nursing service provided by a home health agency or by a registered nurse when no home health agency exists in the area.
      /X/ Provided  // No limitation  /X/ With limitations*
   b. Home health aide services provided by a home health agency.
      /X/ Provided  // No limitation  /X/ With limitations*
   c. Medical supplies, equipment, and appliances suitable for use in the home
      /X/ Provided  // No limitation  /X/ With limitations*
   d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.
      /X/ Provided  // No limitation  /X/ With limitations*

* Description provided on attachment
AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO MEDICALLY NEEDLY GROUP(S): Pregnant Women, Children, Caretaker Relatives

8. Private duty nursing services.
   ☑ Provided  ☐ No limitations  ☑ With limitations*  ☐ Not Provided

9. Clinic services.
   ☑ Provided  ☐ No limitations  ☑ With limitations*  ☐ Not Provided

10. Dental services.
   ☐ Provided  ☐ No limitations  ☐ With limitations*  ☒ Not Provided

11. Physical therapy and related services.
   a. Physical therapy.
      ☑ Provided  ☐ No limitations  ☑ With limitations*  ☐ Not Provided
   b. Occupational therapy.
      ☐ Provided  ☐ No limitations  ☐ With limitations*  ☒ Not Provided
   c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist).
      ☑ Provided  ☐ No limitations  ☑ With limitations*  ☐ Not Provided

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.
   a. Prescribed drugs.
      ☑ Provided  ☐ No limitations  ☑ With limitations*  ☐ Not Provided
   b. Dentures.
      ☐ Provided  ☐ No limitations  ☐ With limitations*  ☒ Not Provided

*Description provided on attachment

SUPERSEDES: TN: 90-04

TN: 12-27  Approval Date: 9-20-12  Effective Date: 6-1-12
Supersedes TN: 90-06
AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED MEDICALLY NEEDY GROUP(S):

c. Prosthetic devices.
   - Provided  ☒  No limitations  ☒  With limitations*

d. Eyeglasses.
   - Provided  ☒  No limitations  ☒  With limitations*

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in this plan.

   a. Diagnostic services.
      - Provided  ☐  No limitations  ☒  With limitations
      - Not Provided

   b. Screening services.
      - Provided  ☐  No limitations  ☒  With limitations
      - Not Provided

   c. Preventive services.
      - Provided  ☒  No limitations  ☒  With limitations*
      - Not Provided

   d. Rehabilitative services.
      - Provided  ☒  No limitations  ☒  With limitations*

14. Services for individuals age 65 or older in institutions for mental diseases.

   a. Inpatient hospital services.
      - Provided  ☒  No limitations  ☒  With limitations*

   b. Skilled nursing facility services.
      - Provided  ☐  No limitations  ☒  With limitations
      - Not Provided

*Description provided on attachment
AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED TO MEDICALLY NEEDY GROUP(S): Pregnant Women, Children, Caretaker Relatives

15. Services in an intermediate care facility for the mentally retarded, as defined in section 1905(d), (other than in an institution for mental diseases) for individuals who are determined, in accordance with sanction 1902(a)(31)(A), to be in need of such care.

- Provided: □ No Limitations  □ With Limitations*
- Not provided

16. Inpatient psychiatric facility services for individuals under 21 years of age.

- Provided: □ No Limitations*  □ With Limitations
- Not provided

17. Nurse-midwife services.

- Provided: □ No Limitations*  □ With Limitations
- Not provided

18. Hospice care (in accordance with section 1905(o) of the Act.

- Provided: □ No Limitations*  □ With Limitations
- Not provided

*Description provided on attachment.
State/Territory: TEXAS

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NECESSARY GROUP(S): PREGNANT WOMEN,

CHILDREN, CARETAKER RELATIVES

19. Case management services and Tuberculosis related services
   a. Case management services as defined in, and to the group specified in,
      Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19)
      or section 1915(g) of the Act).
         X Provided: X With limitations
            ___ Not provided.
   b. Special tuberculosis (TB) related services under section 1902(g)(2)(F) of
      the Act.
         ___ Provided: ___ With limitations
         X Not provided.

20. Extended services for pregnant women.
   a. Pregnancy-related and postpartum services for a 60-day period after the
      pregnancy ends and for any remaining days in the month in which the 60th
      day falls.
         X Provided: ___ Additional coverage
            ++ Not provided.
   b. Services for any other medical conditions that may complicate pregnancy.
         X Provided: ___ Additional coverage
            ++ Not provided.

21. Certified pediatric or family nurse practitioners' services.
   X Provided: ___ No limitations X With limitations
            ___ Not provided.
   + Attached is a list of major categories of services (e.g., inpatient
      hospital, physician, etc.) and limitations on them, if any, that are
      available as pregnancy-related services or services for any other medical
      condition that may complicate pregnancy.
   ++ Attached is a description of increases in covered services beyond
      limitations for all groups described in this attachment and/or any
      additional services provided to pregnant women only.

*Description provided on attachment.
AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): Pregnant Women, Children, Caretaker Relative

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

- Provided: [ ] No limitations [ ] With limitations*
- Not Provided.

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

- Provided: [ ] No limitations [ ] With limitations*
- Not Provided.

b. Services provided in Religious Nonmedical Health Care Institutions.

- Provided: [ ] No limitations [ ] With limitations*
- Not Provided.

c. Reserved

d. Nursing facility services for patients under 21 years of age.

- Provided: [ ] No limitations [ ] With limitations*
- Not Provided.

e. Emergency hospital services.

- Provided: [ ] No limitations [ ] With limitations*
- Not Provided.

f. Personal care services in recipient’s home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

- Provided: [ ] No limitations [ ] With limitations*
- Not Provided.

* Description provided on attachment

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Supersedes TN No. TX-03-04
Approval Date 03-24-03 Effective Date 01-01-03

TN No. TX-03-06
State/territory: Texas
Revision: HCFA-PM-01-01-02
June 2001
Page 8
OMB No.: 0938

ATTACHMENT 3.1-B
State/Territory: Texas

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): Pregnant Women, Children, Caretaker Relative

g. Ambulatory Surgical Center Services.

- Provided: ☒ No limitations ☑ With limitations*
- Not Provided.

h. Birthing Center Facility Services.

- Provided: ☒ No limitations ☑ With limitations*
- Not Provided.

* Description provided on attachment

STATE: Texas
DATE REC'D: 03-14-03
DATE APP'ED: 03-24-03
DATE EFF: 01-01-03
HCFA 179: TX-03-06

TN No. TX-03-06
Supersedes Approval Date 03-24-03 Effective Date 01-01-03
TN No. SUPERSEDES: NONE - NEW PAGE
AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED MEDICALLY NEEDY GROUP(S): 

24. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

___ Provided  ___ Not Provided

25. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home.

___ Provided:  ___ State approved (not physician) Service Plan Allowed

___ Services outside the home also allowed

___ Limitations described on Attachment

___ Not provided.
AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE PROVIDED TO MEDICALLY NEEDY

Programs of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 to Attachment 3.1-A.

☐ Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

☒ No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.
State/Territory: TX

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

MEDICALLY NEEDY GROUP(S)

30. Coverage of Routine Patient Cost in Qualifying Clinical Trials

Provided: ✓

I. General Assurances:

Routine Patient Cost – Section 1905(gg)(1)

✓ Coverage of routine patient cost for items and services as defined in section 1905(gg)(1) that are furnished in connection with participation in a qualified clinical trial.

Qualifying Clinical Trial – Section 1905(gg)(2)

✓ A qualified clinical trial is a clinical trial that meets the definition at section 1905(gg)(2).

Coverage Determination – Section 1905(gg)(3)

✓ A determination with respect to coverage for an individual participating in a qualified clinical trial will be made in accordance with section 1905(gg)(3).

PRA Disclosure Statement - This information is being collected to assist the Centers for Medicare & Medicaid Services in implementing Section 210 of the Consolidated Appropriations Act of 2021 amending section 1905(a) of the Social Security Act (the Act), by adding a new mandatory benefit at section 1905(a)(30). Section 210 mandates coverage of routine patient services and costs furnished in connection with participation by Medicaid beneficiaries in qualifying clinical trials effective January 1, 2022. Section 210 also amended sections 1902(a)(10)(A) and 1937(b)(5) of the Act to make coverage of this new benefit mandatory under the state plan and any benchmark or benchmark equivalent coverage (also referred to as alternative benefit plans, or ABPs). Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #74). Public burden for all of the collection of information requirements under this control number is estimated to take about 56 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

TN: 22-0006 Approval Date: 05-09-2022
Supersedes TN: New Page Effective Date: 01-01-2022
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State: TEXAS
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State: TEXAS

Case Management Services

A. Target Group: Persons with Mental Retardation or Related Conditions or Pervasive Developmental Disability

See page 1B.1 of this Supplement.

B. Areas of State in which services will be provided:

☐ Entire State

☐ Only in the following geographic areas (authority of section 1915(g)(1) or the Act is invoked to provide services less than Statewide)

C. Comparability of Services:

☐ Services are provided in accordance with section 1902(a)(10)(B) of the Act

☒ Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

See page 1B.1 of this Supplement.

E. Qualification of Providers:

See page 1B.3 of this Supplement.
Case Management Services for Persons with
Mental Retardation or Related Conditions or Pervasive Developmental Disability

1) Target Group:
   a) Individuals with mental retardation or a related condition or pervasive developmental
disability who require long-term care in the community.
      i) Mental retardation is defined as significantly sub-average general intellectual
functioning existing concurrently with deficits in adaptive behavior and originating
during the developmental period. Sub-average general intellectual functioning refers
to measured intelligence on standardized psychometric instruments of two or more
standard deviations below the age group mean for the tests used. Developmental
period means the period of time from conception to 18 years. Arrest or deterioration
of intellectual ability that occurs after this period is functional retardation and does
not meet the definition of mental retardation.
      ii) Related condition is defined as a severe, chronic disability that meets the criteria
outlined in 42 CFR 435.1010.
      iii) Pervasive developmental disorder (PDD) is characterized by severe and pervasive
impairment in several areas of development: reciprocal social interaction skills,
communication skills, or the presence of stereotyped behavior, interests, and
activities that meet the criteria outlined in the current version of the American
Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.
   b) Individuals who meet the criteria in a) who are transitioning to a community setting from
a medical institution during the last 180 days of a covered long-term stay.

2) Areas of state in which services will be provided:
   Entire State

3) Comparability of services:
   Services are not comparable in amount, duration and scope. Under section 1915(g) of the
Social Security Act, a state may provide case management services without regard to the
comparability requirements of section 1902(a)(10)(B).

4) Definition of services:
   a) Case management services are services furnished to assist individuals, eligible under
the State Plan, in gaining access to needed medical, social, educational, and other
services that will help them achieve a quality of life and community participation
acceptable to each individual. Case management includes the following assistance:
(Case Management Services for Persons with Mental Retardation or Related Conditions or Pervasive Developmental Disability, Continued.)

i) Comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social or other services. These assessment activities include:

(1) taking a client's history;

(2) identifying the individual's presenting problem and service needs and completing related documentation; and

(3) gathering information from other sources, such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.

ii) Development (and periodic revision) of a specific care plan that:

(1) is based on the information collected through the assessment;

(2) conforms to the principles of person-directed planning, which is a process that empowers the individual (and the legally authorized representative (LAR) on the individual's behalf) to direct the development of a plan of supports and services that meet the individual's personal outcomes or goals;

(3) specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;

(4) includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and

(5) identifies a course of action to respond to the assessed needs of the eligible individual and includes a description of the desired outcomes identified by the individual (or LAR) and a description of the services and supports (including service coordination) to be provided to the individual, with specifics concerning frequency and duration.

iii) Referral and related activities to help an eligible individual obtain needed services, including activities that help link an individual with:

(1) medical, social, and educational providers, or

(2) other programs and services that can provide needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.
(Case Management Services for Persons with Mental Retardation or Related Conditions or Pervasive Developmental Disability, Continued.)

iv) Monitoring and follow-up activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the individual's needs.

(1) Such activities may be with the individual, family members, providers, or other entities or individuals and conducted as frequently as necessary, and at least every 90 calendar days, to determine whether the following conditions are met:

(a) services are being furnished in accordance with the individual's care plan;

(b) services in the care plan are adequate; and

(c) the care plan and service arrangements are modified when the individual's needs or status change.

(2) Case management includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. (42 CFR 440.169(e)).

(3) Case management services are coordinated with and do not duplicate activities provided as part of institutional services and discharge planning activities.

5) Qualifications of providers (42 CFR 441.18(a)(8)(v) and 42 CFR 441.18(b)):

Specify provider qualifications that are reasonably related to the population being served and the case management services furnished:

a) A provider agency of case management must be an entity that is designated as the local intellectual and developmental disability authority (LIDDA). Only an employee of a provider agency may provide case management services.

b) Effective November 1, 2022, an employee of a provider agency who provides case management services must have:

i) a bachelor's or advanced degree from an accredited college or university;

ii) an associate degree in a social, behavioral, human service, or health-related field including, but not limited to, psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human development, gerontology, educational psychology, education, and criminal justice; or

a high school diploma or a certificate recognized by the state as the equivalent of a high school diploma and two years of paid or unpaid experience with individuals with intellectual or developmental disabilities.
(Case Management Services for Persons with Mental Retardation or Related Conditions or Pervasive Developmental Disability, Continued.)

c) Effective April 1, 1999 through November 1, 2022, an employee of a provider agency who provides case management services must have:

i) a bachelor’s or advanced degree from an accredited college or university with a major in a social, behavioral, or human service field, including, but not limited to, psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human development, gerontology, educational psychology, education, and criminal justice; or

ii) a high school diploma or a certificate recognized by the state as the equivalent of a high school diploma; and

(1) two years of paid experience as a case manager in a state or federally funded Parent Case Management Program or have graduated from Partners in Policy Making; and

(2) personal experience as an immediate family member of an individual with mental retardation

d) A person who was authorized by a provider agency to provide case management services to an individual with an intellectual disability or related condition or pervasive developmental disability prior to April 1, 1999, may provide case management services without meeting the minimum qualifications described in c) above.

e) Until December 31, 2011, a provider agency may hire a person to provide case management services who does not meet the minimum qualifications described in c) above if the person was employed as a case manager in the Home and Community-based Services (HCS) waiver program for any period of time prior to June 1, 2010.

f) Beginning January 1, 2012, a provider agency may hire a person to provide case management services who does not meet the minimum qualifications described in c) above if the person had been hired by another provider agency in accordance with d) above.

g) Supervision of case managers (service coordinators) is provided by the provider agency. Supervisors are staff with considerable experience in the provision of service and supports to persons with intellectual disabilities. Supervisors are knowledgeable about local resources available to provide supports. Additionally, state rules require specific training for staff that supervise or oversee the provision of service coordination. Additionally, provider agencies are required to conduct quality assurance activities that review processes and outcomes of service coordination activities.
(Case Management Services for Persons with Mental Retardation or Related Conditions or Pervasive Developmental Disability, Continued.)

6) Freedom of choice of provider agency (42 CFR 441.18(a)(1)):
The State assures that the provision of case management services will not restrict an individual’s free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible individuals will have free choice of any qualified Medicaid provider within the specified geographic area identified in this plan.
2. Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.

Freedom of Choice Exception (§1915(g)(1) and 42 CFR 441.18(b)):
Target group consists of eligible individuals with developmental disabilities or with chronic mental illness. Providers are limited to qualified Medicaid providers of case management services capable of ensuring that individuals with developmental disabilities or with chronic mental illness receive needed services:

Section 1915(g)(1) of the Social Security Act is invoked to limit the provider agencies of case management services to each local intellectual and developmental disability authority (LIDDA) that is designated as such by the Executive Commissioner of the Texas Health and Human Services Commission.

Eligible individuals will have free choice of any qualified Medicaid providers of other medical care under the plan.
7) Access to Services:
   a) The State assures that case management services will not be used to restrict an individual’s access to other services under the plan.
   b) The State assures that individuals will not be compelled to receive case management services, condition receipt of case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services.
   c) The State assures that providers of case management services do not exercise the agency’s authority to authorize or deny the provision of other services under the plan.
   d) The State assures that the amount, duration, and scope of the case management activities will be documented in an individual’s plan of care, which includes case management activities prior to and post-discharge, to facilitate a successful transition to the community.
   e) The State assures that case management is only provided by and reimbursed to provider agencies.

8) Case Records:
   a) A provider agency maintains case records that document for all individuals receiving case management the following:
      i) the name of the individual;
      ii) dates of the case management services;
      iii) the name of the provider agency and the employee providing the case management service;
      iv) the nature, content, and units of the case management services received and whether goals specified in the plan of care have been achieved;
      v) whether the individual has declined services in the plan of care;
      vi) the need for, and occurrences of, coordination with other case managers;
      vii) a timeline for obtaining needed services; and
      viii) a timeline for reevaluation of the plan of care.
(Case Management Services for Persons with Mental Retardation or Related Conditions or Pervasive Developmental Disability, Continued.)

1) Payment:

   a) Payment for case management services under the state plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

   b) Provider agencies are paid based on the reimbursement methodology described in Attachment 4.19 B, Page 15.

2) Limitations:

   a) Case Management does not include the following:

      i) Case management activities that are an integral component of another covered Medicaid service;

      ii) Direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred;

      iii) Activities integral to the administration of foster care programs; or

      iv) Activities for which an individual may be eligible that are integral to the administration of another non-medical program, except for case management that is included in an individualized education program or individualized family service plan consistent with section 1903(c) of the Social Security Act.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State: TEXAS

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CASE MANAGEMENT SERVICES
High Risk Pregnant Women Age 21 and Over

1) Target Group:
   a) Women age 21 and over who are pregnant and have one or more high-risk medical
      and/or personal/psychosocial condition(s) during pregnancy.

2) Areas of state in which services will be provided:
   a) Entire State

3) Comparability of services:
   a) Services are not comparable in amount duration and scope. Under section 1915(g) of
      the Social Security Act, a state may provide services without regard to the
      comparability requirements of section 1902(a)(10)(B) of the Act.

5) Definition of services:
   a) Case management services are services furnished to assist individuals, eligible under
      the State Plan, in gaining access to needed medical, social, educational, and other
      services. Case Management includes the following assistance:

      i) Comprehensive face-to-face assessment of individual needs to determine the
         need for any medical, educational, social, or other services required to address
         short- and long-term health and well-being. All eligible clients are assessed at the
         initiation of services. If a client later transitions to a new provider or has a major
         change in his or her health status or environment, a second assessment may be
         necessary and can be requested. These assessment activities include:

         (1) taking a client’s history;

         (2) identifying the individual’s needs and assessing and addressing family issues
             that impact the client’s health condition/risk or high-risk condition and
             completing related documentation; and

         (3) gathering information from other sources, such as family members, medical
             providers, social workers, and educators (if necessary), to form a complete
             assessment of the individual.
ii) Development (and periodic revision) of a specific care plan that:

(1) is based on the information collected through the face-to-face needs assessment, face-to-face follow up contacts, or telephone follow up contacts;

(2) specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;

(3) includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and

(4) identifies a course of action to respond to the assessed needs of the eligible individual, including identifying the individual responsible for contacting the appropriate health and human service providers; and designating the time frame within which the eligible recipient should access services.

iii) Referral and related activities to help an eligible individual obtain needed services, including activities that help link an individual with:

(1) medical, social, and educational providers, and

(2) other programs and services that can provide needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.

iv) Follow-up activities and contacts that are necessary to ensure the care plan is implemented and adequately addresses the individual's needs.

(1) Such activities may be with the individual, family members, providers, or other entities or individuals and conducted as frequently as necessary up to the 59th day postpartum, and including at least one annual follow-up contact for clients who are eligible for case management for longer than 12 consecutive months, to determine whether the following conditions are met:

(a) services are being furnished in accordance with the individual's care plan;

(b) services in the care plan are adequate; and

(c) the care plan and service arrangement are modified when the individual's needs or status change.
(1) Case management may include contacts with non-eligible individuals that are directly related to identify the needs and supports for helping the eligible individual access services.

c) Qualifications of providers:

i) Registered nurse (with a bachelor’s or advanced degree), registered nurse (without a bachelor’s or advanced degree and with two years of experience) or social worker (with bachelor’s or advanced degree), currently licensed by the respective Texas licensure board and whose license is not temporary, limited, or provisional in nature; and

ii) Completion of a standardized Department of State Health Services case management training.

7) Freedom of choice:

a) The State assures that the provision of case management services will not restrict an individual’s free choice of providers in violation of section 1902(a)(23) of the Act.

i) Eligible recipients will have free choice of the providers of case management services within the specified geographic area identified in this plan.

b) Eligible recipients will have free choice of the providers of other medical care under the plan.

8) Access to Services:

a) The State assures that case management services will be provided in a manner consistent with the best interest of the recipient and will not be used to restrict an individual’s access to other services under the plan.

b) The State assures that individuals will not be compelled to receive case management services, condition receipt of case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services.

c) The State assures that providers of case management services do not exercise the agency’s authority to authorize or deny the provision of other services under the plan.
7) Case Records

a) Providers maintain case records that document for all individuals receiving case management as follows:
   i) The name of the individual;
   ii) The dates of the case management services;
   iii) The name of the provider agency (if relevant) and the person providing the case management service;
   iv) The nature, content, units of the case management services received and whether goals specified in the care plan have been achieved;
   v) Whether the individual has declined services in the care plan;
   vi) The need for, and occurrences of, coordination with other case managers;
   vii) A timeline for obtaining needed services, and
   viii) A timeline for reevaluation of the plan.

8) Limitations:

a) Case Management does not include:
   i) Activities for which third parties are liable to pay;
   ii) Activities not consistent with the definition of case management services under section 6052 of the Deficit Reduction Act, codified at section 1915(g)(2) of the SSA; and
   iii) The direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred.

b) Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

9) Other Limitations:

a) Case management services are prior authorized by the Department of State Health Services. The number of billable contacts that are prior authorized is based on the client’s level of need, level of medical involvement, and complicating psychosocial factors.

b) Case management services are available only through the 59th day post partum.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State: ________ TEXAS ________

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State of Texas

1905(a)(29) Medication-Assisted Treatment (MAT)

Citation: 3.1(b)(1) Amount, Duration, and Scope of Services: Medically Needy (Continued)

1915(a)(29) MAT as described and limited in Supplement 4 to Attachment 3.1-B.

ATTACHMENT 3.1-B identifies the medical and remedial services provided to the medically needy.
State of Texas

1905(a)(29) Medication-Assisted Treatment (MAT)

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Medically Needy (continued)

i. General Assurance

MAT is covered under the Medicaid state plan for all Medicaid beneficiaries who meet the medical necessity criteria for receipt of the service for the period beginning October 1, 2020 and ending September 30, 2025.

ii. Assurances

a. The state assures coverage of Naltrexone, Buprenorphine, and Methadone and all of the forms of these drugs for MAT that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262).

b. The state assures that Methadone for MAT is provided by Opioid Treatment Programs that meet the requirements in 42 C.F.R. Part 8.

c. The state assures coverage for all formulations of MAT drugs and biologicals for opioid use disorder (OUD) that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological drugs licensed under section 351 of the Public Health Service Act (42 U.S.C. 262).

iii. Service Package

The state covers the following counseling and behavioral health therapies as part of MAT.

a) Please set forth each service and components of each service (if applicable), along with a description of each service and component service.

MAT for treatment of OUD is covered exclusively under section 1905(a)(29) of the Act from October 1, 2020, through September 30, 2025.

The state covers substance use disorder (SUD) counseling for MAT for the treatment of OUD consistent with the requirements of 1905(a)(29).

1. SUD counseling

a. SUD counseling is available on a group or individual basis.
1905(a)(29) Medication-Assisted Treatment (MAT)

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Medically Needy (continued)

b. Counseling for SUDs is designed to assist a person in developing a better understanding of their SUD, help to establish treatment goals and plans for achieving those goals, and provide interventions to assist the person in accordance with the plan. SUD counseling assists a person in developing the skills and supports needed to address their SUD over time.

b) Please include each practitioner and provider entity that furnishes each service and component service.

**SUD counseling is provided by:**

- Qualified credentialed counselors (QCCs)
- Counselor interns under the supervision of a QCC

SUD counseling is payable to state-licensed and Medicaid-enrolled chemical dependency treatment facilities and opioid treatment programs that employ QCCs or counselor interns, but QCCs and counselor interns cannot directly bill Medicaid for their services.

c) Please include a brief summary of the qualifications for each practitioner or provider entity that the state requires. Include any licensure, certification, registration, education, experience, training and supervisory arrangements that the state requires.

**Qualified credentialed counselor (QCC)**

All QCCs must be licensed and in good standing in the State of Texas, and act within the scope of the individual’s license. The credentialing requirement minimums for a QCC is a licensed chemical dependency counselor (LCDC) or one of the following practitioners who have at least 1,000 hours of documented experience treating substance-related disorders:

- Licensed professional counselor (LPC)
- Licensed master social worker (LMSW)
State of Texas

1905(a)(29) Medication-Assisted Treatment (MAT)

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Medically Needy (continued)

- Licensed marriage and family therapist (LMFT)
- Licensed psychologist
- Licensed physician
- Licensed physician assistant (PA)
- Certified addictions registered nurse (CARN) - Registered nurse with current certification in addictions nursing by a nationally recognized certification entity.
- Advanced practice registered nurse licensed by the Texas Board of Nurse Examiners as a clinical nurse specialist or nurse practitioner with a population focus area in psychiatric/mental health (APRN-P/MH)

Counselor Intern

A person in good standing seeking a license as a chemical dependency counselor who is registered with the state and pursuing a course of training in chemical dependency counseling. The counselor intern performing SUD counseling must be under the supervision of a QCC. Counselor interns must:

1. Be at least 18 years old
2. Have a high school diploma or its equivalent
3. Have successfully completed 270 classroom hours, or 18 semester hours (or 27 quarter hours), of chemical dependency curricula*
4. Have completed 300 hours of approved supervised field work practicum*
5. Have passed the criminal history standards
6. Have signed a written agreement to abide by the state ethical standards
7. Be worthy of public trust and confidence

*Applicants holding at least a baccalaureate degree in chemical dependency counseling, sociology, psychology, or a major approved by the Texas Department of State Health Services as one related to human behavior and development are exempt from the 270 hours of education and 300-hour practicum.
State of Texas

1905(a)(29) Medication-Assisted Treatment (MAT)

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Medically Needy (continued)

iv. Utilization Controls

__X__ The state has drug utilization controls in place. (Check each of the following that apply)

_____ Generic first policy
_X__ Preferred drug lists
_X__ Clinical criteria
_X__ Quantity limits

_____ The state does not have drug utilization controls in place.

v. Describe the state’s limitations on amount, duration, and scope of MAT drugs, biologicals, and counseling and behavioral therapies related to MAT.

Pharmacy Benefits:

Texas applies limits to quantities and Morphine Milligram Equivalents for buprenorphine prescriptions through the pharmacy benefit. A quantity limit is applied to naltrexone. The MME limits vary depending on whether the opioid prescription is used for OUD treatment. Under the state’s opioid prescription policy, an opioid prescription cannot exceed 90 MME. However, exceptions can be made to bypass the limit of 90 MME for beneficiaries with an OUD through the safety-related prior authorization process.

Texas applies prospective drug utilization review alerts for concurrent use of certain drugs with opioids, including buprenorphine. Texas utilizes a preferred drug list, and drug utilization review safety-related prior authorization is applied to buprenorphine.
State of Texas

1905(a)(29) Medication-Assisted Treatment (MAT)

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Medically Needy (continued)

Medical Benefits:

When obtained as a medical benefit, methadone and buprenorphine are limited to a certain quantity per day, as specified in the state’s medical policy, for any provider. Take-home doses of methadone or buprenorphine may be dispensed, but are limited to one per date of service and no more than 30 per 30 days, by any provider.

PRA Disclosure Statement - This information is being collected to assist the Centers for Medicare & Medicaid Services in implementing section 1006(b) of the SUPPORT for Patients and Communities Act (P.L. 115-271) enacted on October 24, 2018. Section 1006(b) requires state Medicaid plans to provide coverage of Medication-Assisted Treatment (MAT) for all Medicaid enrollees as a mandatory Medicaid state plan benefit for the period beginning October 1, 2020 and ending September 30, 2025. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 # 60). Public burden for all of the collection of information requirements under this control number is estimated to take about 80 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE MEDICALLY NEEDY

1. Inpatient Hospital Services

Except as otherwise specified in Attachment 3.1-E, Standards for the Coverage of Organ Transplant Services, up to 30 days of care during each Title XIX spell of illness are covered if medically necessary. The Title XIX spell of illness limitations are waived for medically necessary inpatient services provided to recipients less than age 21 to comply with the EPSDT provisions of the Omnibus Budget Reconciliation Act of 1989 and the provisions of Section 4604 of the Omnibus Budget Reconciliation Act of 1990.

A. Full semi-private room, or an allowance of the hospital's most prevalent semi-private rate toward a private room. (Private room is covered in full if medically necessary.)

B. All other care in the nature of usual hospital services.

C. Maternity care, usual and customary care for all female recipients.

The benefits of this program do not extend to:

Any services or supplies provided, on or after November 1, 1988, to a hospital inpatient by practitioners, providers, or suppliers, regardless of where the services are provided, after total benefit expenditures related to the hospitalization(s) under the Texas Medical Assistance Program, per recipient per 12-month benefit period, reach $200,000. This limit does not apply to services provided to hospital inpatients by individuals licensed to practice medicine or osteopathy at the time and place the services are provided. This limit does not apply to medically necessary services provided to an inpatient less than age 21 in compliance with the EPSDT provisions of the Omnibus Budget Reconciliation Act of 1989 and the provisions of Section 4604 of the Omnibus Budget Reconciliation Act of 1990. For purposes of this limit, a 12-month benefit period is defined as the 12 consecutive months period beginning November 1 and ending October 31 each year. This limit will apply to hospitalization related services, while a recipient is a hospital inpatient, irrespective of when it is reached in the 12-month benefit period and irrespective of whether one or more inpatient hospital stays, per recipient, are involved. For purposes of this limit, the state agency or its designee will process claims and pay, if payable, on the basis of the first claim received by the agent.
2.a. Outpatient Hospital Services

These shall include diagnostic, therapeutic, rehabilitative, palliative, or telemonitoring items or services furnished by or under the direction of a physician except that no payment will be made for: (1) drugs and biologicals which can be self-administered; (2) occupational therapy that is not medically prescribed treatment designed to improve or restore an individual's ability to perform those tasks required for independent functioning in the self-care activities of eating, personal hygiene, dressing, and communication.
2.b. Rural Health Clinic Services.

The specifications, conditions and limitations established by the single state agency for coverage of services provided by a rural health clinic under the Texas Medical Assistance Program are as follows:

A. As a condition for receiving payment for rural health clinic services as defined at 42 CFR 440.20 (b), the services must be medically necessary and be provided to an eligible recipient by a certified and approved rural health clinic in accordance with applicable Federal, State and local laws and regulations.

B. As a condition for receiving payment for other ambulatory services which are covered under this State Plan and which are apart from and other than rural health clinic services as defined at 42 CFR 440.20 (c), a rural health clinic, as the provider, must meet the same conditions of participation as any other provider of the same services(s) and is subject to the qualifications, limitations, and exclusions in the amount, duration and scope of benefits and all other provisions specified in this State Plan and elsewhere.

C. The rural health clinic must contract with the single state agency.

D. The rural health clinic must provide reports and other information specified by the single state agency or its authorized representative.

E. Rural health clinic personnel providing primary health care must be licensed in Texas or in the State within the United States in which and at the time and place the service(s) is provided and/or meet all other established qualifications.

F. Any covered service furnished to an eligible recipient in a long term care facility must be ordered by the recipient's treating physician. A physician is defined as a M.D. or D.O.

G. The rural health clinic must be certified and participate under Title XVIII of the Social Security Act.

H. The plan of treatment to be used for visiting nurse services must be developed by the rural health clinic physician and be approved and ordered by the recipient's treating physician.
2.c. Federally Qualified Health Center Services.

(a) Effective for services on or after April 1, 1990, and subject to the specifications, conditions, limitations, and requirements established by the state agency, Federally Qualified Health Center (FQHC) services are available to eligible Medicaid recipients.

(b) Covered services are limited to:

1. services as described in 1861(aa)1(A)-(C) of the Social Security Act, and are medically necessary. These services include:
   (A) physician services;
   (B) physician assistant services;
   (C) nurse practitioner services;
   (D) clinical psychologist services;
   (E) clinical social worker services;
   (F) services and supplies incident to such services as would otherwise be covered if furnished by a physician or as an incident to a physician's services; and
   (G) visiting nurse services to a homebound individual, in the case of those FQHCs that are located in an area that has a shortage of home health agencies as determined by the state survey agency.

2. other ambulatory services which are covered by the Texas Medical Assistance program when provided by other enrolled providers.

(c) Covered services provided by an FQHC must be reasonable and medically necessary as determined by the state agency.

(d) To participate in the Texas Medical Assistance Program, a Federally Qualified Health Center (FQHC) must meet the following requirements:

1. be receiving a grant under Section 329, 330, or 340 of the Public Health Service Act or be designated by the Secretary of the Department of Health and Human Services as meeting the requirements to be receiving such a grant;

2. comply with all federal, state, and local laws and regulations applicable to the services provided;

3. be enrolled and approved for participation in the Texas Medical Assistance program.
2.c. Federally Qualified Health Center Services. (Continued)

(4) sign a written provider agreement with the state agency;
(5) comply with the terms of the provider agreement and all requirements of the Texas Medical Assistance program including regulations, rules, handbooks, standards, and guidelines published by the state agency; and
(6) will bill for covered services in the manner and format prescribed by the state agency.
3. Other Laboratory and X-ray Services.

Laboratory Services are provided by facilities certified to perform testing on human specimens under the Clinical Laboratory Improvement Amendments of 1988 (CLIA) in accordance with 42 CFR §440.30 and 42 CFR Part 493.
4.a Nursing Facility Services for Individuals 21 Years of Age or Older.

Nursing facility services (other than services in an institution for mental disease) provided in a Title XIX nursing facility approved by the single state agency to eligible individuals are limited by a requirement for a medical necessity determination. The treating physician prescribes the nursing facility setting, and the state agency provides the medical necessity determination for which payment will be made.

Nursing facility services includes drugs that are reimbursed through the Vendor Drug Program. This encompasses all drugs contained in the resident's plan of care, subject to the drug rebate provision of Section 1927 of the Social Security Act.
4.a Nursing Facility Services for Individuals 21 Years of Age or Older.

(I) Augmentative communication devices (ACDs) are available to Medicaid-eligible persons residing in a nursing facility when prior authorization is obtained.

(A) To be eligible for reimbursement for an ACD, the nursing facility, prior to purchase of the device, must obtain an evaluation of the resident by a speech-language therapist licensed in the State of Texas. This evaluation must contain all of the following criteria:

i. Diagnosis relevant to the need for an ACD;
ii. Specific ACD being recommended;
iii. Description of how this ACD will meet the specific needs of this individual; and
iv. Description of specific training needs for use of this device to include training needs of the individual, nursing facility staff, and family (when applicable).

(B). The nursing facility must provide a statement of medical necessity for this ACD from the resident's primary care physician in order to request prior authorization.

(II). Prior authorization must be obtained from the Health and Human Services Commission (HHSC) or its designee before purchase of any ACD. For ACDs costing over $10,000, the prior authorization process will include an independently conducted second speech evaluation facilitated by the Department of Aging and Disability Services (DADS). A nursing facility must submit a copy of the completed initial speech evaluation and physician's attestation of medical necessity to request prior authorization.
4.a Nursing Facility Services for Individuals 21 Years of Age or Older.

(I) Customized Powered Wheel Chairs (CPWCs) are available to Medicaid-eligible persons residing in a nursing facility when prior authorization by HHSC or designee is obtained. The CPWC must be medically necessary, adapted and/or fabricated to meet the individualized needs of the client, and intended for the exclusive and ongoing use of the client.

(A) The nursing facility must provide a statement of medical necessity for a CPWC from the resident's primary care physician in order to request prior authorization. Medical necessity must be documented in the resident's plan of care.

(B) To be eligible for reimbursement for a CPWC, the nursing facility must obtain an evaluation of the resident by an occupational and/or physical therapist licensed in the State of Texas prior to purchase of the device. This evaluation must contain all of the following criteria:

i. Diagnosis relevant to the need for a CPWC;
ii. Specific CPWC being recommended;
iii. Description of how this CPWC will meet the specific needs of this individual; and
iv. Description of specific training needs for use of this device to include training needs of the individual, nursing facility staff, and family (when applicable).

(II) Prior authorization must be obtained from the Health and Human Services Commission (HHSC) or its designee before purchase of any CPWC.
Customized adaptive aids are aids that enable an individual to retain or increase the ability to perform activities of daily living or perceive, control, or communicate with the environment in which the individual lives. Customized adaptive aids are intended for use by only the individual for whom the aid is purchased.

Customized adaptive aids are available to individuals with intellectual and developmental disabilities who are receiving services in a nursing facility and have been found through the preadmission screening and resident review process to need a customized adaptive aid. Prior authorization must be obtained from the Health and Human Services Commission before purchase of any customized adaptive aid.

(B) To be eligible for reimbursement for a customized adaptive aid, the nursing facility, prior to the purchase of the aid, must obtain an evaluation of the resident by a physical, occupational, or speech-language therapist licensed in the State of Texas. This evaluation must contain all of the following criteria:

i. Specific item being recommended.
ii. Description of how this item will meet the specific needs of this individual.
iii. Description of specific training needs for use of this device including training needs of the individual, nursing facility staff, and family (when applicable).

(B) The nursing facility must provide a statement of medical necessity for this customized adaptive aid from the resident’s primary care physician in order to obtain prior authorization.

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This term has the same meaning as “mental retardation,” defined at 42 C.F.R. § 483.102(b)(3).
4a. Nursing Facility Services for Individuals 21 Years of Age or Older (continued)

Enhanced therapy services are available as a specialized service to individuals with intellectual and developmental disabilities\(^1\) residing in nursing facilities who have been found through the preadmission screening and resident review process to need these services. Physical therapy, occupational therapy, and speech therapy will be provided to eligible individuals as required to maintain the individual's optimum condition.

\(^1\) This term has the same meaning as "mental retardation," defined at 42 C.F.R. § 483.102(b)(3).
4.a Nursing Facility Services for Individuals 21 years or Age or Older (continued)

Specialized Add-on Services for Certain NF Residents

Covered specialized add-on services include habilitative services. Habilitative services are medically necessary services intended to assist the individual in partially or fully attaining, maintaining, or improving developmental-age appropriate skills that were not fully acquired as a result of a congenital, genetic, or early acquired health condition. Specialized add-on services are habilitative services available to individuals residing in a Medicaid-certified nursing facility ("resident"). Preauthorization is required.

Preauthorization is granted when the individual's need for specialized add-on services is identified, recommended by the individual's interdisciplinary team, and included in the resident's habilitative service plan, which is coordinated with the resident's comprehensive care plan and determined to be medically necessary. Specialized add-on services are provided by community-based providers, not the nursing facility. Each allowable specialized add-on service includes transportation between the nursing facility and the service site. HHSC may reimburse a provider agency for delivering specialized add-on services described below, as set out in Attachment 4.19-D, Page 16.

Services will not be paid as specialized add-on services if the services are included in the nursing facility's per diem rate and include expanded interactions, skills training activities, and programs of greater intensity or frequency than provided under the nursing facility's per diem rate.

Allowable specialized add-on services are behavioral support, employment assistance, supported employment, day habilitation, and independent living skills training.

I. Behavioral Support, Employment Assistance, Supported Employment, Day Habilitation, and Independent Living Skills Training

(a) Definitions

(1) Behavioral support - Assistance provided to a resident to increase adaptive behaviors and to replace or modify maladaptive behaviors that prevent or interfere with the resident's interpersonal relationships across all services and social settings delivered by a community-based provider of behavioral support. Behavioral support consists of:

(A) assessing the behavior(s) to be targeted necessary to design an appropriate behavioral support plan and analyzing those assessment findings;

(B) developing an individualized behavioral support plan that reduces or eliminates the target behaviors, thereby assisting the resident in achieving the outcomes identified in the resident's habilitative service plan;
4.a Nursing Facility Services for Individuals 21 years of age or Older Specialized Add-On Services (continued)

I. Behavioral Support, Employment Assistance, Supported Employment, Day Habilitation, and Independent Living Skills Training (continued)

(a) Definitions (continued)

(4) Day habilitation - Assistance provided to a resident to acquire, retain, or improve self-help, socialization, and adaptive skills necessary to live successfully and actively participate in all service and social settings. Day habilitation will be delivered by a community-based provider of day habilitation in a setting other than a nursing facility. Service provider qualifications are listed on Appendix 1 to Attachment 3.1-A on page 5j. Day habilitation does not include services provided under the Day Activity and Health Services (DAHS) program. Day habilitation consists of expanded interactions, skills training activities, and programs of greater intensity or frequency beyond those 42 CFR §483.24 requires a nursing facility to provide. Day habilitation services include:

(A) individualized activities consistent with achieving the outcomes identified in a resident's habilitative service plan to attain, learn, maintain, or improve skills;

(B) activities necessary to reinforce therapeutic outcomes targeted by other support providers and other specialized services;

(C) services in a group setting at a location other than a resident's nursing facility for up to five days per week, six hours per day, on a regularly scheduled basis;

(D) personal assistance for a resident who cannot manage personal care needs during the day habilitation activity; and

(E) transportation between the nursing facility and the day habilitation site, as well as during the day habilitation activity necessary for a resident's participation in day habilitation activities.

(5) Independent living skills training - Assistance provided to a resident with a disability, that is consistent with the resident's habilitative service plan and provided in the resident's nursing facility or at community locations by a community-based provider of independent living skills training listed on Appendix 1 to Attachment 3.1-A on page 5h. Service provider qualifications are listed on Appendix 1 to Attachment 3.1-A page 5j. Independent living skills training consists of expanded interactions, skills training activities, and programs of greater intensity or frequency beyond those 42 CFR §483.24 requires a nursing facility to provide. Independent living skills training includes:
4.a. Nursing Facility Services for Individuals 21 years of age or Older Specialized Add-On Services (continued)

I. Behavioral Support, Employment Assistance, Supported Employment, Day Habilitation, and Independent Living Skills Training (continued)

(b) Provider Agency Qualifications- A provider agency of a specialized add-on service is a community-based provider agency with experience in delivering services to individuals with intellectual disabilities or developmental disabilities. The community-based provider agency must be a local intellectual and developmental disability authority or licensed or certified by HHSC to provide specified waiver program services for at least one of the following programs:

(1) Home and Community-based Service (HCS) waiver;

(2) Texas Home Living (TxHmL) waiver;

(3) Community Living Assistance and Support Services (CLASS) waiver; or

(4) Deaf Blind and Multiple Disabilities (DMBD) waiver.

(c) Provider Qualifications for Individual Services

(1) Behavior support- An employee or contractor of a fee-for-service provider agency who provides behavioral support must:

(A) Be licensed as a psychologist in accordance with State law;

(B) Be licensed as a psychological associate in accordance with State law;

(C) Have been issued a provisional license to practice psychology in accordance with State law;

(D) Be licensed as a clinical social worker in accordance with State law;

(E) Be licensed as a professional counselor in accordance with State law; or

(F) Be licensed as a behavior analyst in accordance with State law.
4.a Nursing Facility Services for Individuals 21 Years of Age or Older Specialized Add-On Services (continued)

I. Behavioral Support, Employment Assistance, Supported Employment, Day Habilitation, and Independent Living Skills Training (continued)

(a) Definitions (continued)

(3) Supported employment – Assistance provided to a resident who requires intensive, ongoing support to be self-employed, work from home, or perform in an integrated work setting in the community at which individuals without disabilities are employed, and to sustain competitive employment in an integrated work setting and delivered by a community-based provider of supported employment. Supported employment consists of:

(A) making employment adaptations, supervising, and providing training related to the resident's assessed needs;

(B) transporting the resident between the nursing facility and the site where supported employment services are provided and as necessary to support the person to be self-employed, work from the resident's place of residence, or perform in a work setting; and

(C) participating in habilitative service planning team meetings.

Supported employment add-on services are not available to a resident of a nursing facility through a program funded under the Rehabilitation Act of 1973.
4.a Nursing Facility Services for Individuals 21 Years of Age or Older Specialized Add-On Services (continued)

I. Behavioral Support, Employment Assistance, Supported Employment, Day Habilitation, and Independent Living Skills Training (continued)

(a) Definitions (continued)

(4) Day habilitation—Assistance provided to a resident to acquire, retain, or improve self-help, socialization, and adaptive skills necessary to live successfully and actively participate in all service and social settings. Day habilitation will be delivered by a community-based provider of day habilitation in a setting other than the resident's nursing facility in a group setting at day habilitation centers owned or under arrangement by the community provider listed on Appendix 1 to Attachment 3.1-A on page 5h. Service provider qualifications are listed on Appendix 1 to Attachment 3.1-A on page 5j. Day habilitation does not include services provided under the Day Activity and Health Services (DAHS) program. Day habilitation consists of expanded interactions, skills training activities, and programs of greater intensity or frequency beyond those 42 CFR §483.24 requires a nursing facility to provide. Day habilitation services include:

(A) individualized activities consistent with achieving the outcomes identified in a resident’s habilitative service plan to attain, learn, maintain, or improve skills;

(B) activities necessary to reinforce therapeutic outcomes targeted by other support providers and other specialized services;

(C) services in a group setting at a location other than a resident’s nursing facility for up to five days per week, six hours per day, on a regularly scheduled basis;

(D) personal assistance for a resident who cannot manage personal care needs during the day habilitation activity; and

(E) transportation between the nursing facility and the day habilitation site, as well as during the day habilitation activity necessary for a resident’s participation in day habilitation activities.

(5) Independent living skills training—Assistance provided to a resident with a disability, that is consistent with the resident’s habilitative service plan and provided in the resident’s nursing facility or at community locations by a community-based provider of independent living skills training listed on Appendix 1 to Attachment 3.1-A on page 5h. Service provider qualifications are listed on Appendix 1 to Attachment 3.1-A page 5j. Independent living skills training consists of expanded interactions, skills training activities, and programs of greater intensity or frequency beyond those 42 CFR §483.24 requires a nursing facility to provide. Independent living skills training includes:
4.a Nursing Facility Services for Individuals 21 Years of Age or Older Specialized Add-On Services (continued)

I. Behavioral Support, Employment Assistance, Supported Employment, Day Habilitation, and Independent Living Skills Training (continued)

(a) Definitions (continued)

(A) habilitation and support activities that foster improvement of, or facilitate, a resident’s ability to attain, learn, maintain, or improve functional living skills and other daily living activities;

(B) activities that help preserve the resident’s bond with family members, such as educating the family on techniques for teaching the resident appropriate social behaviors and how to effectively respond to the resident’s inappropriate behaviors;

(C) activities that foster inclusion in community activities generally attended by individuals without disabilities; and

(D) transportation to facilitate a resident’s employment opportunities and participation in community activities, and between the resident’s nursing facility and training site.
4.a Nursing Facility Services for Individuals 21 Years of Age or Older Specialized Add-On Services (continued)

I. Behavioral Support, Employment Assistance, Supported Employment, Day Habilitation, and Independent Living Skills Training (continued)

(b) Provider Agency Qualifications - A provider agency of a specialized add-on service is a community-based provider agency with experience in delivering services to individuals with intellectual disabilities or developmental disabilities. The community-based provider agency must be licensed or certified by HHSC to provide program services for at least one of the following programs:

(1) Home and Community-based Service (HCS) waiver;
(2) Texas Home Living (TxHmL) waiver;
(3) Community Living Assistance and Support Services (CLASS) waiver; or
(4) Deaf Blind and Multiple Disabilities (DBMD) waiver.

(c) Provider Qualifications for Individual Services

(1) Behavioral support – An employee or contractor of a fee-for-service provider agency who provides behavioral support must:

(A) be licensed as a psychologist in accordance with State law;
(B) be licensed as a psychological associate in accordance with State law;
(C) have been issued a provisional license to practice psychology in accordance with State law;
(D) be certified by HHSC as an authorized provider in accordance with Texas Administrative Code;
(E) be licensed as a clinical social worker in accordance with State law;
(F) be licensed as a professional counselor in accordance with State law; or
(G) be certified as a behavior analyst by the Behavior Analyst Certification Board®, Inc. (BACB®).
4.a Nursing Facility Services for Individuals 21 Years of Age or Older Specialized Add-On Services (continued)

I. Behavioral Support, Employment Assistance, Supported Employment, Day Habilitation, and Independent Living Skills Training (continued)

(c) Provider Qualifications for Individual Services (continued)

(2) Employment assistance – An employee or contractor of a fee-for-service community-based provider agency who provides employment assistance must:

(A) be at least 18 years of age;

(B) not be the LAR of the resident receiving employment assistance or the spouse of the resident;

(C) have at least one of the following:

(i) a bachelor's degree in rehabilitation, business, marketing, or a related human services field, and at least six months of paid or unpaid experience providing services to people with disabilities;

(ii) an associate's degree in rehabilitation, business, marketing, or a related human services field, and at least one year of paid or unpaid experience providing services to people with disabilities; or

(iii) a high school diploma or a certificate recognized by a state as the equivalent of a high school diploma, and at least two years of paid or unpaid experience providing services to people with disabilities.

(3) Supported employment – An employee or contractor of a fee-for-service community-based provider agency who provides supported employment must:

(A) be at least 18 years of age;

(B) not be the LAR of the resident receiving supported employment or the spouse of the resident;

(C) have at least one of the following:

(i) a bachelor's degree in rehabilitation, business, marketing, or a related human services field, and at least six months of paid or unpaid experience providing services to people with disabilities;

(ii) an associate's degree in rehabilitation, business, marketing, or a related human services field, and at least one year of paid or unpaid experience providing services to people with disabilities; or

(iii) a high school diploma or a certificate recognized by a state as the equivalent of a high school diploma, and at least two years of paid or unpaid experience providing services to people with disabilities.
4.a Nursing Facility Services for Individuals 21 Years of Age or Older
Specialized Add-On Services (continued)

I. Behavioral Support, Employment Assistance, Supported Employment, Day Habilitation, and Independent Living Skills Training (continued)

(c) Provider Qualifications for Individual Services (continued)

(4) Day habilitation and independent living skills training – An employee or contractor of a fee-for-service community-based provider agency who provides day habilitation must

(A) be at least 18 years of age; and

(B) have one of the following:

(i) a high school diploma or a certificate recognized by a state as the equivalent of a high school diploma; or

(ii) documentation of a proficiency evaluation of experience and competence to perform the job tasks that includes:

(I) a written competency-based assessment of the ability to document service delivery and observations of a resident to be served; and

(II) at least three written personal references from persons not related by blood or marriage to the employee or contractor that indicate the employee or contractor has the ability to provide a safe, healthy environment for a resident being served.
4.a Nursing Facility Services for Individuals 21 Years of Age or Older

II. Habilitation Coordination

(a) Definition of Habilitation Service Plan. The habilitative service plan is developed by the interdisciplinary team and includes specialized add-on services and specialized services recommended by PASRR. The habilitative service plan is shared with all community-based providers who deliver specialized add-on services. Implementation of the services identified on the habilitative service plan is monitored by the habilitation coordinator.

(b) Definition of Habilitation Coordination. Assistance for a nursing facility resident with a disability who has chosen to remain in the facility to access appropriate specialized add-on services necessary for the resident to achieve a quality of life and level of community participation acceptable to the resident (and LAR on the resident's behalf). If the resident decides to leave the nursing facility, a service coordinator will be assigned to assist the resident with transitioning into the community. Habilitation coordination consists of:

(1) assessing and periodically reassessing habilitative service needs by gathering information from the resident and other appropriate sources, such as the family members, social workers, and service providers, to determine the resident's habilitative needs and the specialized add-on services that will address those needs;

(2) developing (and periodically revising) an individualized habilitative service plan by identifying with the resident and LAR, if any, desired habilitation outcomes and specifying a course of action to accomplish those outcomes;

(3) assisting the resident to access needed specialized add-on services and other habilitative programs and services that can provide services to address needs and achieve outcomes identified in the habilitative service plan;

(4) monitoring and follow-up activities that consist of ensuring the resident receives needed specialized add-on services, evaluating the effectiveness and adequacy of specialized add-on services, facilitating the coordination of the resident's habilitative service plan and the nursing facility comprehensive care plan, and determining if outcomes identified in the habilitative service plan are being achieved; and

(5) offering educational opportunities and informational activities about community living options, arranging visits to community providers, and addressing concerns about community living.
4.a Nursing Facility Services for Individuals 21 Years of Age or Older

II. Habilitation Coordination

(c) Qualifications of Service Provider of Habilitation Coordination. A service provider of habilitation coordination must:

1. be an employee of the habilitation coordination provider agency;
2. have a bachelor's or advanced degree from an accredited college or university with a major in a social, behavioral, or human service field, such as psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human development, gerontology, educational psychology, education, or criminal justice; and,
3. have at least one year of experience working directly with individuals with intellectual or other developmental disabilities.
4.b. EPSDT Services

EPSDT prior authorization requirement: Prior authorization is required for payment of dental services in excess of the ceiling amount established for initial services or if subsequent appointments and services are required. Also, prior authorization is required for hospitalization expenses in connection with dental services. An orthodontic plan of treatment must be received, authorized, and prepaid while the client is Medicaid eligible and under 21 years of age.

Eligible medical assistance recipients covered under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program are entitled to optometric and eyeglass services as described below and elsewhere in this State Plan, when provided by an appropriate and qualified provider enrolled in the Texas Medical Assistance Program at the time the service(s) is provided.

Each EPSDT recipient is entitled to one eye exam by refraction by an appropriate and qualified provider once every 12 months. An eye exam by refraction may be offered to an EPSDT recipient before 12 months have elapsed since the last such exam if there is a significant change in visual acuity, measured in diopter or axis changes as defined by the single state agency, or if an eye exam by refraction is otherwise medically necessary. The limit of one eye exam by refraction per recipient every 12 months applies to both prosthetic (aphakic) eyewear and non-prosthetic eyewear; the limit of one exam by refraction for either aphakic or non-prosthetic eyewear every 12 months may be waived in either case for a significant change in visual acuity or medical necessity. This limit does not apply to other diagnostic and/or treatment of the eye for medical conditions, other than determination of visual acuity. Diagnostic and treatment services provided by an appropriate and qualified provider are covered by the Texas Medical Assistance Program if the services are (1) within the appropriate and qualified provider's scope of practice, as defined by state law; and (2) reasonable and medically necessary as determined by the single state agency or its designee. Other diagnostic and treatment services provided by a physician are described elsewhere in this State Plan.

Eyewear, including contacts and eyeglasses (lenses and frames), that significantly improves visual acuity or impedes the progression of visual problems is a program benefit. In addition, payment is limited to serviceable and prescription quality eyeglass frames and lenses that meet federal and state requirements, standard prescription requirements, and other specifications as established by the single state agency.

Prosthetic eyewear, including contact lenses and eyeglasses (lenses and frames), is a program benefit provided to an eligible recipient if the eyewear is prescribed for congenital absence of the eye lens, loss of an eye lens because of trauma or post cataract surgery without the placement of an intraocular lens.
4.b. **EPSDT Services, continued**

Reimbursement is made for as many temporary lenses as are medically necessary during post-surgical cataract convalescence (the four-month period following the date of cataract surgery).

Nonprosthetic eyeglasses or contact lenses are available for lost or destroyed nonprosthetic eyewear or if required because of a change in visual acuity measured in diopter or axis changes as defined by the single state agency.

The repair of prosthetic or non-prosthetic eyeglasses is a benefit when the needed repairs do not exceed the cost of replacement, except that repairs costing less than $2.00 are not reimbursable.
4.b EPSDT Services (Continued)

Repairs to prosthetic eyewear are reimbursable if the cost of materials exceeds $2. Repairs costing less than $2 are not reimbursable by the program and the provider may not bill the recipient for these services.

Nonprosthetic eyewear is available only once every 24 months, unless a recipient's eyes undergo a change in visual acuity of .5 diopters or more, or the eyewear is lost or destroyed. Provisions have been made for the necessary repair or replacement of lost or destroyed nonprosthetic eyewear.

Optometric services provided in skilled or intermediate care facilities are reimbursable by the program if the recipient's attending physician has ordered the services(s) and the order is included in the recipient's medical records at the nursing facility.

EPSDT Expansion under OBRA of 1989 - The single state agency will provide other health care described in Section 1905(a) of the Social Security Act that is found to be medically necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the EPSDT screen, even when such health care is not otherwise covered under the State Plan.
4b. EPSDT Services (continued)

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SUPERSEDES: TN-06-08

TN No. 16-17 Approval Date 7-26-10 Effective Date 9-1-10

Supersedes TN No. 06-08
4.b. EPSDT Services (Continued)

Rehabilitative Chemical Dependency Treatment Facility Services (Continued).

(5) Sign a written provider agreement with the single state agency. By signing the agreement, the chemical dependency treatment facility agrees to comply with the terms of the agreement and all requirements of the Texas Medical Assistance Program, including regulations, rules, handbooks, standards, and guidelines published by the single state agency or its designee; and

(6) Bill for services covered by the Texas Medical Assistance Program in the manner and format prescribed by the single state agency or its designee.
4.b. EPSDT Services (Continued)

**Audiology and Hearing Services**

**Definition:**
Audiology and hearing services outlined in this section of the state plan are available to Medicaid-eligible recipients under the age of 21 years who are eligible for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services and for whom services are medically necessary.

**Services:**

**Audiology Services**
Pursuant to 42 CFR § 440.110, medically necessary audiology services include, but are not limited to:

1. Identification of children with hearing loss;
2. Determination of the range, nature and degree of hearing loss, including the referral for medical or other professional attention for the amelioration of hearing;
3. Provision of amelioration activities, such as language amelioration, auditory training, speech reading (lip reading), hearing evaluation and speech conversation;
4. Determination of the child's need for group and individual amplification; and
5. Hearing aid services, including necessary equipment and supplies (hearing aid instruments are described under "Prosthetics").

**Hearing Services**
Hearing aid and audiometric evaluation services for Medicaid clients younger than 21 years of age are reimbursed to willing and qualified Medicaid providers, meeting the qualifications described below.

Audiology and hearing services may be provided in an individual or group setting.

Audiology and hearing services must be prescribed by a physician or by another licensed practitioner within the scope of his or her practice under state law.

**Providers:**
Audiology and hearing services must be provided by a qualified audiologist who meets the requirements of 42 CFR § 440.110(c)(3) and in accordance with applicable state and federal law or regulation.

Services may be provided by:
- A qualified audiologist licensed by the state to furnish audiologist services; or
- A qualified audiology assistant licensed by the state, when the services are provided in a facility setting (such as a comprehensive outpatient rehabilitation facility, an outpatient rehabilitation facility, an outpatient hospital, an inpatient hospital, or a school) and when the assistant is acting
4.b. EPSDT Services (Continued)

Audiology and Hearing Services (continued)

under the supervision or direction of a qualified audiologist in accordance with 42 CFR § 440.110 and other applicable state and federal law.

Place of Service:
Audiology and hearing services may be delivered in the following places of service: office, home, outpatient setting, or other location, e.g., school.
4b. EPSDT Services (Continued)

Counseling Services

Definition:
Counseling services outlined in this section of the state plan are available to Medicaid-eligible recipients under the age of 21 years, who are eligible for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), and for whom the services are medically necessary.

Services:
Medically necessary EPSDT services are health care, diagnostic services, treatment, and other measures described in section 1905(a) of Title XIX of the Social Security Act that are necessary to correct or ameliorate any defects and physical and mental illnesses and conditions. These services are intended for the exclusive benefit of the Medicaid eligible child and include but are not limited to:

1. Services provided to assist the child and/or parents in understanding the nature of the child's disability;
2. Services provided to assist the child and/or parents in understanding the special needs of the child;
3. Services provided to assist the child and/or parents in understanding the child's development;
4. Health and behavior interventions to identify the psychological, behavioral, emotional, cognitive, and social factors important to the prevention, treatment, or management of physical health problems.
5. Counseling services by providers identified in Appendix 1 to Attachment 3.1-A, Items 6d(5), 6d(6), 6d(7), and 6d(8) of the state plan; and
6. Assessing needs for specific counseling services.

Counseling services may be provided in an individual or group setting.

Providers:
Counseling services must be provided by a qualified counselor who meets the qualification requirements of 42 CFR § 440.60(a) and all other applicable state and federal law or regulation.

Services may be provided by a:

- Licensed Psychologist;
- Provisionally Licensed Psychologist (PLP);
- Licensed Psychological Associate (LPA);
- Licensed Physician;
- Licensed Clinical Social Worker (LCSW);
- Licensed Marriage and Family Therapist (LMFT);
- Licensed Professional Counselor (LPC); or
- Licensed Specialist in School Psychology (LSSP) when the services are provided in a school setting.

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4.b.  EPSDT Services (Continued)

Counseling Services (continued)

Place of Service:

Counseling services may be delivered in the following places of service: office, home, outpatient setting, or other location, e.g., school.
4.b. EPSDT Services (Continued)

Nursing Services

Definition:
Nursing services outlined in this section of the state plan are available to Medicaid-eligible recipients under the age of 21 years, who are eligible for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services and for whom the service is medically necessary.

Services:
Nursing services are defined as the promotion of health, prevention of illness, and the care of ill, disabled and dying people through the provision of services essential to the maintenance and restoration of health.

Nursing services may be provided in an individual or group setting.

Providers:
Nursing services must be provided by a qualified nurse who meets qualification requirements of, and in accordance with, 42 CFR § 440.60 and other applicable state and federal law or regulation, including nursing services delivered by advanced practice nurses (APNs) including nurse practitioners (NPs) and clinical nurse specialists (CNSs), registered nurses (RNs), licensed vocational nurses (LVNs), licensed practical nurses (LPNs).

Nursing services provided on a restorative basis under 42 CFR § 440.130(d), including services delegated in accordance with the Texas Board of Nurse Examiners to individuals who have received appropriate training from a RN.

Place of Service:
Nursing services may be delivered in the following places of service: office, home, outpatient setting, or other location, e.g., school.
4.b. EPSDT Services (Continued)

**Occupational Therapy**

**Definition:**
Occupational therapy services outlined in this section of the state plan are available to Medicaid-eligible recipients under the age of 21 years, who are eligible for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services and for whom the services are medically necessary.

**Services:**
Occupational therapy services must be prescribed by a physician. These services include any necessary supplies and equipment utilized during the therapy session.

Medically necessary EPSDT services are health care, diagnostic services, treatments, and other measures necessary to correct or ameliorate any disability and chronic conditions. These services include but are not limited to:

1. Identification of children with occupational therapy needs;
2. Evaluation for the purpose of determining the nature, extent and degree of the need for occupational therapy services;
3. Improving, developing, or restoring functions impaired or lost through illness, injury, or deprivation;
4. Improving ability to perform tasks for independent functioning when functions are impaired or lost; and
5. Preventing, through early intervention, initial or further impairment or loss of function.

Occupational therapy services may be provided in an individual or group setting.

**Providers:**
Occupational therapy services must be provided by a qualified occupational therapist who meets the requirements of 42 CFR §440.110(b) and in accordance with applicable state and federal law or regulation.

Services may be provided by:

- A qualified occupational therapist licensed by the state to furnish occupational therapy services; or
- A certified occupational therapy assistant (COTA) when the services are provided in a facility setting (including a comprehensive outpatient rehabilitation facility, an outpatient rehabilitation facility, an outpatient hospital, an inpatient hospital, or a school) and when the assistant is acting under the supervision or direction of a qualified occupational therapist in accordance with 42 CFR § 440.110 and other applicable state and federal law.
4.b. EPSDT Services (Continued)

Occupational Therapy (continued)

Place of Service:
Occupational therapy services may be delivered in the following places of service: office, home, outpatient setting, or other location, e.g., school.
4b. EPSDT Services (Continued).

Personal Care Services

Personal care services are available to Medicaid-eligible clients under the age of 21 years, who are eligible for the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program and for whom services are medically necessary.

Services:
EPSDT services are health care, diagnostic services, treatments, and other measures necessary to correct or ameliorate defects and physical and mental illnesses and conditions.

Personal care services are support services furnished to a client who has physical, cognitive, or behavioral limitations related to the client's disability or chronic health condition that limit the client's ability to accomplish activities of daily living (ADLs), instrumental activities of daily living (IADLs), or health-related functions.

Services must be authorized by a physician in accordance with a plan of treatment or (at the State's option) in accordance with a service plan approved by the State.

Personal care services may be provided in an individual or group setting.

Providers:
Individuals providing personal care services must be a qualified provider in accordance with 42 CFR § 440.167, who is 18 years or older and has been trained to provide the personal care services required by the client. Personal care services will not be reimbursed when delivered by someone who is a legally responsible relative or guardian. Service providers include: individual attendants, attendants employed by agencies that meet the state requirements, attendants employed by agencies contracting with the State, special education teachers, and special education teacher's aides. Bus monitors/aides may be considered for reimbursement when the personal care services are provided on a specially adapted school bus.

Providers delivering personal care services must be enrolled in the Medicaid program and meet State requirements for a provider of personal care services or meet State contracting requirements for a consumer directed services agency.

Place of Service:
Personal care services are furnished in a home, school, day care facility or other community setting, excluding hospitals, nursing facilities, intermediate care facilities for the mentally retarded, and institutions for mental disease.
4.b. EPSDT Services (Continued)

Physical Therapy

Definition:
Physical therapy services outlined in this section of the state plan are available to Medicaid-eligible recipients under the age of 21 years, who are eligible for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services and for whom services are medically necessary.

Services:
Physical therapy services must be prescribed by a physician. These services include any necessary supplies and equipment utilized during the therapy session.

Medically necessary EPSDT services are health care, diagnostic services, treatments, and other measures to correct or ameliorate any disability and chronic conditions. These services include but are not limited to:

1. Identification of children with physical therapy needs;
2. Evaluation for the purpose of determining the nature, extent and degree of the need for physical therapy services;
3. Physical therapy services provided for the purpose of preventing or alleviating movement dysfunction and related functional problems; and
4. Obtaining, interpreting, and integrating information appropriate to program planning.

Physical therapy services may be provided in an individual or group setting.

Providers:

Physical therapy services must be provided by a qualified physical therapist who meets the requirements of 42 CFR § 440.110(a) and in accordance with applicable state and federal law or regulation.

Services may be provided by:

- a qualified physical therapist licensed by the state to furnish physical therapy services; or
- a licensed physical therapy assistant (LPTA) when the services are provided in a facility setting (including a comprehensive outpatient rehabilitation facility, an outpatient rehabilitation facility, an outpatient hospital, an inpatient hospital, or a school) and when the assistant is acting under the supervision or direction of a qualified physical therapist in accordance with 42 CFR § 440.110 and other applicable state and federal law.
4.b.  EPSDT Services (Continued)

Physical Therapy (continued)

Place of Service:
Physical therapy services may be delivered in the following places of service: office, home, outpatient setting, or other location, e.g., school.
4.b. EPSDT Services (Continued)

Physician Services

Definition:

Physician services outlined in this section of the state plan are available to Medicaid-eligible recipients under the age of 21 years, who are eligible for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services and for whom the service is medically necessary.

Services:

EPSDT medically necessary services are health care, diagnostic services, treatments, and other measures necessary to correct or ameliorate any disability and chronic conditions. These services include but are not limited to:

1. Physician services; and
2. Diagnostic and evaluation services to determine a child’s medically related condition that results in the child’s need for Medicaid services.

Physician services may be provided only in an individual setting.

Providers:

Physician services must be provided by a qualified physician who meets the requirements of, and in accordance with, 42 CFR § 440.50(a) and other applicable state and federal law or regulation.

Place of Service:

Physician services may be delivered in the following places of service: office, home, outpatient setting, or other location, e.g., school.
Psychological Services

Definition:
Psychology services outlined in this section of the state plan are available to Medicaid-eligible recipients under the age of 21 years, who are eligible for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services, and for whom the services are medically necessary.

Services:
Medically necessary EPSDT services are health care, diagnostic services, treatment, and other measures described in section 1905(a) of Title XIX of the Social Security Act that are necessary to correct or ameliorate any defect and physical and mental illnesses and conditions. These services include but are not limited to:
1. Psychology services as identified in Appendix I to Attachment 3.1A, Item 6d(8), of the state plan;
2. Administering psychological tests and other assessment procedures, and interpreting testing and assessment results;
3. Obtaining, integrating and interpreting information about child behavior and conditions related to learning and functional needs, planning and managing a program of psychological services;
4. Evaluating a Medicaid recipient for the purpose of determining the needs for specific psychological, health or related services; and
5. Assessing the effectiveness of the delivered services on achieving the goals and objectives of the child's individual educational program (IEP).

Psychological services may be provided in an individual or group setting.

Providers:
Psychological services must be provided by a qualified psychologist who meets the requirements of, and in accordance with, 42 CFR § 440.60 and other applicable state and federal law or regulation.

Services may be provided by:
- A qualified psychologist licensed by the state;
- A qualified psychiatrist licensed by the state;
- Provisionally Licensed Psychologist (PLP);
- Licensed Psychological Associate (LPA);
- A Licensed Specialist in School Psychology (LSSP) when the services are provided in a school setting.

Place of Service:
Psychological services may be delivered in the following places of service: office, home, outpatient setting, or other location, e.g. school.
4.b. EPSDT Services (Continued)

Speech and Language Services

Definition:
Speech and language services outlined in this section of the state plan are available to Medicaid-eligible recipients under the age of 21 years, who are eligible for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services and for whom services are medically necessary.

Services:
Medically necessary EPSDT services are health care, diagnostic services, treatments, and other measures to correct or ameliorate any disability and chronic conditions. These services include but are not limited to:
1. Identification of children with speech or language disorders;
2. Diagnosis and appraisal of specific speech or language disorders;
3. Referral for medical or other professional attention necessary for the habilitation of speech or language disorders; and
4. Provision of speech or language services for the habilitation or prevention of communicative disorders.

Speech and language services must be prescribed by a physician. In a school setting, speech and language services may be prescribed by either a physician or by an other licensed practitioner of the healing arts within the scope of his or her practice under state law in accordance with 42 CFR § 440.110(c).

Speech and language therapy services may be provided in an individual or group setting.

Providers:
Speech and language services must be provided by:
- A qualified speech/language pathologist (SLP) who meets the requirements of, and in accordance with, 42 CFR § 440.110(c), and other applicable state and federal law or regulation;
- American Speech-Language-Hearing Association (ASHA) certified SLP with Texas license and ASHA-equivalent SLP (i.e., SLP with master's degree and Texas license) when the services are provided in a school setting. (Pending equivalency ruling by Texas Attorney General's opinion.);
- A qualified assistant in SLP licensed by the state, when the services are provided in a facility setting (including a comprehensive outpatient rehabilitation facility, an outpatient rehabilitation facility, an outpatient hospital, an inpatient hospital, or a school) and when the assistant is acting under the supervision or direction of a qualified SLP in accordance with 42 CFR § 440.110 and other applicable state and federal law; or
4.b. EPSDT Services (Continued)

Speech and Language Services (continued)

- A provider with a state education agency certification in speech language pathology, a licensed SLP intern, and a grandfathered SLP (has a Texas license and no master’s degree) when the services are provided in a school setting and when these providers are acting under the supervision or direction of a qualified SLP in accordance with 42 CFR § 440.110 and other applicable state or federal law.

Place of Service:
Speech and language services may be delivered in the following places of service: office, home, outpatient setting, or other location, e.g., school.
4.b. EPSDT Services (Continued)

Transportation Services in the School Setting

Definition:
Transportation services outlined in this section of the state plan are available to Medicaid-eligible recipients under the age of 21 years, who are eligible for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services and for whom the services are medically necessary.

Services:
Medically necessary transportation services are provided to all Medicaid-eligible children when the Medicaid-eligible children are receiving school-based services (also known as School Health and Related Services (SHARS)) on the same day. Transportation services are provided on a specially adapted school bus to and/or from the location where the school-based service is provided.

Providers:
Transportation services must be provided by a qualified Medicaid provider. Transportation services include direct services personnel, e.g. bus drivers employed by the school districts.
4.b EPSDT Services (continued)

1) Private Duty Nursing Services:

a) Private duty nursing (PDN) services are prior authorized and the services must be performed by a licensed registered nurses or licensed vocational nurse. In Texas, licensed practical nurses are referred to as licensed vocational nurses (LVNs). PDN services must be in accordance with 42 CFR § 440.80. PDN services are available to Medicaid recipients eligible for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).

b) Services:

i) EPSDT services are screening services, vision services, dental services, and other health care, diagnostic services, treatments, and other measures described in §1905(a) necessary to correct or ameliorate defects and physical and mental illness and conditions. §1905(r); 42CFR §440.40(b)

ii) PDN is skilled nursing services for EPSDT eligible recipients who meet the medical necessity criteria for PDN and require individualized, continuous skilled care beyond the level of skilled nursing visits authorized under the Texas Medicaid Home Health Services.

c) Providers:

i) PDN services must be provided by a qualified nurse who meets the requirements of applicable state licensing standards, state and federal laws, policy, and in accordance with 42 CFR § 440.80. This requirement applies to nursing services delivered by registered nurses (RNs), licensed vocational nurses (LVNs), and licensed practical nurses (LPNs).

d) Place of Service:

i) PDN services may be delivered in the following places of service: home or other location, e.g., school or daycare.
4b. EPSDT Services (Continued)

1) ESPDT Case Management:
   a) Children birth through age 20 with a health condition/health risk.

2) Areas of state in which services will be provided:
   a) Entire State

3) Comparability of services:
   a) Services are not comparable in amount duration and scope. Under section 1915(g) of the Social Security Act, a state may provide services without regard to the comparability requirements of section 1902(a)(10)(B) of the Act.

4) Definition of services:
   a) Case management services are services furnished to assist individuals, eligible under the State Plan, in gaining access to needed medical, social, educational, and other services. Case Management includes the following assistance:
      i) Comprehensive face-to-face assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social, or other services required to address short- and long-term health and well being. The frequency of assessment and reassessment is based upon client need and the complexity of the case. Additional follow-up visits can be requested based upon client need. Assessment activities include:
         (1) taking a client's history;
         (2) identifying the individual's needs and assessing and addressing family issues that impact the client's health condition/risk or high-risk condition and completing related documentation; and
         (3) gathering information from other sources, such as family members, medical providers, social workers, and educators (if necessary), to form a complete assessment of the individual.
      ii) Development (and periodic revision) of a specific care plan that:
         (1) is based on the information collected through the face-to-face needs assessment, face-to-face follow-up contacts, or telephone follow up contacts;
         (2) specifies the goals and actions to address the medical, social, educational, and other services needed by the individual;
4b. EPSDT Services (Continued)

EPSDT Case Management (Continued)

(3) includes activities such as ensuring the active participation of the eligible individual, and working with the individual (or the individual's authorized health care decision maker) and others to develop those goals; and

(4) identifies a course of action to respond to the assessed needs of the eligible individual, including identifying the individual responsible for contacting the appropriate health and human service providers; and designating the time frame within which the eligible recipient should access services.

iii) Referral and related activities to help an eligible individual obtain needed services, including activities that help link an individual with:

(1) medical, social, and educational providers; and

(2) other programs and services that can provide needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.

iv) Monitoring, follow-up activities, and contacts that are necessary to ensure the care plan is implemented and adequately addresses the individual's needs.

(1) Such activities may be with the individual, family members, providers, or other entities or individuals and conducted as frequently as necessary, and include at least one annual follow-up contact for clients who are eligible for case management for longer than 12 consecutive months, to determine whether the following conditions are met:
   (a) services are being furnished in accordance with the individual's care plan;
   (b) services in the care plan are adequate; and
   (c) the care plan and service arrangement are modified when the individual's needs or status change.

(2) Case management may include contacts with non-eligible individuals that are directly related to identifying the needs and supports for helping the eligible individual access services.

(3) Monitoring includes face-to-face follow-up visits and phone monitoring calls. The frequency of the follow up visits is based upon the complexity of client need. Additional follow-up visits can be requested based upon client need.

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4b. **EPSDT Services (Continued)**

b) Qualifications of providers:

   i) Registered nurse (with a bachelor's or advanced degree), registered nurse (without a bachelor's or advanced degree and with two years of experience), or social worker (with bachelor's or advanced degree), currently licensed by the respective Texas licensure board and whose license is not temporary, limited, or provisional in nature; and

   ii) Completion of a standardized Department of State Health Services case management training.

5) **Freedom of choice**:

   a) The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a) (23) of the Act.

      i) Eligible recipients will have free choice of the providers of case management services within the specified geographic area identified in this plan.

   b) Eligible recipients will have free choice of the providers of other medical care under the plan.

6) **Access to Services**:

   a) The State assures that case management services will be provided in a manner consistent with the best interest of the recipient and will not be used to restrict an individual's access to other services under the plan.

   b) The State assures that individuals will not be compelled to receive case management services, condition receipt of case management services on the receipt of other Medicaid services, or condition receipt of other Medicaid services on receipt of case management services.

   c) The State assures that providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.
4b. EPSDT Services (Continued)

EPSDT Case Management (Continued)

7) Limitations:
   a) Case Management does not include:
      i) Activities for which third parties are liable to pay;
      ii) Activities not consistent with the definition of case management services under section 6052 of the Deficit Reduction Act, codified at section 1915(g)(2) of the SSA;
      iii) The direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred.

8) Other Limitations:
   a) Case management services are prior authorized by the Department of State Health Services. The number of billable contacts that are prior authorized is based on the client’s level of need, level of medical involvement, and complicating psychosocial factors.

9) Payment:
   a) Payment for case management or targeted case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

10) Case Records:
    a) For all individuals receiving case management, providers maintain case records that document the following:

       i) The name of the individual;
       ii) the dates of the case management services;
       iii) the name of the provider agency (if relevant) and the person providing the case management service;
       iv) the nature, content, units of the case management services received and whether goals specified in the care plan have been achieved;
       v) whether the individual has declined services in the care plan;
       vi) the need for, and occurrences of, coordination with other case managers;
       vii) a timeline for obtaining needed services; and
       viii) a timeline for reevaluation of the plan.
4.b. EPSDT Services (continued)

Diagnostic Services - Environmental Lead Investigation Services

Definition:

Environmental lead investigation services outlined in this section of the state plan are available to Medicaid-eligible recipients under the age of 21 years, who are eligible for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services and for whom the service is medically necessary.

Services:

An environmental lead investigation is an EPSDT medically necessary service when a child has an elevated blood lead level in accordance with federal guidelines and the investigation is recommended by a child’s provider. This service includes a one-time investigation to determine the source of lead at the child’s home or primary residence.

Providers:

In accordance with the regulations at 42 CFR §431.51, all willing and qualified providers may participate in this program. Qualified providers are public health entities. These entities will ensure that all staff and contractors performing environmental lead investigation services are qualified lead risk assessors as stipulated in 40 CFR §745.226.

Place of Service:

Environmental lead investigation services may be delivered at the child’s home or primary residence.
4b. EPSDT Services (continued)

**Specialized Rehabilitative Services**

Specialized Rehabilitative Services correct deficits in the child's physical/motor, communication, adaptive, cognitive, social/emotional and sensory skills that are caused by medical, developmental, or other health-related conditions. Services are provided only as part of, or directed exclusively toward, the treatment of the Medicaid-eligible child as part of a specific, goal-oriented plan of care.

Services are:

- Recommended and developed by a multidisciplinary team that includes a physician or licensed practitioner of the healing arts acting within their scope of practice under state law;
- Documented in an Individualized Family Service Plan (IFSP), which serves as the plan of care;
- Monitored at least every six months for their effectiveness in reducing functional limitations and achieving proper growth and development, modified as necessary; and
- Provided by employees or contractors of a qualified Early Childhood Intervention (ECI) agency. Provider qualifications are listed below for each type of service.

**A. Specialized Skills Training**

Rehabilitation services promote age-appropriate development by providing skills training to correct deficits and teach compensatory skills for deficits that directly result from medical, developmental, or other health-related conditions. Services are provided in the child’s natural environment and include providing information related to the health and development of the child, skills training, and anticipatory guidance for family members, legal guardians, or other significant caregivers to ensure effective treatment of the recipient.

Services may be delivered on an individual or group basis.

**Provider Qualifications**

A provider of this service is an Early Intervention Specialist who must:

a) Hold an associate's degree or higher in a relevant field as specified by the Department of Assistive and Rehabilitative Services (DARS);

b) Demonstrate standardized competencies established by DARS;

c) Complete continuing education and ethics training on a schedule identified by DARS; and
4b. EPSDT Services (continued)

Provider Qualifications (continued)

d) Receive routine supervision from a qualified EIS supervisor. A qualified EIS supervisor must have two years of experience providing early childhood intervention services and hold a bachelor’s degree from an accredited university either with a specialization in child development, special education, psychology, social work, sociology, nursing, rehabilitation counseling, human development, or related field; or with a specialization in an unrelated field and have at least 18 hours credit in child development.

e) Supervision includes consultation, record review and observation.

B. Speech and Language Therapy

Speech and language therapy includes services designed to promote rehabilitation and remediation of delays or disabilities in language-related symbolic behaviors, communication, language, speech, emergent literacy, and/or feeding and swallowing behavior.

Speech therapy services must be delivered in accordance with 42 CFR 440.110 and §401.001(6) of the Texas Occupations Code.

Licensed speech-language pathologists may perform an evaluation without a physician’s order.

A licensed speech-language pathologist may reevaluate the child every 30 days to determine if changes to the plan of care are necessary.

Services must be identified on the IFSP and may be performed without a physician’s order.

Services may be delivered on an individual or group basis.

Speech therapy services are provided in the home or other community setting (the child’s natural environment).
4b. EPSDT Services (continued)

Speech and Language Therapy (continued)

Provider Qualifications
Speech and language therapy services must be provided by a:
   a) licensed speech language pathologist (SLP) who meets the requirements of 42 CFR 440.110(c), and all other applicable state and federal law or
   b) licensed assistant in SLP when the assistant is acting under the direction of a licensed SLP in accordance with 42 CFR 440.110 or
   c) licensed intern when the intern is acting under the direction of a qualified SLP in accordance with 42 CFR 440.110 and all other applicable state and federal law.

C. Physical Therapy

Physical therapy includes services to address the promotion of sensorimotor function through enhancement of musculoskeletal status, neurobehavioral organization, perceptual and motor development, cardiopulmonary status, and effective environmental adaptation.

Services must be performed in accordance with 42 CFR 440.110.

A licensed physical therapist may perform an evaluation without a physician referral as allowed by 22 TAC 322.1(a)(2)(A).

A licensed physical therapist may reevaluate the child every 30 days to determine if changes to the plan of care are necessary.

Physical therapy services must be identified on the IFSP and prescribed by a physician.

Services may be delivered on an individual or group basis.

Physical therapy services are provided in the home or other community setting (the child's natural environment)

Provider Qualifications
Physical therapy services must be provided by
   c) a licensed physical therapist who meets the requirements of 42 CFR 440.110(a) or

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4b. EPSDT Services (continued)

Provider Qualifications (continued)

d) a licensed physical therapy assistant (LPTA) when the assistant is acting under the direction of a licensed physical therapist in accordance with 42 CFR 440.110 and all other applicable state and federal law.

D. Occupational Therapy

Occupational therapy includes services to address the functional needs of a child related to adaptive development, adaptive behavior and play, and sensory, motor, and postural development. These services are designed to improve the child's functional ability to perform tasks in the home and community settings.

Services must be performed in accordance with 42 CFR 440.110

A licensed occupational therapist may perform an evaluation without a physician referral as allowed by §454.213 of the Texas Occupations Code.

A licensed occupational therapist may reevaluate the child every 30 days to determine if changes to the plan of care are necessary.

Occupational therapy services must be identified on the IFSP and prescribed by a physician.

Services may be delivered on an individual or group basis.

Occupational therapy services are provided in a home or other community setting (the child's natural environment).

Provider Qualifications

Occupational therapy services must be provided by

c) a licensed occupational therapist who meets the requirements of 42 CFR 440.110(b) or

d) a certified occupational therapy assistant (COTA) when the assistant is acting under direction of a licensed occupational therapist in accordance with 42 CFR 440.110 and all other applicable state and federal law.
4b. EPSDT Services (continued)

**Enrolled ECI Agency Qualifications**

To be considered a qualified ECI agency the entity must:

a) Contract with the Department of Assistive and Rehabilitative Services for the provision of ECI services;

b) Comply with all applicable federal and state laws and regulations, including provision of a multi-disciplinary team to recommend and oversee the IFSP for each child;

c) Provide supervision from a qualified supervisor according to DARS requirements, and;

d) Provide flexible scheduling to address family needs, including the provision of services outside of normal business hours.
4b. EPSDT Services (continued)

Prosthetics

a) Definition

Prosthetics outlined in this section of the state plan include orthotic devices and prosthetic devices and are available to Medicaid-eligible recipients under the age of 21 years who are eligible for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services and for whom services are medically necessary.

Orthotic and prosthetic devices are defined as replacement, correction, or support devices prescribed by the physician or other licensed practitioner of the healing arts within the scope of professional practice as defined by Texas law to:

(1) artificially replace a missing portion of the body;
(2) prevent or correct physical deformity or malfunction; or
(3) support a weak or deformed portion of the body.

Hearing aids are considered prosthetic devices and defined as an electronic device that amplifies sound to compensate for impaired hearing.

b) Services

(1) Hearing Aids. Medical necessity for hearing aids must be determined through an examination conducted by a physician or other licensed practitioner of the healing arts within the scope of his practice as defined by State law.

(2) Prosthetics/Orthotics. Orthotic and prosthetic devices require prior authorization and must be medically necessary. The services are provided under 42 CFR §§440.120(c) and 440.225 and in accordance with applicable state and federal law and regulation. Orthotic and prosthetic devices are available to Medicaid EPSDT-eligible recipients under the age of 21 years when medically necessary and eligible for federal financial participation.

Other prosthetics, which are not limited to Medicaid EPSDT-eligible recipients, are described in item 12c of this section.
c) Providers

Hearing aids must be furnished by an audiologist or by approved hearing aid fitter and dispenser providers. Providers must meet all federal and state licensing laws and regulations applicable to provision of the service.

Orthotic and prosthetic devices are a benefit of the Texas Medicaid Program when provided by a

- Medicaid-enrolled orthotist, prosthetist, or a prosthetist/orthotist licensed by the state and in accordance with applicable state and federal laws and regulations;
- Physician or other licensed practitioner of the healing arts within the scope of professional practice as defined by Texas law; or
- Medicaid-enrolled provider of durable medical equipment and supplies.

These devices may also be provided by physicians or other licensed practitioners of the healing arts within the scope of professional practice as defined by Texas law.
4b. EPSDT Services (continued)

Prescribed Pediatric Extended Care Center Services

(a) Definition:

Prescribed Pediatric Extended Care Center (PPECC) services are an array of physician-prescribed services designed to meet the medical, social and developmental needs of a child who is medically or technologically dependent and requires ongoing nursing services and other therapeutic interventions. Services are provided under the supervision of a registered nurse licensed by the state of Texas. These services are performed in a Medicaid-enrolled PPECC, which is a community-based non-residential provider licensed by the state, and compliant with state licensing standards. A PPECC serves at least four Medicaid-eligible recipients who are not related by blood, marriage, or adoption.

(b) Eligibility:

This service is available to individuals under the age of 21 based on a determination of medical necessity.

The utilization of PPECC services does not supplant the recipient's choice of private duty nursing, when medically necessary.

(c) Services:

Services are provided in a Medicaid-enrolled PPECC, licensed by the Texas Department of Aging and Disability Services and compliant with state licensing standards. PPECC services require prior authorization.

PPECC services include the development, implementation, and monitoring of a comprehensive plan of care (POC), developed in conjunction with the Medicaid recipient’s responsible adult, that specifies the recipient’s medical, nursing, psychosocial, therapeutic, dietary, functional, and developmental service needs, as well as the caregiver training needs of the recipient’s responsible adult(s).

A PPECC must provide the following basic services, prescribed by a physician, in accordance with a recipient's assessment and comprehensive plan of care:
4b. EPSDT Services (continued)

Prescribed Pediatric Extended Care Center Services (continued)

(c) Services: (continued)

(1) Nursing Services—Nursing services provided in accordance with 42 CFR § 440.130(d).

Nursing services must, under state law, be provided by a registered nurse (RN) or licensed vocational nurse (LVN). The provision of nursing services must comply with state licensure requirements related to nursing services and to PPECCs. Direct care staff may perform certain nursing services under the supervision of a RN, as permitted by state regulation related to nurse delegation.

(2) Functional developmental services—Provided in accordance with 42 CFR § 440.130(d). Functional developmental services assist a recipient in maintaining or restoring functional abilities, such as adaptive, motor, and speech. For example, a recipient may receive daily reinforcement through:

- Guided practice in using a utensil during lunch or snack time;
- Guided practice in swallowing;
- Guided use of speech to make a request; or
- Guided physical activities or play that help to restore a motor function.

(B) Functional developmental services are provided by an RN or LVN licensed under state authority or a direct care staff person under the supervision of an RN. Functional developmental services are based on the needs of the recipient, in accordance with the recipient’s plan of care and physician order.

(B) Functional services respond to needs identified in a functional assessment. The functional assessment is part of the comprehensive assessment performed by a RN and includes the following:

(i) measurable goals that maintain or restore independent functioning in daily activities and promote socialization;

(ii) a description of a recipient’s strengths and present performance level with respect to each goal, and;

(iii) planning for specific areas identified as needing restoration.
4b. EPSDT Services (continued)

Prescribed Pediatric Extended Care Center Services (continued)

(c) Services: (continued)

(3) Psychosocial services—Provided in accordance with 42 CFR § 440.130(d).

(A) Psychosocial services are behavioral and cognitive interventions to maintain or restore a recipient's psychosocial wellbeing that has been negatively impacted by medical or technological dependence or other psychosocial stressors. Psychosocial services respond to needs identified in a comprehensive assessment conducted by a RN. Examples of psychosocial services include:

(i) Guided practice to manage or reduce feelings of frustration, anxiety, depression, stress or fear, including:

(I) Using anger or stress management techniques, such as cueing a recipient to count to 10 before responding.

(II) Breathing exercises and other relaxation techniques.

(III) Assistance with breaking tasks into manageable components.

(ii) Redirection strategies to reduce verbal aggressiveness or hostility.

(iii) Providing supportive interventions and positive reinforcement to foster healthy social interactions and interpersonal behaviors.

(iv) Reinforcing age-appropriate assertiveness and decision-making.

(B) Psychosocial services are provided by a physician, RN, or psychologist licensed by the state, consistent with the recipient's plan of care and physician order. These services may also be rendered by an LVN or direct care staff person under the supervision of the physician, RN, or psychologist.
4b. EPSDT Services (continued)

Prescribed Pediatric Extended Care Center Services (continued)

(c) Services: (continued)

(4) Nutritional Counseling–Provided in accordance with 42 CFR § 440.60.

PPECC services include nutritional counseling provided by a dietitian or RN licensed by the state, in accordance with state law governing scope of practice. These services may also be rendered by an LVN or direct care staff person under the supervision of the dietitian or RN. Nutritional counseling includes advising and assisting a recipient or the recipient's responsible adult to ensure the recipient's appropriate nutritional intake.

(5) Responsible adult training and education to facilitate skill development relevant to a recipient's care are conducted by a physician (per 42 CFR §440.50), RN, or LVN (per 42 CFR §440.60). Direct care staff may perform these services under the supervision of a physician, RN, or LVN.

(6) Personal care services–Provided in accordance with 42 CFR § 440.167.

(A) Personal care services include support services provided to a recipient who meets the definition of medical necessity and requires assistance with activities of daily living (ADLs), instrumental activities of daily living (IADLs), and health-related functions because of a physical, cognitive, or behavioral limitation related to the recipient's disability or chronic health condition.

(B) Personal Care Services will be provided by direct care staff under supervision of the RN in accordance with state PPECC licensure requirements.
4b. EPSDT Services (continued)

Prescribed Pediatric Extended Care Center Services (continued)

(c) Services: (continued)

(7) Transportation–Provided in accordance with 42 CFR § 440.170(a).

(A) Transportation services must be provided either by the PPECC or a contractor of the PPECC, when a recipient has a stated need or physician order. In accordance with state PPECC licensure requirements, the recipient must be accompanied by a PPECC nurse during transport to and from the PPECC.

(B) Transportation to and from the PPECC will be reimbursed on a per case basis (i.e., only when utilized) in accordance with 42 CFR § 440.170(a).

(C) Transportation services are subject to PPECC licensure requirements related to transportation, including the following:

(1) the driver must hold a valid and appropriate Texas driver's license, a copy of which the PPECC must keep on file;

(2) the vehicle used to transport a minor must have a current Texas safety inspection sticker and vehicle registration decal properly affixed to a vehicle;

(3) the PPECC must maintain commercial insurance for the operation of its vehicles, including coverage for minors and staff in the PPECC vehicle in the event of accident or injury; and

(4) the PPECC must maintain documentation of insurance.

(5) PPECC transportation is not provided by the transportation broker.

(6) Recipients have a choice of PPECC providers, who render the transportation services.
4b. EPSDT Services (continued)

Prescribed Pediatric Extended Care Center Services (continued)

(d) Providers and Provider Qualifications:

In accordance with state PPECC licensure standards, the following may render PPECC services:

(1) Medical Director

Medical Director Qualifications. A medical director must:

(A) Hold a valid, unrestricted license to practice medicine or osteopathy in Texas in accordance with state statute; and

(B) Be board-certified in a pediatric specialty recognized by the American Board of Medical Specialties or the American Osteopathic Association.

(C) Meet all requirements as specified in state PPECC licensure regulations.

(2) Administrator and Alternate Administrator

Administrator and Alternate Administrator Qualifications. An administrator and alternate administrator must:

(A) Have at least two years of experience in supervision and management in a pediatric health care setting; and

(B) Meet one of the following criteria:

(i) be a physician licensed in Texas to practice medicine in accordance with state statute; or

(ii) be an RN with a master's or baccalaureate degree in nursing and be licensed in accordance with state statute with no disciplinary actions;

(C) Must meet all requirements as specified in state PPECC licensure regulations.
4b. EPSDT Services (continued)

Prescribed Pediatric Extended Care Center Services (continued)

(d) Providers and Provider Qualifications: (continued)

(3) Nursing Director and Alternate Nursing Director

Nursing Director and Alternate Nursing Director Qualifications. A nursing director and alternate nursing director must:

(A) Have a baccalaureate degree in nursing;

(B) Have a valid RN license in accordance with state statute with no disciplinary action;

(C) Have a valid certification in Cardio Pulmonary Resuscitation or Basic Cardiac Life Support; and

(D) Have a minimum of two years of supervision and management in employment in a pediatric setting caring for a medically or technologically dependent minor or at least two years of supervision in one of the following specialty settings:

(i) pediatric intensive care;

(ii) neonatal intensive care;

(iii) pediatric emergency care;

(iv) center;

(v) home health or hospice agency specializing in pediatric care;

(vi) ambulatory surgical center specializing in pediatric care; or (G) have comparable pediatric unit experience in a hospital for two consecutive years before the person applies for the position of nursing director.

(E) Meet all requirements as specified in state PPECC licensing regulations.
4b. EPSDT Services (continued)

Prescribed Pediatric Extended Care Center Services (continued)

(d) Providers and Provider Qualifications: (continued)

(4) Registered Nurse

Registered Nurse Qualifications. An RN must:

(A) Hold a valid RN license in accordance with state statute with no disciplinary action;

(B) Hold valid certifications in Cardio Pulmonary Resuscitation and Basic First Aid; and

(C) Have at least one of the following:

(i) one year of pediatric specialty experience with emphasis on medically and technologically dependent minors, obtained within the previous five years; or

(ii) skills sufficient to meet the competency and training requirements described in subsection (b) of this section.

(D) Meet all requirements as specified in PPECC state licensing regulations.

(5) Licensed Vocational Nurse

Licensed Vocational Nurse Qualifications: An LVN must:

(A) Hold a valid LVN license with no disciplinary action;

(B) Hold valid certifications in Cardio Pulmonary Resuscitation and Basic First Aid; and

(C) Have at least one of the following:

(i) one year of pediatric specialty experience with emphasis on medically and technologically dependent minors obtained within the last consecutive five years; or

(ii) skills sufficient to meet the competency and training requirements described in subsection (b) of this section;

(D) Meet all requirements as specified in state PPECC licensure regulations.
4b. EPSDT Services (continued)

Prescribed Pediatric Extended Care Center Services (continued)

(d) Providers and Provider Qualifications: (continued)

(6) Psychologist

Psychologist Qualifications: Each Psychologist must have a valid Psychologist license in accordance with state statute with no disciplinary action.

(7) Direct Care Staff

Direct Care Staff Qualifications. Each direct care staff member must:

(A) Be 18 years of age or older;

(B) Hold a high school diploma or a general equivalency degree;

(C) Meet at least one of the following:

(i) one year of experience employed in a health care setting providing direct care to minors who are medically or technologically dependent;

(ii) two years of experience employed in a health care, childcare, or school setting providing direct care to minors who are medically or technologically dependent;

(iii) two years of experience employed in a health care setting providing direct care to adults; or

(iv) sufficient skills to meet the competency and training requirements described in subsection (b) of this section; and

(D) Maintain current certification in Pediatric Cardio Pulmonary Resuscitation and basic First Aid.

(E) Meet all requirements as specified in state PPECC licensure regulations.

(F) Direct care staff are supervised by a licensed RN.

(8) Dietician

Dietician Qualifications: A dietician must:

(A) Hold a valid license to use the title of licensed dietitian

(B) Meet all requirements as specified in state PPECC licensure regulations.
4b. EPSDT Services (continued)

Prescribed Pediatric Extended Care Center Services (continued)

(e) Limitations:

(1) Services must not exceed 12 hours per day per recipient.

(2) Services must be a one-to-one replacement of private duty nursing hours, unless additional hours are medically necessary. While PPECC services do not supplant a recipient's right to private duty nursing services, PPECC services may not be performed or billed during the same hours that a recipient receives private duty nursing services or personal care services from a non-PPECC provider in another setting, such as the home.

(3) Medicaid will not reimburse a PPECC for services that are the responsibility of a local school district.

(f) Excluded Benefits:

(1) Baby food or formula

(2) Durable medical equipment (DME) and medical supplies provided to the recipient by Medicaid's DME and medical supply services

(3) Services that are mainly respite care or child care, or that do not directly relate to the recipient's medical needs or disability

(4) Services that are primarily the responsibility of a local school district

(5) Individualized comprehensive case management beyond required service coordination

(6) Services covered separately by Texas Medicaid, such as:

   (A) Speech, occupational, physical, respiratory care practitioner services, and early childhood intervention services.

   (B) Durable medical equipment (DME), medical supplies, nutritional products provided to the recipient by Medicaid's DME and medical supply service providers.

   (C) Private duty nursing, skilled nursing, and home health aide services provided in the home setting. To prevent duplication, these services may be provided before or after PPECC services on a given day when medically necessary, but not at the same time as PPECC services.
4.c. Family Planning Services

1) The Medicaid Program includes those Family Planning Services specified by the single state agency when provided by physicians, advanced nurse practitioners, certified nurse-midwives and certain family planning clinics directed by physicians.

   a) The benefits have been designed to cover expenses by the physician and the advanced nurse practitioners for the usual examinations and laboratory tests needed before starting patients on oral contraceptives or other methods of birth control.

   b) The benefits also include permanent birth control by surgery, when performed within the scope of applicable laws and regulations.

   c) One complete physical examination is allowed per client, per fiscal year, per provider.

2) The State assures that termination of pregnancy (i.e., abortion) is not considered a family planning service and is only covered at the federal medical assistance percentage (FMAP) rate for rape, incest and when, due to a physical condition, the life of the mother would be endangered if the pregnancy went to term.
4d. **1) Face-to-Face Tobacco Cessation Counseling Services provided (by):**

- (i) By or under supervision of a physician;
- (ii) By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services other than tobacco cessation services; * or
- (iii) Any other health care professional legally authorized to provide tobacco cessation services under State law and who is specifically designated by the Secretary in regulations. (None are designated at this time)

*describe if there are any limits on who can provide these counseling services

**2) Face-to-Face Tobacco Cessation Counseling Services Benefit Package for Pregnant Women**

Provided: ☐ No limitations ☑ With limitations*

*Any benefit package that consists of less than four (4) counseling sessions per quit attempt, with a minimum of two (2) quit attempts per 12 month period (eight (8) per year) should be explained below.

Please describe any limitations: In accordance with the Clinical Practice Guidelines published by the U.S. Public Health Service (PHS) and consistent with U.S. Preventive Services Task Force (USPSTF) grade A recommendation, pregnant women may receive four face-to-face counseling sessions per quit attempt with two quit attempts per year. Pregnant women may receive up to eight counseling sessions from the prenatal through the postpartum period.
5. **Physicians’ and Dentists’ Services.**

   a. **Physicians’ Services.** Services by or under the personal supervision of a physician licensed to practice medicine or osteopathy are covered by the Texas Medical Assistance Program as specified in 42 CFR §440.50.

      (1) **Telemedicine**

      Services provided via telemedicine are a benefit of the Texas Medicaid Program. Telemedicine is defined as the practice of health care delivery by a provider who is located at a site other than the site where the patient is located for the purposes of evaluation, diagnosis, consultation, or treatment that requires the use of advanced telecommunications technology. Chart reviews, electronic mail messages, and facsimile transmissions are not considered telemedicine.

      The distant site provider uses telemedicine to provide a service to the client at the patient site. Qualifying distant site providers are reimbursed in accordance with the standard Medicaid reimbursement methodology. Qualifying patient sites are reimbursed a facility fee.

      (2) **Optometrists’ Services**

      Physician services include services of the type which an optometrist is also legally authorized to perform and such services are reimbursed whether furnished by a physician or an optometrist.

      Diagnostic and treatment services provided by an optometrist are covered by the Texas Medical Assistance Program if the services are (1) within the optometrist’s scope of practice, as defined by state law and (2) reasonable and medically necessary as determined by the single state agency or its designee.

   b. **Dentists’ Services.** Subject to the specifications, conditions and limitations established by the single state agency, services by a Doctor of Dental Surgery or Doctor of Dental Medicine (Dentists’ services) are covered by the Texas Medical Assistance Program if the services (1) are within the dentist scope of practice, as defined by law; and (2) would be covered by the Texas Medical Assistance Program when they are provided by a licensed physician (M.D. or D.O.).
5. Physicians' and Dentists' Services.

c. Services provided by Anesthesiologist Assistants

1. Subject to the specifications, conditions, requirements, and limitations established by the single state agency, medically directed anesthesia services provided by an anesthesiologist assistant (AA), as permitted by Texas Occupations Code § 157.001, are covered by the Texas Medical Assistance Program.

2. An AA is a health care professional who works under the direction of an anesthesiologist; is in compliance with all applicable requirements of state law; is a graduate of a medical school-based anesthesiologist's assistant educational program that is accredited by the Commission on Accreditation of Allied Health Education Programs or its predecessor, the Committee on Allied Health Education and Accreditation, and includes approximately two years of specialized basic science and clinical education in anesthesia at a level that builds on a premedical undergraduate science background; and is certified by the National Commission for Certification of Anesthesiologist Assistants. For services to be payable to these professionals, the professional must comply with all applicable federal and state laws governing the service provided; be enrolled in, and approved for participation in, the Texas Medical Assistance Program; sign a written agreement with the single state agency or its designee; comply with the terms of the provider agreement and all requirements of the Texas Medical Assistance Program, including federal and state regulations, rules, handbooks, standards, and guidelines published by the single state agency or its designee; and bill for services covered by the Texas Medical Assistance Program in the manner and format prescribed by the single state agency or its designee.

3. The Texas Medical Assistance Program will not reimburse the AA for equipment or supplies. Equipment and supplies are the responsibility of the facility in which the AA services are provided. If the equipment and supplies are covered and reimbursable by the Texas Medical Assistance Program, payment may be made to the facility if the facility is approved for participation in the Texas Medical Assistance Program. The basis and amount of reimbursement depends on the reimbursement methodology utilized by the Texas Medical Assistance Program for the services and providers involved.

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Services include those services provided by a licensed podiatrist, which are within the scope of practice of the profession as defined by state law and are covered by Medicare.
6.b. **Optometric Services**

Eligible medical assistance recipients covered under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program receive optometric and eyeglasses services through the EPSDT program as described elsewhere in this State Plan.

Optometric services provided in skilled or intermediate care facilities are reimbursable by the program if the recipient’s attending physician has ordered the service(s) and the order is included in the recipient’s medical records at the nursing facility.

Coverage of chiropractic services is limited to services that consist of medically necessary treatment or correction by means of manual manipulation of the spine, by use of hands only, to correct a subluxation demonstrated by x-ray to exist to the same extent that such benefits are provided under Medicare Part B. The x-ray must be done prior to such treatment. The chiropractor must be licensed to practice when and where the services are performed and must meet the uniform minimum standards promulgated by the Secretary of the Department of Health and Human Services under Title XVIII of the Social Security Act.

Coverage for such treatment is limited to no more than 12 visits per recipient per 12 consecutive month period. A 12 consecutive month period begins with the first month in which services are provided.

Documenting x-rays will be kept on file and are subject to utilization review and audit procedures. Coverage of chiropractic services will be determined by the single state agency or its designated agent in accordance with the regulations, rules, and procedures governing chiropractic services under Part B of Title XVIII of the Social Security Act. Coverage does not extend to the diagnostic, therapeutic services or adjunctive therapies furnished by a chiropractor or by others under his or her orders or direction. This exclusion applies to the x-ray taken for the purpose of determining the existence of a subluxation of the spine. Additionally, braces or supports, even though ordered by an M.D. or D.O. and supplied by a chiropractor, are not reimbursable items.
6.d. Other Practitioners’ Services
6.d.(3) Certified Registered Nurse Anesthetists' Services. Subject to the specifications, conditions, requirements, and limitations established by the single state agency, anesthesia services provided by a certified registered nurse anesthetist (CRNA) are covered by the Texas Medical Assistance Program. A CRNA is defined as a registered nurse who is approved as an advanced nurse practitioner by the state in which he or she practices and who is currently certified by either the Council on Certification of Nurse Anesthetists or the Council on Recertification of Nurse Anesthetists.

Covered services must be provided by a CRNA enrolled and approved for participation in the Texas Medical Assistance Program. The CRNA must sign a written provider agreement with the single state agency. By signing the agreement, the CRNA agrees to comply with the terms of the agreement and all requirements of the Texas Medical Assistance Program, including regulations, rules, handbooks, standards, and guidelines published by the single state agency or its designee. The CRNA must bill for services covered by the Texas Medical Assistance Program in the manner and format prescribed by the single state agency or its designee.

The Texas Medical Assistance Program will not reimburse the CRNA for equipment or supplies. Equipment and supplies are the responsibility of the facility in which the CRNA services are provided. If the equipment and supplies are covered and reimbursable by the Texas Medical Assistance Program, payment may be made to the facility if the facility is approved for participation in the Texas Medical Assistance Program. The basis and amount of reimbursement depends on the reimbursement methodology utilized by the Texas Medical Assistance Program for the services and providers involved.
6.d.(4) Other Categories of Advanced Nurse Practitioner Services

Advanced nurse practitioner--A registered professional nurse, currently licensed in the State of Texas, who is prepared for advanced nursing practice by virtue of knowledge and skills obtained through a post-basic or advanced educational program of study acceptable to the Board of Nurse Examiners for the State of Texas. The advanced nurse practitioner is prepared to practice in an expanded role to provide health care to individuals, families, and/or groups in a variety of settings. The advanced nurse practitioner functions in a collegial relationship with other health care professionals making independent decisions about nursing needs and interdependent decisions with health care professionals regarding health regimens.

In addition to coverage of services performed by certified nurse midwives, certified registered nurse anesthetists, certified pediatric nurse practitioners, and certified family nurse practitioners described elsewhere in this state plan and subject to the specification, conditions, requirements, and limitations established by the Single State Agency or its designee, services performed by advanced nurse practitioners are covered if the services: 1) are within the scope of practice for advanced nurse practitioners, as defined by state law; 2) are consistent with rules and regulations promulgated by the Board of Nurse Examiners for the State of Texas or other appropriate state licensing authority; and 3) would be covered by the Texas Medical Assistance Program if provided by a licensed physician (M.D. or D.O.).

To be payable, services must be reasonable and medically necessary as determined by the Single State Agency or its designee.

The advanced nurse practitioner must comply with all applicable federal and state laws and regulations governing the services provided; be enrolled and approved for participation in the Texas Medical Assistance Program; sign a written provider agreement with the Single State Agency or its designee; comply with the terms of the provider agreement and all requirements of the Texas Medical Assistance Program, including regulations, rules, handbooks, standards, and guidelines published by the Single State Agency or its designee; and bill for services covered by the Texas Medical Assistance Program in the manner and format prescribed by the Single State Agency or its designee.

Advanced nurse practitioners who are employed or remunerated by a physician, hospital, facility, or other provider must not bill the Texas Medical Assistance Program directly for their services if that billing would result in duplicate payment for the same services. If the services are coverable and reimbursable by the program, payment may be made to the physician, hospital, or other provider (if the provider is approved for participation in the Texas Medical Assistance Program) who employs or reimburses advanced nurse practitioners. The basis and amount of Medicaid reimbursement depend on the services actually provided, who provided the services, and the reimbursement methodology determined by the Texas Medical Assistance Program as appropriate for the services and the providers involved.

Mental health counseling services for emotional disorders or conditions provided to Medicaid eligible clients by a licensed clinical social worker (LCSW) are covered services. Services provided by an LCSW are available to Medicaid eligible recipients. To be payable, the services must be reasonable and medically necessary as determined by the single state agency or its designee.

To be considered for reimbursement by the Texas Medical Assistance Program LCSW must be licensed as a licensed master social worker and be recognized as being qualified for the practice of clinical social work by the Texas State Board of Social Worker Examiners. These providers must comply with all federal and state laws and regulations governing the services provided.

Participating LCSWs must be enrolled in the Texas Medical Assistance Program and comply with all of the terms of the provider agreement and all of the regulatory provisions published by the single state agency or its designee.

LCSWs who are employed or remunerated by another provider may not bill the Texas Medical Assistance Program directly for counseling services if that billing would result in duplicate payment for the same services.

6.d. (6) Licensed Professional Counselor (LPC). Mental health counseling services for emotional disorders or conditions provided to Medicaid eligible recipients by a licensed professional counselor (LPC) are covered services. Services provided by an LPC are available to Medicaid eligible recipients. To be payable, the services must be reasonable and medically necessary as determined by the single state agency or its designee.

To be considered for reimbursement by the Texas Medical Assistance Program, LPCs must be licensed by the Texas Board of Examiners of Professional Counselors in accordance with the Texas Licensed Professional Counselor Act. These providers must comply with all federal and state laws and regulations governing the service provided. Participating LPCs must be enrolled in the Texas Medical Assistance Program and comply with all of the terms of the provider agreement and all of the regulatory provisions published by the single state agency or its designee. LPCs who are employed or remunerated by another provider may not bill the Texas Medical Assistance Program directly for counseling services if that billing would result in duplicate payment for the same services.
6.d.(7) Licensed Marriage and Family Therapist (LMFT). Mental health counseling services for emotional disorders or conditions provided to Medicaid eligible clients by a licensed marriage and family therapist (LMFT) are covered services. Services provided by an LPC are available to Medicaid eligible recipients. To be payable, the services must be reasonable and medically necessary as determined by the single state agency or its designee.

To be considered for reimbursement by the Texas Medical Assistance Program, LMFTs must be licensed by the Board of Examiners of Marriage and Family Therapists in accordance with the Texas Licensed Marriage and Family Therapist Act. These providers must comply with all federal and state laws and regulations governing the service provided.

Participating LMFTs must be enrolled in the Texas Medical Assistance Program and comply with all of the terms of the provider agreement and all of the regulatory provisions published by the single state agency or its designee.

LMFTs who are employed or remunerated by another provider may not bill the Texas Medical Assistance Program directly for counseling services if that billing would result in duplicate payment for the same service.
6d(8) Psychologists' Services

Services provided by a licensed psychologist are available to Medicaid-eligible recipients. Psychological counseling and services provided by a licensed psychologist are covered if the services (1) are within the psychologist's scope of practice, as defined by state law; and (2) would be covered by the Texas Medical Assistance Program when they are provided by a licensed physician (M.D. or D.O.).

Psychologists' services must be provided by a licensed psychologist enrolled in and approved for participation in the Texas Medical Assistance Program. A psychologist is defined as a person who is licensed to practice as a psychologist in the state in which the service is performed.

Services performed by a provisionally licensed psychologist (PLP) or a licensed psychological associate (LPA) are a benefit of the Texas Medical Assistance Program only when the services are provided within the PLP's or LPA's scope of practice and under the direct supervision of a licensed psychologist.

A licensed psychologist who is employed by or remunerated by a physician, hospital, facility, or other provider may not bill the Texas Medical Assistance Program directly for psychologist's services if that billing would result in duplicate payment for the same services. If the services are covered and reimbursable by the program, payment may be made to the physician, hospital, or other provider (if approved for participation and who is enrolled in the Texas Medical Assistance Program) who employs or reimburses the licensed psychologist. The basis and amount of Medicaid reimbursement depends on the service actually provided, who provided the service, and the reimbursement methodology used by the Texas Medical Assistance Program as appropriate for the service and provider(s) involved.
6.d.(9). Services provided by Physician Assistants.

(a) Services performed by physician assistants are covered if the services are within the scope of practice for physician assistants, as defined by state law; are consistent with rules and regulations promulgated by the Texas Physician Assistant Board or other appropriate state licensing authority; and are covered services under the Texas Medical Assistance Program.

(b) Physician Assistants are health care professionals who are licensed by the state to practice as physician assistants, who have met and maintained the eligibility requirements set forth in the law (such as successful completion of an educational program accredited by the Accreditation Review Commission on Education for the Physician Assistant for the training of physician assistants and certification as such by the National Commission on Certification of Physician Assistants). For services to be payable to these professionals, the professional must be licensed as a Physician Assistant; comply with all applicable federal and state laws governing the service provided; be enrolled in, and approved for participation in, the Texas Medical Assistance Program; must sign a written agreement with the single state agency or its designee; must comply with the terms of the provider agreement and all requirements of the Texas Medical Assistance Program, including federal and state regulations, rules, handbooks, standards, and guidelines published by the single state agency or its designee; and bill for services covered by the Texas Medical Assistance Program in the manner and format prescribed by the single state agency or its designee.

(c) Physician Assistants who are employed or remunerated by a physician may bill the Texas Medical Assistance Program and be paid directly for their services. (Both the physician assistant and the employing/contracting entity may not bill services if that billing would result in duplicate payment for the same services.) If the services are reimbursable by the program, payment may be made to the entity (if approved for participation in the Texas Medical Assistance Program) that employs or reimburses the Physician Assistant. The basis and amount of Medicaid reimbursement depends on the services actually provided, who provided the service, and the reimbursement methodology utilized by the Texas Medical Assistance Program as appropriate for the services and provider(s) involved.
Other Practitioners’ Services (continued)

6.d (10). Licensed Midwife

Birthing services provided in a Medicaid certified freestanding birthing center by a licensed direct-entry midwife are covered services. Services provided by a licensed direct-entry midwife are available to Medicaid beneficiaries. Services provided by a licensed direct-entry midwife must be reasonable and medically necessary as determined by the single state agency or its designee.

To be considered for Medicaid reimbursement, licensed direct-entry midwives must be licensed by the Texas Midwifery Board at the Department of State Health Services in accordance with the Texas Midwifery Act. These providers must comply with all federal and state laws and regulations governing the service provided. Participating licensed direct-entry midwives must be enrolled in the Texas Medical Assistance Program and comply with all the terms of the provider agreement and all the regulatory provisions published by the single state agency or its designee.
6.d (11). **Pharmacist.**

a. Administration Services

1. Certain injectable drugs and vaccines administered by a participating pharmacy are covered services. Administration services do not require prior authorization.

2. HHSC lists the injectable drugs and vaccines that may be provided by a participating pharmacy on its Internet website.

3. Participating pharmacies are licensed pharmacies enrolled as Title XIX providers with the Vendor Drug Program.

4. Administering pharmacists are health care professionals who are licensed by the Texas State Board of Pharmacy to practice as a pharmacist, who have met and maintained the eligibility requirements set forth in law, and who have been certified by the State Board of Pharmacy to administer injectable drugs and vaccines. Administering pharmacists are under the supervision of a physician in accordance with Texas law. Pharmacists are employed and remunerated by a pharmacy for their services. If the services are covered and reimbursable by the program, payment may be made to the pharmacy who employs the licensed pharmacist.

b. Vaccine Services

1. Certain vaccines may be provided by a participating pharmacy. Coverage of vaccines do not require a prescription for Medicaid-eligible clients age seven and older. Vaccines do not require prior authorization.

2. HHSC lists the vaccines that may be provided by a participating pharmacy on its Internet website.

3. Participating pharmacies are licensed pharmacies enrolled as Title XIX providers with the Vendor Drug Program.
4. Administering Pharmacists are health care professionals who are licensed by the Texas State Board of Pharmacy to practice as a pharmacist, who have met and maintained the eligibility requirements set forth in law, and who have been certified by the State Board of Pharmacy to administer vaccines. Administering pharmacists are under the supervision of a physician in accordance with Texas law. Pharmacists may administer immunizations or vaccinations only under a physician’s written protocol authorizing the administration. Pharmacists are employed and remunerated by a pharmacy for their services. If the services are covered and reimbursable by the program, payment may be made to the pharmacy who employs the licensed pharmacist.
6.d. Other Practitioners’ Services

(12) Licensed Behavior Analysts

a. To the extent required by EPSDT, a licensed behavior analyst (LBA) operating within the LBA’s state scope of practice and licensure requirements may provide applied behavior analysis (ABA) evaluation and treatment services to children under 21 who have a diagnosis of autism spectrum disorder (ASD) when the services are delivered in accordance with state licensure requirements.

LBAs must provide direct supervision to licensed assistant behavior analysts (LaBAs) and behavior technicians (BTs), if LaBAs or BTs are utilized to deliver covered ABA services. LBAs shall assume professional responsibility for and ensure the quality of ABA services rendered by the LaBAs and BTs under the LBA’s direct supervision. The supervision of an LaBA and BT is within state scope of practice for the LBA. The supervision of a BT by an LaBA who is supervised by an LBA is within state scope of practice for the LBA and LaBA.

b. Provider Qualifications

1. LBAs must:
   a. Be licensed by the Texas Department of Licensing and Regulation (TDLR);
   b. Have a current certification of Board-Certified Behavior Analyst-Doctoral (BCBA-D) or Board-Certified Behavior Analyst (BCBA) by the Behavior Analyst Certification Board (BACB) or other certification as required by TDLR;
   c. Have no active, disqualifying sanctions or disciplinary actions; and
   d. Have a completed criminal background check according to the State's requirements.

2. LaBAs must:
   a. Be licensed by the TDLR;
   b. Have a current certification of Board-Certified assistant Behavior Analyst (BCaBA) by the BACB or other certification as required by TDLR;
   c. Have no active, disqualifying sanctions or disciplinary actions;
   d. Have a completed criminal background check according to the State's requirements;
   e. Work under the direct supervision of an LBA; and
   f. Have the supervisory relationship documented in writing.
3. BTs must:
   a. Be 18 years old or older;
   b. Be currently registered by the BACB or another national body that is accredited by the American National Standards Institute (ANSI) or National Commission for Certifying Agencies (NCCA) and that certifies BTs specializing in ABA or autism spectrum disorder;
   c. Have a high school diploma or national equivalent;
   d. Have a completed criminal background check that meets the certifying body’s requirements;
   e. Work under the direct supervision of an LBA or an LaBA, who is supervised by an LBA; and
   f. Have the supervisory relationship documented in writing.
7. **Home Health Care Services**

In accordance with the provisions or specifications established by the single state agency, home health care services are as follows:

A. Authorized services, supplies, equipment, or appliances must be suitable for treatment and/or related to the medical condition of the recipient. The services provided through home health are intended for the recipient and must be related to the medical condition, rather than primarily for the convenience of the recipient, caregiver/guardian, or the provider. The service, supply, equipment, or appliance must be provided to an eligible recipient in his or her place of residence. The recipient's place of residence does not include a hospital, nursing facility, or intermediate care facility for the mentally retarded. The only exception for services provided in an intermediate care facility for the mentally retarded occurs when the facility is not required to provide services as defined in Subpart I of 42 CFR Part 483. All home health services are provided in accordance with 42 CFR 440.70.

B. The recipient for whom home health care services are authorized must be under the continuing care and supervision of a licensed physician or allowed practitioner. An allowed practitioner is a licensed physician assistant (PA) or an advanced practice registered nurse, who is licensed as a certified nurse practitioner (CNP) or clinical nurse specialist (CNS). Allowed practitioners, (PAs, CNPs, and CNSs) must maintain a valid and registered prescriptive authority agreement in accordance with state law. Medical necessity criteria include supporting documentation of the medical need and the appropriateness of the equipment, service, or supply prescribed by the physician or allowed practitioner for the treatment of the individual recipient.

C. Services, supplies, equipment, or appliances must be prescribed by a physician or allowed practitioner as medically necessary and appropriate and documented as part of the physician’s or allowed practitioner’s plan of treatment for the recipient in the written, dated, and signed plan of care and/or order form.

D. All home health benefits require prior authorization for payment, unless otherwise specified by the Title XIX single state agency and must be furnished by a home health agency or a durable medical equipment/supplier enrolled to provide Title XIX home health services. Insulin syringes and needles are obtained with a physician's or allowed practitioner's prescription from a participating pharmacy and do not require prior authorization.

E. To become enrolled as a Title XIX home health agency or home health durable medical equipment supplier, the home health agency or durable medical equipment supplier must be approved as a Title XVIII (Medicare) home health services provider or durable medical equipment/supplier and must be enrolled with the Title XIX single state agency.
7 Home Health Care Services (continued)

F. Services are limited to:

(i) Part-time or intermittent professional nursing services provided by a registered nurse or licensed vocational nurse with appropriate supervision furnished through a Title XIX home health agency or by a registered nurse when no home health agency exists in the area.

(ii) Services of a home health aide who has been assigned by a professional registered nurse and who is under the supervision of a professional registered nurse.

(iii) Visits by either a nurse or a home health aide as defined under this program.

(iv) Certain medical supplies, equipment, and appliances suitable for use in the recipient's place of residence.

(v) Physical therapy services, provided by a physical therapist meeting the criteria defined in §440.110, are available only for treatment of acute musculoskeletal or neuromuscular conditions or acute exacerbations of a chronic musculoskeletal or neuromuscular condition.

(vi) Occupational therapy services, provided by an occupational therapist meeting the criteria defined in §440.110, are available for the evaluation and function-oriented treatment of individuals whose ability to function in life roles is impaired by recent or current physical illness, injury, or condition. There must be specific goals to achieve a functional level within a reasonable amount of time based on the therapist's evaluation and the physician's or allowed practitioner's assessment and plan of care.

G. Medicare must be utilized as a primary resource for payment of home health benefits for those persons who are enrolled in Medicare.
In-Home Services for Total Parenteral Nutrition (TPN)

a) **Definition:** In-home Total Parenteral Nutrition (TPN)/Hyperalimentation activities outlined in this section of the State plan are available to Medicaid eligible recipients for the treatment of conditions which require long-term nutritional support. TPN/Hyperalimentation is not available when oral/enteral intake will maintain adequate nutrition.

b) **Services:** Home health services, including in-home Total Parenteral Nutrition (TPN)/hyperalimentation activities, are provided to a recipient on his or her physician's or allowed practitioner's orders as part of a written plan of care that the physician or allowed practitioner reviews every 60 days.

Medically necessary TPN/hyperalimentation services include:

i) **Medical Supplies** in accordance with 42 C.F.R. § 440.70(b)(3) including:
   
   (A) TPN/Hyperalimentation solutions and additives as ordered by the client's physician or allowed practitioner.
   
   (B) Supplies and equipment that are required for the administration of prescribed solutions and additives.
   
   (C) Enteral supplies, nutritional products, and equipment, if medically necessary, in conjunction with TPN/hyperalimentation.

ii) **Nursing Services** in accordance with 42 C.F.R. § 440.70(b)(1):

   (A) Visits by a registered nurse appropriately trained in the administration of TPN/Hyperalimentation.
   
   (B) Education of the client and/or caregivers regarding the administration of in-home TPN/Hyperalimentation before the service begins. Education also must include the use and maintenance of required supplies and equipment.

c) **Providers:** In-home TPN/hyperalimentation equipment and supplies must be provided by an enrolled Medicaid durable medical equipment supplier or a medical supply provider who meets the requirements of, and provides the services in accordance with, 42 C.F.R. § 440.70 and other applicable state and federal laws and regulations. Nursing services are delivered by Home Health Agencies meeting requirements for participation in Medicare and requirements at 42 CFR §440.70(d).

d) **Place of Service:** In home TPN/hyperalimentation services must be delivered in the recipient's place of residence as defined in 42 C.F.R. § 440.70.
7. **Home Health Care Services (continued)**

**Home Health Supplies Provided by a Pharmacy**

(a) Certain home health supplies that may be provided by a participating pharmacy are specified by the Title XIX single state agency and require a physician's or allowed practitioner's prescription. These supplies do not require prior authorization unless otherwise specified.

(b) HHSC lists home health supplies that may be provided by a participating pharmacy on its website. This list includes the insulin syringes and needles referenced on Page 14 of **this** Appendix.

(c) Participating pharmacies are licensed pharmacies enrolled as Title XIX providers with the Vendor Drug Program.
7. **Home Health Care Services (continued)**

**Home Telemonitoring Services**

(a) Home telemonitoring services are a benefit of the Texas Medicaid Program as provided in this section, are based on medical necessity, and are subject to the specifications, conditions, limitations, and requirements established by the Texas Health and Human Services Commission (HHSC) or its designee.

(b) Home telemonitoring services require scheduled remote monitoring of data related to a patient's health and transmission of the data to a licensed home health agency or a hospital.

(c) Home telemonitoring service providers must:

1. comply with all applicable federal, state, and local laws and regulations;

2. be enrolled and approved for participation in the Texas Medicaid Program as home telemonitoring service providers;

3. bill for services covered under the Texas Medicaid Program in the manner and format prescribed by HHSC;

4. share clinical information gathered while providing home telemonitoring services with the patient's physician or allowed practitioner; and

5. not duplicate disease management program services provided by the Texas Medicaid Wellness Program.

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1) Private Duty Nursing Services are available to Medicaid recipients under the age of 21 years through EPSDT (Early and Periodic, Screening, Diagnosis and Treatment). Refer to Appendix 1 to Attachment 3.1-B, Item 4.b.

2) Reserved
9. Clinic Services.

Maternity Clinic Services.

Subject to the specifications, conditions, limitations and requirements established by the single state agency, payment will be made for maternity clinic services as defined at 42 CFR 440.90 and elsewhere when provided to eligible recipients by approved providers.

A. Covered maternity clinic services include but are not necessarily limited to risk assessment, medical services, laboratory/screening services, case coordination/outreach, nutritional counseling, psychosocial counseling, family planning counseling and patient education regarding maternal and child health.

B. As a condition for receiving payment for maternity clinic services, the services must be determined by a licensed physician (MD or DO) to be reasonable and medically necessary for the care of an eligible pregnant woman (patient) during the patient's prenatal period and subsequent 60 day post partum period.

C. The physician prescribing the services must be directly affiliated with the clinic either by employment or by a contractual agreement/ formal arrangement with the clinic to assume professional responsibility for services provided to the clinic patients.

D. The physician must see each patient and prescribe each patient's plan of care.

E. The plan of care must be based on a risk assessment. The risk assessment must be based on findings obtained from a health history, laboratory/screening services and a physical examination. Criteria for assessing the patient's risk is established by the single state agency.

F. The level of services provided to the patient must be commensurate with the risk assessment and be available to patients experiencing a normal or high risk pregnancy.

G. Covered services must be provided to outpatients by the physician or by licensed, professional clinic staff under the direction of the physician. The physician and professional clinic staff must be licensed by the state in which the services are provided. Services provided by the professional clinic staff must be within the staffs' scope of practice as defined by state law.

H. Although the physician does not have to be present in the clinic during all hours covered services are provided, the physician must assume professional responsibility for the services provided in the clinic and must ensure these services are medically appropriate and
in conformance with the plan of care. The physician must spend as much time in the clinic as is necessary to assure that patients are receiving services in a safe and efficient manner in accordance with accepted standards of medical practice.

I. Clinics must have arrangements for referral of non-stress test (NST), sonography, and amniocentesis for high-risk patients.

J. A provider of maternity clinic services must:

1. Be a facility that is not an administrative, organizational or financial part of a hospital.

2. Be organized and operated to provide maternity clinic services to outpatients.

3. Comply with all applicable federal, state and local laws and regulations.

4. Employ or have a contractual agreement/formal arrangement with a licensed physician(s) (MD or DO) who assumes professional responsibility for the services provided to the clinic's patients.

5. Adhere to the Bureau of Maternal and Child Health Maternity Guidelines, dated June 20, 1988, and subsequent revisions issued by the Texas Department of Health, unless otherwise specified by the single state agency.

6. Ensure that services provided to each patient are commensurate with the patient's medical needs based on the patient's risk assessment, plan of care and physician direction and are documented in the patient's medical records.

7. Be enrolled and approved for participation in the Texas Medical Assistance Program.

8. Sign a written provider agreement with the single state agency or its designee. By signing the agreement, the maternity clinic agrees to comply with the terms of the agreement and all requirements of the Texas Medical Assistance Program including regulations, rules, handbooks, standards, and guidelines published by the single state agency or its designee, and

9. Bill for services covered by the Texas Medical Assistance Program in the manner and format prescribed by the single state agency or its designee.
K. As a condition for receiving payment for services other than maternity clinic services which are covered under the Texas Medical Assistance Program, a maternity clinic, as the provider, must meet the same conditions of participation as any other provider of the same services(s) and is subject to the qualifications, limitations and exclusions in the amount, duration and scope of benefits and all other provisions specified in this state plan and elsewhere.
9. Clinic Services (Continued).

Tuberculosis (TB) Clinic Services

Subject to the specifications, conditions, limitations, and requirements established by the single state agency or its designee, payment will be made for TB clinic services to eligible recipients by approved providers.

A. TB Clinic Services include:

1. Directly Observed Therapy (DOT) – Includes the delivery of prescribed anti-tuberculosis medication, direct observation of the patient swallowing the medication, monitoring for side effects, and documentation of the provision of DOT.

2. Nursing Assessment – Includes conducting a brief mental and physical assessment, referral for social or other medical services, and other assessments per protocol.

B. Provider Qualifications:

1. Must be a facility that is not an administrative, organizational, or financial part of a hospital;

2. Must be organized and operated to provide TB-related services;

3. Must be a local health department or certified by the Texas Department of State Health Services as a provider of TB clinic services; and

4. Must employ or have a formal arrangement with a licensed physician(s) (M.D. or D.O.) who assumes professional responsibility for the services provided to the clinic’s patients.
9. Clinic Services (continued)

Renal Dialysis Facility Services

Subject to the specifications, conditions and limitations established by the single state agency, renal dialysis facility services are covered as follows:

a) Renal dialysis facility services must be provided in a "renal dialysis facility" as defined by 42 CFR §405.2102 and other applicable federal and state laws, rules, and regulations.

b) Covered renal dialysis facility services include outpatient dialysis and home dialysis services defined by 42 CFR §405.2102 and other applicable federal and state laws, rules, and regulations.

c) Renal dialysis facilities must be certified by and participating in Medicare (Title XVIII of the Social Security Act) and be approved by the single state agency or its designated agent and have a written provider agreement with the single state agency.

d) Renal dialysis facility services are furnished on an outpatient basis.
9. Clinic Services (Continued)

Ambulatory Surgical Center Services.

Subject to the specifications, conditions and limitations established by the single state agency, ambulatory surgical center services are covered as follows:

a) Ambulatory surgical procedures provided in ambulatory surgical center facilities are limited to those approved by CMS for Medicare, unless otherwise specified by the single state agency.

b) Ambulatory surgical center services must be provided in an "Ambulatory Surgical Center" or "ASC" as defined by 42 CFR 416 and other applicable federal and state laws, rules, and regulations.

c) Ambulatory surgical centers must meet applicable state laws, rules, regulations, and licensure requirements.

d) Ambulatory surgical center facilities or entities must be approved for and participating in Medicare (Title XVIII of the Social Security Act) and be approved by the single state agency or its designated agent and have a written provider agreement with the single state agency.

e) Ambulatory surgical center facility services are limited to those services furnished in connection with or directly related to a covered surgical procedure approved by CMS for Medicare unless otherwise specified by the single state agency.
10. Dental Services.

Not provided.

Subject to the specifications, conditions, requirements, and limitations established by the Single State Agency, physical therapy services, which include necessary equipment and supplies, provided by a licensed physical therapist are covered by the Texas Medical Assistance Program. A licensed physical therapist is an individual who is a graduate of a program of physical therapy approved by the Commission on Accreditation in Physical Therapy Education, and who is licensed by the Texas State Board of Physical Therapy Examiners or other appropriate state licensing authority.

To be payable, services must be within the physical therapist's scope of practice, as defined by state law; and be reasonable and medically necessary, as determined by the Single State Agency or its designee. Therapy must be prescribed by a licensed physician (M.D. or D.O.) and performed under a plan of care developed by the physician and/or physical therapist. Covered services also include the services of a physical therapist assistant when the services are provided under the direction of and billed by the licensed physical therapist. Therapy to maintain function once maximum benefit has been reached, or to promote general fitness or well being is not a benefit of the program.

Licensed physical therapists who are employed by or remunerated by a physician, hospital, facility, or other provider may not bill the Texas Medical Assistance Program directly for physical therapy services if that billing would result in duplicate payment for the same services. If the services are covered and reimbursable by the Texas Medical Assistance Program, payment may be made to the physician, hospital, or other provider (if approved for participation in the Texas Medical Assistance Program) who employs or reimburses the licensed physical therapist. The basis and amount of Medicaid reimbursement depends on the services actually provided, who provided the services, and the reimbursement methodology utilized by the Texas Medical Assistance Program as appropriate for the services and provider(s) involved.
11.b. Occupational Therapy.

Not provided.
11.c. Services for individuals with speech, hearing or language disorders (provided by or under the supervision of a speech pathologist or audiologist).

a) Services

Services are limited to a hearing evaluation.

b) Providers

A hearing evaluation must be provided by a qualified audiologist who meets the requirements of CFR § 440.110(c)(3) and in accordance with applicable state and federal law or regulation.

Providers must meet all federal and state licensing laws and regulations applicable to provision of the service.
12a. Prescribed Drugs

Prescribed drugs are limited as follows:

(a) Number of Prescriptions: Each eligible recipient is entitled to a basic number of prescriptions each month.

(b) Number of Refills: As many as 11 refills may be authorized by the prescriber, but the total number authorized must be dispensed within 12 months of the date of the original prescription subject to state and federal laws for controlled substance drugs.

(c) Coverage of Drugs in the Texas Drug Code Index (TDCI): The state will reimburse only for the drugs of pharmaceutical manufacturers who have entered into and have in effect a rebate agreement in compliance with Section 1927 of the Social Security Act, unless the exceptions in Section 1902(a)(54), 1927(a)(3) or 1927(d) apply. The state permits coverage of participating manufacturers' drugs, even though it may be using other restrictions. The prior authorization program provides for a 24-hour turnaround from receipt of the request for prior authorization. The prior authorization program also provides for a 72-hour supply of drugs in emergency situations.

(d) Prior Authorization Procedures: A health care practitioner who prescribes a drug that is not included on the Preferred Drug List (PDL) for a Medicaid recipient must request prior authorization of the drug to the state agency or its designee. Specific procedures for the submission of requests for prior authorization will be available both on the Health and Human Services Commission's (HHSC) Internet website and in printed form. A health care practitioner may request a printed copy of the procedures and forms from HHSC. This prior authorization requirement does not apply to a newly enrolled Medicaid recipient until the 31st calendar day after the date of the determination of the recipient's Medicaid eligibility.

(e) Preferred Drug List: The state agency will consider a drug listed on the TCDI for inclusion in the PDL based on the following factors:

(1) The recommendations of the DUR Board;

(2) The clinical efficacy of the drug consistent with the determination of the Food and Drug Administration and the recommendations of the DUR Board;

(3) Comparison of the price of the drug and the price of competing drugs to the Texas Medicaid outpatient drug program;
12a. Prescribed Drugs

(4) A program benefit offered by the manufacturer or labeler of the drug partially or wholly in lieu of a supplemental rebate and accepted by the state; and

(5) Written evidence offered by a manufacturer or labeler supporting the inclusion of a product on the PDL.

The state will examine information from any or all of these sources when considering the drugs to be included in the PDL.

The state will only include on the PDL drugs provided by a manufacturer or labeler that: (1) has reached an agreement with the state for supplemental rebates for drugs provided to Medicaid recipients; or (2) has not reached an agreement for supplemental rebates, if the state determines that inclusion of the drug on the PDL will have no negative cost impact. Manufacturers or labelers that offer a program benefit must first have a supplemental rebate agreement.

(f) Supplemental Medicaid Drug Rebate Agreement: Pursuant to Section 1927 of the Act, the state has the following policies for Medicaid supplemental rebates and program benefits:

(1) A model agreement between the state and a drug manufacturer for drugs provided to the Medicaid population, effective February 15, 2018, and entitled "Texas Health and Human Services Commission, Title XIX Vendor Drug Program, Supplemental Rebate Agreement," has been authorized by CMS.

(2) Supplemental rebates received by the state in excess of those required under the national drug rebate agreement will be shared with the federal government on the same percentage basis as applied under the national rebate agreement.

(3) A model program benefit agreement between the state and the drug manufacturer for program benefits provided to the Medicaid program, submitted to CMS on September 14, 2004 and entitled "Texas Health and Human Services Commission Title XIX Vendor Drug Program Benefit Agreement" has been authorized by CMS.

(4) Program benefits will consist of benefits, services, or expenditures that the state would otherwise bear under its state plan as medical or administrative expense.
12a. Prescribed Drugs, continued

(5) For program benefits, only the direct costs associated with the Program Benefit investment, including non-monetary benefits such as in-kind goods and services, in the program by the manufacturer or labeler will count as reducing the amount of the supplemental rebate owed. The savings or reduced claim experience that may result from the investment does not reduce the amount of the supplemental rebate owed.

(6) Program benefits received by the State will be treated as supplemental rebates and will be shared with the Federal government on the same percentage basis as applied under the national rebate agreement. For those manufacturers who have a Program Benefit Agreement, the State will determine the amount of supplemental rebate owed by the manufacturer at the end of a year. This amount represents 1) the potential total amount of Program Benefit investment by the manufacturer for the year, and 2) the basis for determining the amount of supplemental rebate that will be shared with the Federal government. For the CMS-64, the State will reduce its other Federal claims by the amount of the Federal share of the entire supplemental rebate owed at the end of the “Texas Health and Human Services Commission Title XIX Vendor Drug Program Supplemental Rebate Agreement” term.

(7) Where the program benefit amount is less than the supplemental rebate amount, the program benefit amount plus the difference between the full supplemental rebate amount and the program benefit amount will be shared with the Federal government on the same percentage basis as applied under the national rebate agreement.

(g) Drug Utilization Review Board (DUR Board): The DUR Board is established in accordance with Section 531.0736 of the Texas Government Code, and Section 1927 (g)(3) of the Social Security Act. The DUR Board is appointed by the executive commissioner of HHSC.

(1) The DUR Board consists of at least 17 physicians and pharmacists of whom two will be nonvoting managed care organization members. In addition to these 17 members, the DUR Board will include one consumer advocate who represents Medicaid recipients.

(2) The DUR Board shall develop recommendation for PDLs to be adopted by the State Agency, suggest to the State Agency restrictions or prior authorization requirements on prescription drugs, recommend to the State Agency educational interventions for Medicaid providers, review drug utilization across Medicaid, and perform other duties that may be specified by law and otherwise make recommendations to the State Agency.
12a. Prescribed Drugs, continued

(3) The DUR Board shall meet at least quarterly to consider products in PDL categories, and other clinical topics the State Agency recommends for consideration. In developing its recommendations for a PDL, the DUR Board shall consider, for each product included in a category of products, the clinical efficacy, safety, cost-effectiveness and any program benefit associated with the product. The DUR Board shall inform the State Agency of its reasons of recommending drugs for the PDL. The DUR Board shall maintain confidentiality of information used in considering their recommendations including any information deemed confidential by law.

(h) Public Notice: The State Agency will publish notice of the meetings of the DUR Board. The notices will include the topics to be considered at the upcoming meeting and instructions concerning filing of written comments and application to provide public testimony before the committee. The PDL will be published on the HHSC website. Within 10 days following the State Agency’s decision on the recommendations of the DUR Board, the Agency will publish revisions to the PDL on the HHSC website.

(i) No payment will be made for drugs in hospitals, nursing facilities and other institutions where those drugs are included in the reimbursement formula and vendor payments to the institution.

(j) Expanded pharmacy benefits under EPSDT will end on the last day of the month in which the individuals has his or her 21st birthday.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency: Texas

MEDICAID PROGRAM: REQUIREMENTS RELATING TO COVERED OUTPATIENT DRUGS FOR THE MEDICALLY NEEDY

<table>
<thead>
<tr>
<th>Citation(s)</th>
<th>Provision(s)</th>
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<tbody>
<tr>
<td>12.a.1 1935(d)(1)</td>
<td>Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A or Part B.</td>
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</tbody>
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| STATE | Texas |
| DATE REC'D | 11/10/05 |
| DATE AP'D | 5/23/06 |
| DATE EFF | 1/1/06 |
| HCFA 179 | 05-20 |

Supersedes: None. New Page.

TN No. 05-20
Supersedes Approval Date 5/23/06 Effective Date 1/1/06

TN No.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency: Texas

MEDICAID PROGRAM: REQUIREMENTS RELATING TO PAYMENT FOR COVERED OUTPATIENT DRUGS FOR THE CATEGORICALLY NEEDY

Citation(s): 1927(d)(2) and 1935(d)(2)

Provision(s):

1. The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit - Part D.

☒ The following excluded drugs are covered:

☒ (a) selective agents when used for anorexia, weight loss, weight gain (see note below)
☐ (b) agents when used to promote fertility
☒ (c) selective agents when used for the symptomatic relief of cough and colds (see note below)
☒ (d) selective prescription vitamins and mineral products, except prenatal vitamins and fluoride (see note below)
☒ (e) selective non-prescription drugs (see note below)
☐ (f) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee

☐ No excluded drugs are covered

Selective noted excluded drugs above will be covered as listed on the state's website.

TN: 23-0009 Approval Date: 06-23-2023
Supersedes TN: 14-07 Effective Date: 01-01-2023
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency Texas

MEDICAID PROGRAM: REQUIREMENTS RELATING TO PAYMENT FOR COVERED OUTPATIENT DRUGS FOR THE MEDICALLY NEEDY

Citation(s): 1927(d)(2) and 1935(d)(2)

Provision(s):
1. The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit - Part D.

☒ The following excluded drugs are covered:
☒ (a) selective agents when used for anorexia, weight loss, weight gain (see note below)
☐ (b) agents when used to promote fertility
☒ (c) selective agents when used for the symptomatic relief of cough and colds (see note below)
☒ (d) selective prescription vitamins and mineral products, except prenatal vitamins and fluoride (see note below)
☒ (e) selective non-prescription drugs (see note below)
☐ (f) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee

☐ No excluded drugs are covered

Selective noted excluded drugs above will be covered as listed on the state's website.

TN: 23-0009 Approval Date: 06-23-2023
Supersedes TN: 14-07 Effective Date: 01-01-2023
12.b. Dentures.

Not provided.
12.c. Prosthetics

a) Definition

Prosthetics outlined in this section of the state plan include orthotic devices and prosthetic devices.

Orthotic and prosthetic devices are defined as replacement, correction, or support devices prescribed by the physician or other licensed practitioner of the healing arts within the scope of professional practice as defined by Texas law to:

1. artificially replace a missing portion of the body;
2. prevent or correct physical deformity or malfunction; or
3. support a weak or deformed portion of the body.

Hearing aids are considered prosthetic devices and defined as an electronic device that amplifies sound to compensate for impaired hearing.

External breast prosthesis is defined as an external prosthetic device that is used to replace breast tissue and to produce a symmetrical appearance of the breasts.

b) Services

1. Hearing Aids.
   Medical necessity for a hearing aid must be determined through an examination conducted by a physician or other licensed practitioner of the healing arts within the scope of his practice as defined by State law. Coverage for eligible recipients age 21 and older who have hearing loss in both ears is limited to one hearing aid. Coverage is not available for recipients age 21 and older who have hearing loss in only one ear.

2. External Breast Prostheses.
   External breast prostheses are a benefit for all Medicaid eligible recipients with a history of medically necessary mastectomy procedure(s). This benefit includes external breast prostheses for the breast(s) on which medically necessary mastectomy procedure(s) have been performed. Medical necessity for an external breast prosthesis must be determined through an examination, conducted by a physician licensed to practice medicine or osteopathy in the state where and when the service is performed.
12.c. Prosthetics, continued

c) Providers

Hearing aids must be furnished by an audiologist or by approved hearing aid fitter and dispenser providers. Providers must meet all federal and state licensing laws and regulations applicable to provision of the service.

External breast prostheses are a benefit of the Texas Medicaid Program when provided by a licensed prosthetist or prosthetist/orthotist licensed by the state and in accordance with applicable state and federal laws and regulations.

These devices may also be provided by physicians or other licensed practitioners of the healing arts within the scope of professional practice as defined by Texas law.
12.d. Eyeglasses

Eyeglasses are a benefit for eligible recipients of the medical assistance program.

Non-prosthetic eyewear includes contact lenses and lenses and frames. Prosthetic eyewear includes contact lenses and lenses and frames. The eyewear must be medically necessary to be reimbursable.
13.a. Diagnostic Services

Diagnostic Services for Persons with a potential of Mental Retardation

Not Provided
13.b. Screening Services.

Not Provided.
13.c. Preventive Services

Preventive services provided under this section are provided by practitioners who meet individual practitioner certification standards according to federal and state law. Each provider must be approved for participation in the Texas Medical Assistance Program by the Texas Health and Human Services Commission.

Preventive services include services to:

   d) prevent disease, disability and other health conditions or their progression,
   
   e) prolong life, and
   
   f) promote physical and mental health and efficiency

Eligible recipients, other than EPSDT recipients, are entitled to one comprehensive preventive exam per year. The preventive services must be provided in accordance with the United States Preventive Services Task Force (USPSTF).

Optometric Services

Eligible recipients, other than EPSDT recipients, are entitled to one eye exam by refraction every 24 months performed by a provider qualified to provide optometric services under the Texas Medical Assistance Program. Adults may also be offered an eye exam by refraction before the 24 month period has elapsed if there is a significant change in visual acuity, measured in diopter or axis changes. Payment will be made by the Texas Medical Assistance Program for one eye examination with refraction per recipient, every 24 months. This limit applies only to determinations of visual acuity, not to other diagnostic services or to treatment of the eye for medical conditions.
13.d. Rehabilitative Services

Day Activities and Health Services.

Day Activities and Health Services are a component of the Rehabilitative Services defined at 42 CFR 440.130(d). The single state agency will pay for Day Activities and Health Services when provided to eligible recipients in accordance with state agency established conditions, specifications and limitations by providers who are approved by and under contract with the single state agency.

A. Day Activities and Health Services must be prescribed by a physician and provided under the supervision of a nurse licensed in the State of Texas.

B. An individual must have a need because of a chronic medical condition and be able to benefit therapeutically from Day Activities and Health Services. Potential for receiving therapeutic benefit from Day Activities and Health Services will be established by an assessment of the recipient’s medical needs. Reassessment of this need and authorization for continued Day Activities and Health Services is required at least every twelve months.

C. A recipient of Day Activities and Health Services must establish and maintain a living arrangement in the community outside of the Day Activities and Health Services facility.

D. Day Activities and Health Services are limited to no more than 10 hours per day and 230 hours per month for each eligible recipient.*

E. Facilities providing Day Activities and Health Services must meet any licensing requirement imposed by the Texas Department of Health and must meet all other qualifications established by the

* Durational, dollar, and quantity limits are waived for recipients of EPSDT services. Services allowable under Medicaid laws and regulations may be covered when medically necessary for these recipients.
13. d Rehabilitative Services (Continued).

Single state agency.

F. The provider must maintain records and submit reports and other information specified by the single state agency.

Chemical Dependency Treatment Facility Services. (See EPSDT item 4.b)

A. Mental Health Rehabilitative Services – Definition and Authorization Process

Mental Health Rehabilitative Services are those age appropriate services determined via a uniform assessment protocol and recommended by a licensed practitioner of the healing arts as medically necessary to reduce an individual’s disability resulting from severe mental illness for adults, or serious emotional, behavioral, or mental disorders for children; and to restore an individual to his/her best possible functioning level in the community. Services that provide assistance in maintaining functioning may be considered rehabilitative when necessary to help an individual achieve a rehabilitation goal as defined in the rehabilitation plan. In addition to a determination of need based on the uniform assessment protocol, eligible individuals residing in a nursing facility (NFs) must have been determined through PASARR to require specialized services.

The treatment planning process for Mental Health Rehabilitative Services requires the active participation of the Medicaid eligible individual (or their legally authorized representative when necessary due to the individual’s age or legal status). Treatment plans are based on a comprehensive assessment and must address the individual’s strengths, areas of need, the individual’s preferences, and descriptions of the individual’s recovery goals.

1. Authorization of Services

Each person determined to need Mental Health Rehabilitative Services must have a plan of care developed by the Medicaid enrolled provider of Rehabilitative services that describes in writing the type, amount and duration of Mental Health Rehabilitative Services determined to be medically necessary to meet the needs of the person. The plan of care must be recommended by a Licensed Practitioner of the Healing Arts (LPHA) and must be consistent with the State uniform utilization guidelines or include documentation providing clinical justification for the exceptions. The plan of care must be authorized by the state operating agency or its designee. The plan of care will be reviewed by the Medicaid provider on a regular basis and modified as necessary to meet the needs of the person. Changes to the plan of care with regard to type, amount, or duration must be approved by a licensed practitioner of the healing arts practicing within the scope of his/her licensure. All plans of care are subject to review and approval by the state operating agency or its designee.

2. Mental Health Rehabilitative Services – Service Definitions:

Mental Health Rehabilitative Services are age-appropriate, individualized, and designed to ameliorate mental and functional disabilities that negatively affect community integration, community tenure, and/or behaviors resulting from serious mental illness or emotional disturbance that interfere with an individual’s ability to obtain or retain employment or to function in other non-work, role appropriate settings. Day programming for acute needs is provided on a large group basis and is site-based. All other services are provided on a one-to-one or small group basis, either on-site or in the community. Mental health rehabilitative services include:

a. Medication training and support – curriculum-based training and guidance that serves as an initial orientation for the individual in understanding the nature of their mental illnesses or emotional disturbances and the role of medications in ensuring symptom reduction and increased tenure in the community. This service includes: assisting the individual to develop correct procedures for following a prescription medication regimen; strategies to manage symptomology and maximize functioning; developing an understanding of the relationship between mental illness and the medications prescribed to treat the illness; the interaction of medication with other medications, diet, and mood altering substances; the identification and management of potential side effects; and the necessity of taking medications as prescribed and following doctor’s orders.

Providers of medication training and support must be certified as at least one of the following:

1) Qualified Mental Health Professional -Community Services (QMHP-CS)
2) Community Services Specialist (CSSP)
3) Peer Provider
4) Licensed medical personnel
5) Family Partner

b. Psychosocial rehabilitation service – social, educational, vocational, behavioral, and/or cognitive interventions to improve a client's potential for social relationships, occupational or educational achievement, and living skills development. This service is provided by members of a therapeutic team. When appropriate, the provision of services will address the impact of co-occurring disorders upon the individual’s ability to decrease symptomology and increase community tenure. This service includes:

(1) Independent living – skills training and/or supportive interventions that focus on the improvement of communication skills, appropriate interpersonal behaviors, and other skills necessary for independent living or, when age appropriate, functioning effectively with family, peers and teachers. Training for independent living includes: skills related to personal hygiene; transportation utilization; money management; the development of natural supports; access to needed services in the community, e.g., medical care, substance abuse services, legal services, living accommodations; and social skills, e.g., communicating one’s needs to strangers and making appropriate choices for the use of leisure time. Individuals receiving psychosocial rehabilitation service are not eligible to simultaneously receive skills training and development.
Rehabilitative Services (Continued).

(2) Coordination – skills training and/or supportive interventions to assist the individual in improving their ability to gain and coordinate access to necessary care and services. Training for coordination skills includes instruction and guidance in such areas as: identifying areas of need across all life domains, prioritizing needs and setting goals, identifying potential service providers and support systems, initiating contact with providers and support systems, participating in the development and subsequent revisions of their plan of care, coordinating their services and supports, and advocating for necessary changes and improvements to ensure that they obtain maximum benefit from their services and supports. Individuals receiving Psychosocial Rehabilitation Service are not eligible to simultaneously receive Medicaid Targeted Case Management Services.

(3) Employment related service – training and supports that are not job specific and have as their focus the development of skills to reduce or overcome the symptoms of mental illness that interfere with the individual's ability to make vocational choices, attain or retain employment. Included are activities such as: skills training related to task focus, task completion, planning and managing activities to achieve outcomes, personal hygiene, grooming and communication, and skills training related to securing appropriate clothing, developing natural supports, and arranging transportation. Also included are supportive contacts related to the school or work-site situation to reduce or manage behaviors or symptoms related to the individual's mental illness or emotional disturbance that interfere with job performance or progress toward the development of skills that would enable the individual to obtain or retain employment.

(4) Housing related service - training and supports that focus on the development of skills to reduce or overcome the symptoms of mental illness that interfere with the individual's ability to obtain or maintain tenure in independent integrated housing. Included are activities such as: skills training related to home maintenance and cleanliness, problem solving with landlord and other residents, and maintaining appropriate interpersonal boundaries. Also included are supportive contacts related to the housing situation to reduce or manage behaviors or symptoms related to the individual's mental illness or emotional disturbance that interfere with maintaining independent integrated housing.

(5) Medication related service – Training and supportive interventions that focus on individual-specific needs and goals regarding the administration of medication, monitoring efficacy and side-effects of medication, and other nursing services that enable the individual to attain or maintain an optimal level of functioning. Medication related service does not include services or activities that are incidental to physician services provided during a clinical appointment.

Providers of Psychosocial Rehabilitation Services that address independent living, coordination, employment-related issues, and housing-related issues must be certified as at least one of the following:
1) QMHP-CS
2) CSSP
3) Peer Provider

Providers of Psychosocial Rehabilitation Services that address medication issues must be certified as licensed medical personnel.
Service Definitions (continued).

c. Skills Training and development – skills training and/or supportive interventions that focus on the improvement of communication skills, appropriate interpersonal behaviors, and other skills necessary for independent living or, when age appropriate, functioning effectively with family, peers and teachers. Skills training and development may include: skills related to personal hygiene; transportation utilization; money management; the development of natural supports; access to needed services in the community, e.g., medical care, substance abuse services, legal services, living accommodations; and social skills (e.g. communicating one’s needs to strangers and making appropriate choices for the use of leisure time). Individuals receiving skills training and development are not eligible to simultaneously receive psychosocial rehabilitation service.

Providers of skills training and development must be certified as at least one of the following:
1) QMHP-CS  
2) CSSP  
3) Peer Provider  
4) Family Partner

d. Crisis intervention – intensive community-based one-to-one service provided to individuals who require services in order to control acute symptoms that place the individual at immediate risk of hospitalization, incarceration, or placement in a more restrictive treatment setting. This service focuses on behavioral skills training for stress and symptom management, problem solving and reality orientation to help the individual identify and manage their symptoms of mental illness, supportive counseling, and training to adapt to and cope with stressors. Also included is the assessment of dangerousness and, when appropriate, coordination of emergency services.

Providers of crisis intervention must be certified as a QMHP-CS.

e. Day program for acute needs – short-term, intensive, site-based treatment in a group modality to an individual who requires multidisciplinary treatment in order to stabilize acute psychiatric symptoms or prevent admission to a more restrictive setting or reduce the amount of time spent in the more restrictive setting. Day programs for acute needs are goal-oriented, provided in a highly structured and safe environment with constant supervision, and ensure an opportunity for frequent interaction between client and staff. Day programs for acute needs must at all times have sufficient staff to ensure safety and program adequacy according to an established staffing ratio and staff response times. This service focuses on intensive, medically-orientated, multidisciplinary interventions such as behavior skills training, crisis management and nursing services that are designed to stabilize acute psychiatric symptoms. These services may be provided in a residential facility; however, none of the residential facilities are greater than 16 beds.

Providers of day program activities that address symptom management and functioning skills must be certified as at least one of the following:
1) QMHP-CS  
2) CSSP  
3) Peer Provider

Providers of day program activities that address pharmacology issues must be certified as licensed medical personnel. Providers of psychiatric nursing services must be a registered nurse (RN).
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3. Providers and Qualifications

a. QMHP-CS

The credentialing requirement minimums for a QMHP-CS are as follows:

• Demonstrated competency in the work to be performed, and
• Bachelor's degree from an accredited college or university with a minimum number of hours that is equivalent to a major in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education, or early childhood intervention, or
• RN.

An individual who possesses any of the following licenses is automatically certified as a QMHP-CS:

Advanced Practice nurse (APN) – Tex.Occ.Code, Chapter 301
Licensed Psychologist – Tex.Occ.Code, Chapter 501
Licensed Clinical Social Worker (LCSW) – Tex.Occ.Code, Chapter 505
Licensed Marriage and Family Therapist (LMFT) – Tex.Occ.Code, Chapter 502

A QMHP-CS must be clinically supervised by at least another QMHP-CS. If a QMHP-CS is clinically supervised by another QMHP-CS, the supervising QMHP-CS must be clinically supervised by a LPHA.

b. CSSP

The credentialing requirement minimums for a CSSP are as follows:

• High school diploma or high school equivalency,
• Three continuous years of documented full-time experience in the provision of mental health rehabilitative services as of August 30, 2004, and
• Demonstrated competency in the provision and documentation of mental health rehabilitative services.

A CSSP must be clinically supervised by at least a QMHP-CS.

c. Peer Provider

The credentialing requirement minimums for a Peer Provider are as follows:

• High school diploma or high school equivalency, and
• One cumulative year of receiving mental health services.

A Peer Provider must be clinically supervised by an LPHA.

A Peer Provider must satisfy all staff credentialing, competency, training and clinical supervision requirements as stipulated in 13.d.B.2. Services provided by a Peer Provider must be included in the treatment plan as described in 13.d.A.

d. Licensed medical personnel

The credentialing requirement minimum for licensed medical personnel is licensure as at least one of the following:

Physician – Tex.Occ.Code, Chapter 151
APN – Tex.Occ.Code, Chapter 301,
Physician Assistant (PA) – Tex.Occ.Code, Chapter 204
RN – Tex.Occ.Code, Chapter 301,
Licensed Vocational Nurse (LVN) – Tex.Occ.Code, Chapter 301
Providers and Qualifications (continued).

e. Family Partner
The credentialing requirements for a family partner are as follows:
- High school diploma or high school equivalency and
- One cumulative year of participating in mental health services as the parent
  or legally authorized representative (LAR) of a child receiving mental health
  services.

A family partner must be supervised by at least a QMHP.

A family partner must satisfy all staff credentialing, competency, training, and clinical
supervision requirements as stipulated in 13.d.B.2. Services provided by a family
partner must be included in the treatment plan as described in 13.d.A.

Family partners must be credentialed as a certified family partner within one year of
their hire date. The State or its contractor manages the state certification process
for family partners and will make all necessary education and training modules
relevant to the certification process available to all family partners. The State or its
contractor will administer and oversee the testing protocol for certified family
partners.

The family partner service is provided to parents or LARs for the benefit of the
Medicaid eligible child.

4. Mental Health Rehabilitative Services do not include any of the following:

a. services to inmates in public institutions as defined in 42 CFR § 435.1009;
b. services to individuals under 65 years of age residing in institutions for mental diseases as
described in 42 CFR § 435.1009;
c. job task specific vocational services;
d. educational services;
e. room and board residential costs;
f. services that are an integral and inseparable part of another Medicaid-reimbursable service,
   including targeted case management services, residential rehabilitative behavioral health
   services, institutional and waiver services;
g. services that are covered elsewhere in the state Medicaid plan;
h. services to individuals with a single diagnosis of mental retardation or other developmental
disability or disorder and who do not have a co-occurring diagnosis of mental illness in
adults or serious emotional disturbance in children;
i. inpatient hospital services;
j. respite services; and
k. family support services.

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13. d Rehabilitative Services (Continued).

B. Provider Qualifications – To enroll as a provider of Mental Health Rehabilitative Services and to maintain active provider status, an applicant/enrolled provider agency must:

1. Demonstrate a history of providing to adults and children, as well as a capacity to continue to provide to adults and children, a readily accessible, comprehensive, integrated, and well-coordinated system of services and supports, beneficial to adults and children who have been determined to need Mental Health Rehabilitative Services, that includes all of the Mental Health Rehabilitative Services reimbursable under this plan, and be either:

   a. a governmental or non-governmental entity designated as a community mental health center or community mental health and mental retardation center in accordance with §534.001 of the Texas Health and Safety Code that is in compliance with and maintains on-going compliance with the Texas Department of Mental Health and Mental Retardation’s Community Mental Health Standards (25 TAC 412 Subchapter G); or

   b. a corporation authorized to do business in the State of Texas that demonstrates, through the implementation of written and readily available policies, procedures, and practices and on-site confirmation thereof, compliance with standards of care promulgated by the single state agency or its designee with the approval of the single state agency, that are comparable to those required of providers qualifying under 13d(B) (1) (a) and assure:

      (1) The safety, health, rights, privacy and dignity of persons receiving Mental Health Rehabilitative Services.

      (2) Access to emergency services, including a 24-hour-a-day, 365-day-a-year staffed telephone screening and crisis response system, immediate access to emergency medical and psychiatric services, and immediate face-to-face assessment by qualified mental health professional staff, including physicians.

      (3) Competency of staff (including volunteers, interns, and students), appropriate to job duty, including licensure commensurate with state law, and sufficient numbers of staff ensure safety and adequacy of programming, including emergency responses within programming.

      (4) Physical separation of children and adults in residential and other program settings.

      (5) Compliance with the most recent edition of the National Fire Protection Association's Life Safety Code and certification, registration, or licensure, as applicable for all inpatient
13. d

and residential facilities utilized for services provided directly or under arrangement.

(6) Communication with recipients in a language and format understandable to the recipient through the provision of interpretive services; translated materials; and use of native language and staff.

(7) The use of a record system that ensures the integrity of the individual record; provides for organization of content and storage of records; is administered by an appropriately trained and credentialed individual; and is consistent with all federal, state, and local laws and regulations pertaining to storage of records.

(8) A quality improvement process, that includes a plan and an annual self-evaluation of performance, that is based on valid data-driven decisions including both clinical and non-clinical aspects of care.

(9) An infection control plan approved by a physician which includes prevention, education, management, and monitoring of significant infections.

(10) A peer review process that promotes sound clinical practice, professional growth, and credentialing within the provider agency, and that abides by generally accepted guidelines and applicable laws, including necessary investigatory processes to comply with licensing requirement.

(11) A utilization management program which utilizes a formal assessment of medical necessity, efficiency and clinical appropriateness of services and treatment plans on a prospective and concurrent basis, reviews services using established protocols, and allows for an objective appeal process.

2. Assure that covered services are provided to recipients by staff who meet credentialing, competency, and/or training requirements promulgated by the single state agency or its designee, with the approval of the single state agency. Credentialing is to be performed by the provider. All staff, including Peer Providers, must demonstrate competency to perform their job duties (e.g., written exam, role play, mentorship) on an ongoing basis as determined by the provider. All staff, including Peer Providers, must receive training on: the nature of mental illness and serious emotional disturbance, client rights, cultural sensitivity, client abuse and neglect, the uniform assessment protocol, the uniform utilization guidelines, treatment plan development, crisis management, skill training techniques, treatment of co-occurring psychiatric and substance use disorders, availability of community resources, and effective advocacy. Staff, including Peer Providers, must receive ongoing and “refresher” training as required by the provider (e.g., CPR every 3 years, treatment plan development in response to job performance deficit). Staff, including Peer Providers, must receive clinical supervision as required by the single state agency or its designee. Oversight of the credentialing, competency, training and clinical supervision processes is provided by the single state agency or its designee.
13. d Rehabilitative Services (Continued).

3. Comply with all federal, state, and local laws and regulations applicable to Mental Health Rehabilitative Services and the Texas Medical Assistance Program.

4. Sign a written provider agreement with the single state agency or its designee. By signing the agreement, the provider of mental health rehabilitative services agrees to comply with the terms of the agreement and all requirements of the Texas Medical Assistance Program, including regulations, rules, provider manuals, standards, policy clarification statements, and guidelines published by the single state agency or its designee.

5. Document and bill for services covered by the Texas Medical Assistance Program in the manner and format prescribed by the single state agency or its designee.

6. Allow access by the single state agency or its designee to recipient and the recipient’s records when necessary to carry out the single state agency’s responsibilities.

7. Demonstrate a history of providing, as well as the capacity to continue to provide comprehensive system of services and supports required by 13d(B) (1) to, and as needed by individuals required to submit to mental health treatment under the Texas Code of Criminal Procedure, Article 17.032 (relating to Release on Personal Bond of Certain Mentally Ill Defendants), or Article 42.12, Section 5(a) or Section 11(d) (relating to Community Supervision); and to, and as needed by, individuals required to submit to mental health treatment due to involuntary commitment for outpatient treatment under the Texas Health and Safety Code, Chapter 573 (relating to Emergency Detention) and Chapter 574 (relating to Court Ordered Mental Health Services).
13. d  Rehabilitative Services (Continued).

8. Request criminal history record information on all employees and applicants whom an offer of employment or volunteer status is made, as authorized in the Texas Health and Safety Code §411.115 and ensure that no volunteer or employee of the enrolled provider, contracted employee of the enrolled provider, or employee or volunteer of a provider delivering rehabilitative services under arrangement who has a criminal history is allowed to provide services to or interact with persons receiving Mental Health Rehabilitative Services.

9. Comply with state policies and procedures pertaining to financial audits and cost reports as determined by the state auditor and/or the single state agency or its designee, with approval of the single state agency.

10. Ensure that when services are provided under arrangement the provider delivering those services under arrangement:
   
a. Complies with all applicable federal, state, and local laws and regulations pertaining to mental health rehabilitative services.

   b. Has in effect an agreement with the enrolled provider agency stipulating that the provider delivering services under arrangement complies with all requirements of the Texas Medical Assistance Program, including regulations, rules, provider manuals, standards, policy clarification statements, and guidelines.

   c. Is in compliance with all standards applicable to the provision of the Mental Health Rehabilitative Services, as promulgated by the single state agency or its designee, with approval by the single state agency, through rules, regulations, provider manuals, policy clarifications, guidelines, and other documents.

11. Retain responsibility for Mental Health Rehabilitative Services provided directly or under arrangement.
13.d. Rehabilitative Services (continued)
13.d. Rehabilitative Services (continued)
13.d Speech Therapy Evaluation

I. One speech evaluation for the purpose of determining the medical need for speech therapy services does not require prior authorization.

II. Speech Therapy that exceeds one speech evaluation must be prior authorized. Prior authorization of speech therapy requires a statement of medical necessity from the Medicaid recipient's physician.

III. Speech therapy services for persons residing in nursing homes are included in the nursing facility rate described in Attachment 4.19-D (NF).
13.d  Rehabilitative Services, continued

Substance Abuse and Dependency Treatment Services

Substance abuse and dependency services are those age-appropriate treatment services determined via a nationally-recognized screening and assessment protocol, recommended by a licensed practitioner of the healing arts as medically necessary, and appropriate to treat a substance abuse and dependency disorder and restore an individual to his or her best possible functional level. Rehabilitative services, when provided to maintain function, may be considered when medically necessary to assist an individual in achieving a rehabilitative goal, as defined in the rehabilitative treatment plan.

Substance abuse and dependency treatment services include a set of rehabilitative clinical interventions approved under a goal-oriented written treatment plan, designed to promote treatment and recovery and prevent relapse. The treatment plan [or plan of care] includes medical and/or psychotherapeutic modalities aimed at treating substance abuse and dependency disorders, as defined by the current Diagnostic and Statistical Manual of Mental Disorders.

Substance abuse and dependency treatment services include:

1)  **Screening and Assessment**
   a)  Provided by a licensed practitioner of the healing arts using a nationally-recognized screening and assessment tool.
   b)  The purpose of the screening and assessment is to identify the individual’s level of addiction and treatment needs.
   c)  Providers of Screening and Assessment must be certified as a Qualified Credentialed Counselor (QCC)

2)  **Substance abuse detoxification treatment services**
   a)  Provided by:
      i)  Licensed hospitals; or
      ii) Facilities that are licensed and regulated by the Department of State Health Services to provide substance abuse and dependency treatment services, including detoxification.

SUPERSEDES: NONE - NEW PAGE

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13.d Rehabilitative Services, continued

Substance Abuse and Dependency Treatment Services, Continued

2) b) Description of services:
   i. Evaluation to determine the level of intoxication or withdrawal potential and determine the client's treatment plan;
   ii. Monitoring mental status, vital signs, and complications;
   iii. Medication therapy to manage the client's immediate withdrawal symptoms; and
   iv. Counseling regarding the client’s illness that is designed to:
      (1) assess the client’s readiness for change;
      (2) offer general and individualized information on substance abuse and dependency;
      (3) enhance client motivation;
      (4) engage the client in treatment; and
      (5) include a detoxification plan that contains the goals of successful and safe detoxification as well as transfer to another treatment program.

c) Providers of evaluation, monitoring, and medication therapy must be licensed medical personnel. Providers of counseling must be certified as a QCC.

3) Treatment services
   a) Provided by facilities that are licensed and regulated by the Department of State Health Services to provide substance abuse and dependency treatment services.

   b) Description of services: Services include appropriate counseling and psycho-educational modalities designed to promote treatment and recovery and prevent relapse. Treatment services include:
      (1) Evaluation using a nationally-recognized tool to identify the medically appropriate duration of service based on medical need and severity of addiction;
      (2) Development of a goal-oriented written plan of care designed to promote treatment and recovery and prevent relapse, and that is recommended by a licensed practitioner of the healing arts;

SUPERSEDES: NONE - NEW PAGE
13.d Rehabilitative Services, continued

Substance Abuse and Dependency Treatment Services, continued

3) b) (3) Therapeutic modalities including: motivational interviewing; and individual, group and family counseling focused on the individual eligible for Medicaid;

(4) Psycho-education aimed at providing education on the effects of substance use;

(6) Medication management; and

(7) Relapse prevention.

c) Providers of evaluation, development of plan of care, therapeutic modalities, psycho-education, and relapse prevention must be certified as a QCC. Providers of medication management must be licensed medical personnel.

4) Providers and Qualifications

a) Licensed medical personnel

The credentialing requirement minimums for licensed medical personnel is licensure as at least one of the following:

- Physician – Texas Occupations Code (Tex Occ. Code), Chapter 155
- Advanced Practice Nurse (APN) – Tex. Occ. Code, Chapter 301
- Physician Assistant (PA), Tex. Occ. Code, Chapter 204
- Registered Nurse (RN) – Tex. Occ. Code, Chapter 301
- Licensed Vocational Nurse (LVN) – Tex. Occ. Code, Chapter 301

b) Qualified Credentialed Counselor

The credentialing requirement minimums for qualified credentialed counselor is as at least one of the following:

- Licensed Chemical Dependency Counselor (LCDC) – Tex. Occ. Code Chapter 504
- Licensed Professional Counselor (LPC) – Tex. Occ. Code, Chapter 503
- Licensed Clinical Social Worker (LCSW) – Tex. Occ. Code, Chapter 505
- Licensed Marriage and Family Therapist (LMFT) – Tex. Code, Chapter 502
- Licensed Physician – Tex. Occ. Code, Chapter 155
- Licensed Physician Assistant – Tex. Occ. Code, Chapter 204
- Certified Addictions Registered Nurse (CARN) – Tex Occ. Code, Chapter 504

SUPERSEDES: NONE - NEW PAGE
14.a Services for individuals age 65 or older in Institutions for Mental diseases - Inpatient Hospital Services.

1) Eligible population. Inpatient hospital services in an institution for mental disease are limited to individuals:
A. who 65 years old or older;
B. who have one or more mental diseases;
C. who have no acceptable alternative treatment;
D. for whom the single state agency or its designee has determined inpatient hospital services in an institution for mental disease to be reasonable and medically necessary.

2) Definition of services. Inpatient services in an institution for mental disease include but are not limited to:
A. initiation, titration and/or change in medication;
B. monitoring and assessing by qualified mental health professionals;
C. suicide precautions;
D. redirection of inappropriate behaviors and/or reinforcement of appropriate behaviors;
E. group and individual therapies;
F. structured skills training activities;
G. room and board; and
H. nursing services.

3) Provider qualifications. All providers seeking to provide inpatient hospital services in an institution of mental disease must:
A. submit an approved application for enrollment through means established by the single state agency or its designee;
B. meet the Medicare conditions of participation specified in 42 CFR 482.60;
C. be accredited by the Joint Commission on Accreditation of Healthcare Organizations;
D. if applicable, be licensed as a psychiatric hospital under the provision of the Health and Safety Code, Chapter 577;
E. meet the requirements of 42 CFR 440.140(a) pertaining to providers of inpatient hospital services in institutions for mental disease;
F. be in compliance with applicable standards promulgated by the state mental health authority as provisions of the Texas Administrative Code, Title 25, Part II, Chapters 401, 402, 403, 404, 405, and 408, relating to patient care and treatment in inpatient mental health facilities;
3) Provider Qualifications. (Continued)

G. be serving a patient population in which more than 50 percent currently require institutionalization because of mental disease;

H. have a consistent historical pattern of accepting involuntary admissions;

I. assure, within a written provider agreement the capacity to: admit, readmit from alternative care, and treat both eligible persons voluntarily seeking services under the provision of the Health and Safety Code, Chapter 572 and persons lawfully compelled to accept inpatient mental health treatment under the provisions of the Health and Safety Code, Chapters 573 and 574;

J. ensure that inpatient hospital care will maintain the patient at, or restore the patient to, the greatest possible degree of health and independent functioning; and

K. allow access by the single state agency or its designee to the institution, the patient, and the patients records when necessary to carry out the agency's responsibilities and provide access to records in accordance with the provisions of Title 42 Code of Federal Regulations §431.107.
14.b. Services for Individuals Age 65 or Older in Institutions for Mental Diseases - Skilled Nursing Facility Services.

Not provided.
14.c. Services For Individuals Age 65 Or Older In Institutions For Mental Diseases - Intermediate Care Facility Services.

Not provided.
15.b. Intermediate Care Facility Services in a Public Institution (or Distinct Part Thereof) for the Mentally Retarded or Persons With Related Conditions.

Intermediate care facilities services (other than such services in an institution for mental diseases) are limited by:

The attending physician's prescription of a level of care setting and the single state agency's level of care determination for which vendor payments will be made.
15.b. Intermediate Care Facility Services in a Public Institution (or Distinct Part Thereof) for the Mentally Retarded or Persons With Related Conditions. (Continued)

Reimbursement methodology for ICF-MR dental services is described in 4.19-B, Item 24, page 17, and such dental services are limited to ICF-MR residents.
15c. Intermediate Care Facility Services.

(I) Augmentative communication devices (ACDs) are available to Medicaid-eligible individuals residing in Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) when prior authorization is obtained.

(A) To be eligible for reimbursement for an ACD, the ICF/MR, prior to purchase of the device, must obtain an evaluation of the individual by a speech language therapist licensed in the State of Texas. This evaluation must contain all of the following criteria:

i. Diagnosis relevant to the need for an ACD;
ii. Specific ACD being recommended;
iii. Description of how this ACD will meet the specific needs of this individual; and
iv. Description of specific training needs for use of this device to include training needs of the individual, ICF/MR staff, and family (when applicable).

(B) The ICF/MR must provide a statement of medical necessity for this ACD from the individual's primary care physician in order to request prior authorization.

(II) Prior authorization must be obtained from the Health and Human Services Commission (HHSC) or its designee before purchase of any ACD. For ACDs costing over $10,000, the prior authorization process will include an independently conducted second speech evaluation facilitated by the Department of Aging and Disability Services (DADS). An ICF/MR must submit a copy of the completed initial speech evaluation and physician's attestation of medical necessity to request prior authorization.
16. Inpatient Psychiatric Facility Services for Individuals Under 21 Years of Age.

Inpatient psychiatric facility services for individuals under 21 years of age are prior authorized. Reimbursement is subject to the requirements set out in 42 CFR 441.
17. Nurse-Midwife Services

(a) In addition to the specifications, conditions, requirements, and limitations established by the single state agency or its designee, which are applicable generally to all Medicaid providers in accordance with Federal law, rules and regulations, the following provisions are applicable to Nurse-Midwife Services for purposes of the Texas Medical Assistance Program:

(1) Nurse-Midwife services must be provided by a Certified Nurse-Midwife (CNM), enrolled and approved for participation in the Texas Medical Assistance Program. A certified Nurse-Midwife is defined as a licensed registered nurse approved by the State Board of Nursing as an advanced practice nurse in midwifery, and who is also certified by the American College of Nurse-Midwives.

(2) To the extent and under the circumstances authorized under State laws, rules and regulations, and in the case of services furnished in an institution, hospital or other facility to the extent permitted by the institution, hospital or facility, Nurse-Midwife services are covered if the services:
   (A) are within the scope of practice for Certified Nurse Midwives, as defined by State law;
   (B) are consistent with rules and regulations promulgated by the Board of Nursing or other appropriate state licensing authority; and
   (C) would be covered by the Texas Medical Assistance Program if provided by a licensed physician (M.D. or D.O.).

(3) Home deliveries performed by a Certified Nurse-Midwife are covered when the single state agency or its designee has prior authorized the home delivery.

(4) Certified Nurse-Midwives who manage the medical aspects of a case under the control and supervision of a physician in accordance with the rules of the State Board of Nursing and the Texas Nursing Practice Act will only be directly reimbursed by the Texas Medical Assistance Program for such services to the extent that they are performed under the written protocols required by the Board of Nursing and are not duplicative of other charges to the Medicaid program.

(5) For services other than Nurse-Midwife Services, other applicable provisions of this Title XIX State Plan and the Texas Medical Assistance Program will apply.

(6) Child birth education classes are not reimbursable.
17. Nurse-Midwife Services (continued)

(7) For purposes of coverage and reimbursement by the Texas Medical Assistance Program, deliveries by a Certified Nurse-Midwife, that are performed in a general or acute care hospital or a special hospital or facility such as a birthing center, must be done in a hospital or facility licensed and approved by the appropriate state licensing authority for the operation of maternity and newborn services and approved by the single state agency for participation in the Texas Medical Assistance Program.

(8) To participate in the Texas Medical Assistance program, a Certified Nurse-Midwife must identify the licensed physician or group of physicians with whom an arrangement has been made for referral and consultation in the event of medical complications. If the collaborating physician or group is not a participating provider in the Texas Medical Assistance Program, the Nurse-Midwife must inform recipients of their potential financial responsibility in accordance with requirements of the Texas Medical Assistance Program applicable to all Medicaid providers. If and when the physician or group with whom an arrangement has been made for referral and consultation in the event of medical complications is changed or cancelled, the CNM must notify the single state agency or its designee in writing of the identity of the new physician or group within two weeks after the cancellation or change.
18. **Hospice Care.**

The Texas Department of Aging and Disability Services (DADS) administers the Texas Medicaid Hospice Program through provider enrollment contracts with hospice agencies. These agencies must be licensed by the DADS and be Medicare certified as hospice agencies by the Centers for Medicare and Medicaid Services (CMS), Department of Health and Human Services. Coverage of services in the Texas Medicaid Hospice Program follows the amount, duration, and scope of services specified in the Medicare Hospice Program, with the following three exceptions:

1. The Texas Medicaid Hospice Program has unlimited benefit periods of unlimited duration.

2. The Texas Medicaid Hospice Program does not have a maximum number of days for which a recipient can receive hospice services under Medicaid.

3. The Texas Medicaid Hospice Program does not allow cost sharing to be imposed on Medicaid recipients for hospice services rendered to Medicaid recipients.

The recipient must file a Medicaid election statement with a particular Medicaid hospice provider. In doing so, the recipient waives rights to other Medicaid services that are related to the treatment of his or her terminal illness(es) with the exception of individuals less than 21 years of age. Individuals less than 21 years of age may receive concurrent hospice and acute care treatment. The recipient has the right to cancel the election at any time without forfeiting additional Medicaid hospice coverage at a later time. The recipient does not waive rights to Medicaid services for conditions not related to the terminal condition. Dually eligible (Medicare and Medicaid) recipients must participate in the Medicare and Medicaid hospice programs simultaneously in order to receive Medicaid hospice services.

HHSC meets the requirements of section 1905(o) of the Social Security Act and section 4305-4308 of the State Medicaid manual.
19. Case Management Services - Chronically Mentally Ill

See Supplement 1 to Attachment 3.1-A, page 1A
19. Case Management Services - Persons with Mental Retardation or Related Conditions or Pervasive Developmental Disability

See Supplement 1 to Attachment 3.1-B, Page 1B.
19. Case Management Services - Blind and Visually Impaired Children was deleted in SPA 17-0001:

Page 41b (TN-92-32)
19. Case Management Services – High-Risk Pregnant Women

See Supplement 1 to Attachment 3.1-B, page 1D.
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Page 41.d

State Plan Amendment /TN 07-016, approved in April 2009,
deleted page 41d (TN 92-32)

See Supplement 1 to Attachment 3.1-A, page 1 F.
20.a. Extended Services To Pregnant Women - Pregnancy-related and Postpartum Services for 60 Days after the Pregnancy Ends.

Services within the amount, duration and scope of the Texas Medical Assistance Program contained in this state plan are available as pregnancy-related services, postpartum services, or services for any other medical condition that may complicate pregnancy when medically necessary and provided by a participating provider.
20.b. Extended Services To Pregnant Women - Services For Any Other Medical Conditions That May Complicate Pregnancy.

Services within the amount, duration and scope of the Texas Medical Assistance Program contained in this state plan are available as pregnancy-related services, postpartum services, or services for any other medical condition that may complicate pregnancy when medically necessary and provided by a participating provider.
21. Services by Certified Family and Pediatric Practitioners.

(a) Services performed by Certified Family and Pediatric Practitioners are covered if the services are within the scope of practice for an advanced practice nurse, as defined by state law; are consistent with rules and regulations promulgated by the Texas State Board of Nursing or other appropriate state licensing authority; and are covered services under the Texas Medical Assistance Program.

(b) Certified Family and Pediatric Practitioners are defined as registered nurses who are approved by the State Board of Nursing to practice as nurse practitioners and clinical nurse specialists as a result of graduation from an accredited program for the training of nurse practitioners and clinical nurse specialists. For services to be payable to these practitioners, the practitioner must be enrolled in and approved for participation in the Texas Medical Assistance Program; must sign a written agreement with the single state agency or its designee; must comply with the terms of the provider agreement and all regulations, rules, handbooks, standards, and guidelines published by the single state agency or its designee; and must bill for services covered by the Texas Medical Assistance Program in the manner and format prescribed by the single state agency or its designee.

(c) Certified Family and Pediatric Practitioners who are employed or remunerated by a physician may bill the Texas Medical Assistance Program and be paid directly for their services. (For the physician to bill, the practitioner must agree that charges for his or her services may be included in the other entity’s billing.) Services may not be billed by both the practitioner and the employing/contracting entity if that billing would result in duplicate payment for the same services. If the services are reimbursable by the program, payment may be made to the entity (if approved for participation in the Texas Medical Assistance Program) who employs or reimburses the practitioner. The basis and amount of Medicaid reimbursement depends on the services actually provided, who provided the service, and the reimbursement methodology utilized by the Texas Medical Assistance Program as appropriate for the services and provider(s) involved.
22. **Respiratory Care services.**

(a) In-Home Respiratory Therapy services are available through Medicaid in accordance with 42 CFR §440.185. Services are provided to Medicaid eligible recipients who:

(1) are ventilator-dependent for life support at least six hours per day;
(2) have been ventilator dependent for at least 30 consecutive days as an inpatient in one or more hospitals, skilled nursing facilities (SNF), or intermediate care facilities (ICF);
(3) but for the availability of these respiratory care services at home, would require respiratory care as an inpatient in a hospital, SNF, or ICF; and would be eligible to have payment made for such inpatient care under the state Medicaid plan;
(4) have adequate social support services to be cared for at home;
(5) wish to be cared for at home; and
(6) receive services under the direction of a physician who is familiar with the recipient’s medical history and care, and who has medically determined that in-home care is safe and feasible for the individual.

(b) **Services:**

(1) Medically necessary In-Home Respiratory Therapy services include:

(A) Respiratory therapy services and treatments prescribed by the recipient’s physician.
(B) Education of the recipient and/or appropriate family members/support persons regarding the in-home respiratory care. Education must include the use and maintenance of required supplies, equipment, and techniques appropriate to the situation.

(2) Disposable respiratory supplies are a benefit through Home Health and are not reimbursed to the certified respiratory therapist.

(c) **Providers:** In-Home Respiratory Therapy services must be provided by a Certified Respiratory Care Practitioner who is certified by the Department of State Health Services (DSHS) to practice under Texas Occupations Code § 604.051.

(d) **Place of Service:** In-Home Respiratory Therapy services must be delivered in the home setting.
24.a. Transportation

Payment will be made for ambulance services, provided the following conditions are met and the services are provided in accordance with laws, regulations and guidelines governing ambulance services under Part B of Medicare.

A. To be covered, ambulance services must be medically necessary and reasonable. Medical necessity is established when the recipient's condition is such that use of any other method of transportation is contraindicated and no other suitable transportation is available. For a recipient receiving ambulance services, when some means of transportation other than ambulance could be used without endangering the recipient's health, no payment may be made for ambulance services.

B. Any recipient whose condition is such that use of any other method of transportation is contraindicated will be transported to and from the provider of his choice who is generally available and used by other residents of the community for any appropriate medical care included under the state agency's Title XIX plan. The transport must be prior authorized by the state agency or its designee.

If no participating provider of the appropriate care is available within the community, transportation will be to and from the nearest participating provider who can provide appropriate medical care included under the state agency's Title XIX plan.

Any recipient whose condition is such that use of any other method of transportation is not contraindicated will be transported to the nearest hospital, skilled nursing facility or other destination that would ordinarily be expected to have the appropriate facilities for the treatment of the injury or illness involved. Ambulance services from a hospital or skilled nursing facility to such recipient's home is covered if the recipient's home is within the locality of the hospital or skilled nursing facility or if the recipient's home is outside of the locality but such hospital or skilled nursing facility is the nearest one with appropriate facilities.
24.a. Transportation (Continued)

(Continued) The term "locality," with respect to ambulance service for recipient's whose condition is such that use of any other method of transportation is not contraindicated, means the service area surrounding the hospital or skilled nursing facility from which individuals normally come or are expected to come for hospital or skilled nursing services. The term "appropriate facilities," with respect to ambulance service for recipients whose condition is such that use of any other method of transportation is not contraindicated, means that the facility is generally equipped to provide the needed care for the illness or injury involved. It is the institution, its equipment, its personnel and its capability to provide the services necessary to support the required medical care that determine whether it has appropriate facilities.

C. The ambulance services must be provided by an ambulance service supplier and the ambulance must be equipped as an ambulance and operated by trained personnel in accordance with state laws, and under the appropriate rules, licensing, or regulations of the area in which the ambulance is operated.

In addition to limitations specified above, medical transportation is limited as follows:

• The use of medical transportation must be for health-related purposes.
• Reimbursement will not be made to Title XIX recipients.
• Payment for medical transportation to and/or from providers of covered Title XIX services on behalf of eligible recipients will be made only where transportation is not otherwise available through the individual recipient's family, friends or community resources who will provide the services free or transportation of any means other than ambulance is contraindicated and no other suitable transportation is available.
• Payment will only be made to approved medical transportation providers.
24.a. Transportation (Continued)

- Exceptions to the transportation provisions contained in this plan may be authorized by the Health and Human Services Commission or its designee when, in the opinion of the commission, circumstances of medical necessity warrant such exceptions.
- In order to be a covered benefit for which reimbursement may be made, the transportation provided must be appropriate to each eligible recipient's particular combination of physical limitations, geographic location, and available source of care.
- Transportation for full benefit dual eligible recipients to obtain prescription medications covered under the Medicare Part D benefit will be provided at the same level of service, and under the same restrictions, as is offered to all Medicaid recipients.
23.b. Services provided in Religious Nonmedical Health Care Institutions.

Christian Science Sanatoria Services for which payment will be made are nursing facility services (as defined at 42 CFR 440.155) considered appropriate by the single state agency, which are provided to eligible recipients in Christian Science Sanatoriums that are operated by, or listed and certified by the First Church of Christ Scientists, Boston, Massachusetts.
23.d Nursing Facility Services for Individuals Under 21 Years of Age.

Nursing facility services (other than services in an institution for mental disease) provided in a Title XIX nursing facility approved by the single state agency to eligible individuals are limited by a requirement for a medical necessity determination. The treating physician prescribes the nursing facility setting, and the state agency provides the medical necessity determination for which payment will be made.

Nursing facility services includes drugs that are reimbursed through the Vendor Drug Program. This encompasses all drugs contained in the resident's plan of care, subject to the drug rebate provision of Section 1927 of the Social Security Act.
23.e. Emergency Hospital Services.

Payment for emergency hospital services is limited to hospitals approved for Title XIX participation by the single state agency.
25. Birthing Center Facility Services.

1) Licensed or Otherwise State-Approved Freestanding Birth Centers

Provided:  □ No limitations  □ With limitations

Please describe any limitations:

Subject to the specifications, conditions, requirements, and limitations established by the single state agency or its designee, birthing center facility services under this State Plan are limited to birthing centers licensed by the State of Texas pursuant to the Texas Birthing Center Licensing Act (Texas Health & Safety Code Chapter 244) or other legally authorized licensing authority under applicable state laws to provide a level of service commensurate with the professional skills of a physician (M.D. or D.O.), a certified nurse-midwife (CNM), or licensed midwife (LM) who acts as the birth attendant. The center, the physician, CNM, and LM must be licensed at the time and place the services are provided. The birthing center must be enrolled and approved by the state agency or its designee to participate in the Texas Medical Assistance Program.

Coverage of birthing center facility services is limited to certain birthing services provided by the center and determined by the attending physician, CNM, or LM to be necessary for the care of the mother and live newborn child following the mother's normal, uncomplicated pregnancy. Reimbursable services are limited to facility services provided during the labor, delivery, and postpartum periods. Birthing center facility services furnished prior to or after the above described period are not considered birthing center facility services and are not covered or reimbursed as such under this State Plan. Services provided by a physician, CNM, or LM are not considered to be birthing center facility services. For services other than birthing center facility services, other applicable provisions of this Title XIX State Plan and the Texas Medical Assistance Program will apply.

2) Licensed or Otherwise State-Recognized covered professionals providing services in the Freestanding Birth Center

Provided:  □ No limitations  □ With limitations (please describe below)

□ Not applicable (there are no licensed or State-approved freestanding birth centers)

Please describe any limitations:

Subject to the specifications, conditions, requirements, and limitations established by the single state agency or its designee, the State will reimburse an LM for a service in accordance with provisions of the State Plan only if the LM is licensed by the State of Texas pursuant to the Texas Midwifery Act or other legally authorized licensing authority under applicable state laws to provide...
25. Birthing Center Facility Services (continued).

services consistent with rules and protocols promulgated by the Texas Midwifery Board or other appropriate state licensing authority that are provided in a freestanding birthing center. The services must be within the LM’s scope of practice, as defined by state law and permitted by the freestanding birthing center, and must be one of the following: prenatal care; labor and delivery; postpartum care immediately following delivery and until discharge or transfer from the freestanding birthing center; or newborn care immediately following delivery and until discharge or transfer from the freestanding birthing center.

Please check all that apply:

☒ (a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan (i.e., physicians and certified nurse midwives).

☒ (b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.80 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife).*

☐ (c) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.).*

*For (b) and (c) above, please list and identify below each type of professional who will be providing birth center services:

Licensed midwives who are licensed by the State of Texas.

STATE: Texas
DATE REC'D: 3-29-13
DATE APV'D: 6-24-13
DATE EFF: 1-1-13
HCFR 179: 13-07

TN: 13-07 Approval Date: 6-24-13 Effective Date: 1-1-13

Supersedes TN: None - New Page
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State: TEXAS

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26. **Personal Care Services**

Subject to the specifications, conditions, and limitations established by the Texas Department of Aging and Disability Services, payments will be made for Personal Care Services as defined at 42 CFR 440.167 when provided to eligible recipients by providers who are approved by and under contract with the Texas Department of Aging and Disability Services.

A. Prior approval to provide services is required in all cases.

B. Providers of Personal Care Services must meet qualifications established by the Texas Department of Aging and Disability Services.

C. Services are limited to the lesser of:
   - no more than fifty (50) hours per week per recipient,
   - the number of hours per week per recipient that may be provided within the limit of the cost of the average Medicaid nursing facility rate for recipients whose assessed medical needs can be met by long-term, non-technical medical observation and authorized assistance with the activities of daily living that are necessary because of a chronic medical condition complicated by functional limitations. *

D. As a condition for payment, Personal Care Services must be the primary need and may not be substituted for services needed to bring about improvement of an acute medical condition.

E. The range of Personal Care Services to be provided is established by an assessment of the recipient’s medical and functional needs. Reassessment of the functional need and authorization for continued Personal Care Services are required at least every twelve months.

F. A recipient’s home is the recipient’s full time abode but does not include a hospital, nursing facility, intermediate care facility for the mentally retarded, institution for mental disease, or any other setting in which Personal Care Services are already available or could be made available by family members or sources outside the Personal care services provided in home.

* Durational, dollar, and quantity limits are waived for recipients of EPSDT services. Personal Care Services allowable under the title XIX of the Social Security Act and its implementing regulations may be covered when medically necessary for these recipients.
26. Personal Care Services (Continued).

G. A family member is defined as an individual with a duty under the Texas Family Code, Sections 2.501 and 151.001, to support the recipient, i.e., spouse for spouse and parent for minor child.

H. The provider must maintain records and submit reports and other information specified by the Texas Department of Aging and Disability Services.

I. Personal care services are supervised by an employee designated as "supervisor" when provided by an agency under contract with the Texas Department of Aging and Disability Services to provide personal care services.
28. Any other medical care, and any other type of remedial care recognized under State law, specified by the Secretary (in accordance with section 1905(a)(29) of the Social Security Act and 42 C.F.R. § 440.170)

a. Transportation (provided in accordance with 42 C.F.R. § 440.170) excluding "school-based" transportation

☐ Not provided
☒ Provided without a broker as an optional medical service

☐ Non-emergency transportation is provided through a brokerage program as an optional medical service in accordance with 1902(a)(70) of the Social Security Act and 42 C.F.R. § 440.170(a)(4).
28. Any other medical care (continued)
   a. Transportation (continued)

As an optional service, the following nonemergency medical transportation (NEMT) services meet the definition outlined in the Medicaid regulations (at 42 CFR 440.170(a)) and all other requirements relating to Medicaid services. These services include:

   (i) Demand response transportation services. Curb-to-curb transportation that involves using a transportation provider, including a transportation network company, who dispatches vehicles in response to requests for individual or shared one-way trips. Demand response transportation services are provided when fixed route services are either unavailable or do not meet the health care needs of clients. Services must be timely and provided by licensed, qualified, courteous, knowledgeable, and trained personnel.

   (ii) Mass transit. Transportation by bus, rail, air, ferry, or intra-city bus, either publicly or privately owned, which provides to the public general or special service on a regular and continuing basis. Mass transit is intercity or intra-city transportation. Mass transit also involves using commercial air service to transport an eligible Medicaid recipient to an authorized covered Medicaid service.

The single state agency purchases tickets from intra-city and intercity mass transit providers (e.g., bus, rail, air) with state funds as an administratively efficient way to assure the availability of NEMT service by participating mass transit providers for eligible recipients whose medical conditions allow. The claim for FFP will not be made until an eligible recipient uses the ticket to obtain transportation for a necessary medical service.

   (iii) Individual Transportation Participant. Transportation by an individual transportation participant (ITP) who is approved for mileage reimbursement at a prescribed rate to provide transportation for a prior authorized MTP client to a prior authorized health care service.

   Exclusion: Mileage reimbursement made directly to a Medicaid beneficiary or to a beneficiary’s immediate family member (ITP-Self) does not qualify for the federal medical assistance percentage (FMAP) match.
28. Any other medical care (continued)
   a. Transportation (continued)

   (i) **Lodging.** Transportation-related services authorized by the single state agency to provide overnight lodging for eligible recipients in conjunction with a healthcare service. Lodging services are arranged through a lodging establishment (e.g., hotel, motel, charitable home, or hospital that provides overnight lodging), that has agreed to provide lodging paid by the single state agency. Direct payment is made to a lodging establishment either as a reimbursement or direct bill or up front utilizing the State credit card.

   **Exclusion:** Reimbursement of eligible lodging expenses directly to a Medicaid beneficiary or to a beneficiary’s immediate family member is not eligible for FMAP.

   (ii) **Meals.** Transportation-related services authorized by the single state agency for the purpose of funding meals for eligible recipients during an extended stay away from the recipient’s residence.

   **Exclusion:** Reimbursement of eligible meal expenses directly to a Medicaid beneficiary or to a beneficiary’s immediate family member is not eligible for FMAP.

   (iii) **Advanced Funds.** Transportation-related services authorized by the single state agency and provided in advance and disbursed by the financial services vendor to a recipient, responsible party, or Individual Transportation Participant (ITP) for the purpose of funding transportation or transportation-related services (e.g., gasoline, meals and/or lodging, etc.). The state’s claim for(FFP) in these expenditures will not be made until after the recipient has received the medical care for which the expenditures were necessary.

   (iv) **Attendant.** Cost to transport parent, responsible party, or services animal who accompanies a recipient for the purpose of providing necessary mobility or personal or language assistance to the recipient during the time that transportation and healthcare services are provided. Additionally, if a services animal is authorized to accompany a beneficiary, the state reimburses the provider for the space occupied by the services animal at the rate established in the services area for an adult attendant.
28. Any other medical care (continued)
   a. Transportation (continued)

**Exclusion of Transportation by a Prescribed Pediatric Extended Care Center (PPECC)**

Transportation provided by a prescribed pediatric extended care center (PPECC) is not included as a non-emergency transportation service.
28. Any other medical care (continued)
a. Transportation (continued)

- Individuals terminally ill if in a medical institution and will receive hospice care
- Individuals aged or disabled with income not above 100% FPL
- Individuals working disabled who buy into Medicaid (BBA working disabled group)
- Employed medically improved individuals who buy into Medicaid under TWWIA Medical Improvement Group
- Individuals disabled age 18 or younger who would require an institutional level of care (TEFRA 134 kids).

(6) Payment Methodology:

(F) The State will pay the contracted broker by the following method:

- (i) risk capitation
- (ii) non-risk capitation
- (iii) other

The contracted broker will be paid a monthly capitated rate for each eligible client residing in their designated area. The capitated rate includes operating costs coupled with factors that include historical rates in geographical area, approximate distance between travel points, service operation requirements, beneficiary transportation needs, and quality of service cost for providing the service to the Medicaid beneficiary and their attendant.

(G) Who will pay the transportation provider?

- (i) Broker
- (ii) State
- (iii) other

(H) What is the source of the non-Federal share of the transportation payments?

The source of the non-federal share of the transportation payment is the State’s general revenue fund.

(I) The State assures that no agreement (contractual or otherwise) exists between the State or any form of local government and the transportation broker to return or redirect any of the Medicaid payment to the State or form of local government (directly or indirectly). This assurance is not intended to interfere with the ability of a transportation broker to contract for transportation services at a lesser rate and credit any savings to the program.
General exclusions and limitations applicable to the amount, duration and scope of medical and remedial care and services provided under this State Plan.

On behalf of the categorically needy, only reasonable costs or reasonable charges as applicable for medical or remedial care will be paid when the items of care furnished are medically necessary for diagnosis, treatment, or both, subject to exclusions and limitations applicable to specific services and third party liability. These exclusions and limitations do not apply to the services covered by the Texas Health Steps Comprehensive Care Program.

The benefits of this program do not include:

1. Services provided to any individual who is an inmate in a public institution (except as a patient in a medical institution approved for participation in the Medicaid program), or is a patient in:
   (A) an institution for tuberculosis,
   (B) the hospital or nursing sections of institutions for the mentally retarded, or
   (C) an institution for mental disease if the patient is between the ages of 22 and 64;

2. Special shoes or other supportive devices for the feet and ambulation aids (except as provided for in the home health services program);

3. Any services provided by military medical facilities, except:
   (A) military hospitals enrolled to provide inpatient emergency services,
   (B) Veterans Administration facilities, or
   (C) United States Public Health Service hospitals;

4. Care and treatment related to any condition covered by workmen's compensation laws;

5. Care, treatment or other services by a doctor of dentistry unless:
   (A) the recipient's dental diagnosis is causally related to a life-threatening medical condition; or
   (B) the treatment is specifically authorized by the Health and Human Services Commission (HHSC) or its designee;
6. Any care or services to the extent that a benefit is paid or payable under Medicare;

7. Any services or supplies provided to an individual before the effective date of designation by HHSC as an eligible recipient or after the effective date of denial as an eligible recipient except orthodontic services that are authorized and initiated while the recipient is eligible for Medicaid may be continued for 36 months after a recipient is no longer Medicaid eligible;

8. Any services or supplies provided in connection with cosmetic surgery except as required for the prompt repair of accidental injury or for improvement of the functioning of a malformed body member or as required by federal law;

9. Immunizations specifically for travel to or from foreign countries. Immunizations included on the immunization schedule approved by the Advisory Committee on Immunization Practices (ACIP) are a benefit unless an immunization is specifically excluded by HHSC;

10. Any services provided by an immediate relative of the eligible recipient or member of the eligible recipient's household except for personal care services;

11. Custodial care;

12. Any services or supplies provided outside of the United States, except for deductible and co-insurance portions of Medicare benefits as provided for in this plan;

13. Any service or supplies not provided for in this plan;

14. Any services or supplies to the extent that benefits are available for such services or supplies under any other contract or policy of insurance, or would have been so available in the absence of this contract.

15. Any services or supplies not provided for in this plan for:

   (A) the treatment of flat foot conditions and the prescription of supportive devices therefor;

   (B) the treatment of subluxations of the foot; or

   (C) routine foot care (including the cutting or removal of corns, warts, or calluses, the trimming of nails, and other routine hygiene care);
16. Any services or supplies that are experimental or investigational;

17. Outpatient behavioral health benefits to an individual for the diagnosis or treatment of mental disease, psychoneurotic, and personality disorders while not confined as an inpatient in a hospital which exceed 30 visits to enrolled practitioners per calendar year. This utilization control limitation may be exceeded when prior authorized on a case by case basis;

18. Services provided by ineligible or suspended providers;

19. Any service or supplies for which claims were not submitted within the filing deadline.

20. Institutional Care, separate payments are not made for services and supplies in an institution where the reimbursement formula and vendor payment include such services or supplies as a part of the institutional care.

SUPERSEDES: TN- 94-01
Enclosure

State of Texas

1915(j) Self-Directed Personal Assistance Services State Plan Amendment Pre-Print

Citation 3.1(a)(2) Amount, Duration, and Scope of Services: Medically Needy (Continued)

1915(j) ☑ Self-Directed Personal Assistance Services, as described and limited in Appendix 3 to Attachment 3.1-B.

ATTACHMENT 3.1-B identifies the medical and remedial services provided to the medically needy.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1024. The time required to complete this information collection is estimated to average 20 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
State of Texas
Appendix 3 to Attachment 3.1-B
Page 2

Enclosure __
Attachment 3.1-B

State of Texas
1915(j) Self-Directed Personal Assistance Services State Plan Amendment Pre-Print

Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Medically Needy

☒ Self-Directed Personal Assistance Services, as described in Appendix 3 to Attachment 3.1-B.

☒ Election of Self-Directed Personal Assistance Services: By virtue of this submittal, the State elects Self-Directed Personal Assistance Services as a State Plan service delivery option.

☐ No election of Self-Directed Personal Assistance Services: By virtue of this submittal, the State elects not to add Self-Directed Personal Assistance Services as a State Plan service delivery option.
Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation.

State of Texas (1)
1915(j) Self-Directed Personal Assistance Services State Plan Amendment Pre-Print

i. Eligibility

The State determines eligibility for Self-Directed Personal Assistance Services:

A. ☒ In the same manner as eligibility is determined for traditional State Plan personal care services, described in Item 4b page 7f, Item 25, and Item 26 of the Medicaid State Plan.

B. ☐ In the same manner as eligibility is determined for services provided through a 1915(c) Home and Community-Based Services Waiver.

ii. Service Package

The State elects to have the following included as Self-Directed Personal Assistance Services:

A. ☒ State Plan Personal Care and Related Services, to be self-directed by individuals eligible under the State Plan.

B. ☐ Services included in the following section 1915(c) Home and Community-Based Services waiver(s) to be self directed by individuals eligible under the waiver(s). The State assures that all services in the impacted waiver(s) will continue to be provided regardless of service delivery model. Please list waiver names and services to be included.

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TN No. 08-36 Approval Date 7-29-09 Effective Date 11-3-08

SUPERSEDES: NONE - NEW PAGE
iii. Payment Methodology

A. The State will use the same payment methodology for individuals self-directing their PAS under section 1915(j) than that approved for State plan personal care or for section 1915(c) Home and Community-Based waiver services.

B. The State will use a different payment methodology for individuals self-directing their PAS under section 1915(j) than that approved for State plan personal care services or for section 1915(c) Home and Community-Based waiver services.

iv. Use of Cash

A. The State elects to disburse cash prospectively to participants self-directing personal assistance services. The State assures that all Internal Revenue Service (IRS) requirements regarding payroll/tax filing functions will be followed, including when participants perform the payroll/tax filing functions themselves.

B. The State elects not to disburse cash prospectively to participants self-directing personal assistance services.

v. Voluntary Disenrollment

The State will have the following safeguards in place to ensure continuity of services and assure participant health and welfare during the period of transition between self-directed and traditional service delivery models.

An individual may voluntarily terminate participation in the consumer-directed services (CDS) option at any time by notifying the individual’s case manager/service coordinator. Within 14 calendar days of the individual’s request, the case manager will:
1. provide the individual with a choice of possible agency providers;
2. notify the agency provider of the individual’s choice; and
3. negotiate an end date for the CDS option and a start date for the agency option with no break in service.

The individual’s case manager/service coordinator assists the individual to ensure continuity of PAS services through the traditional agency service delivery option (provider-managed service delivery) and maintenance of the individual’s health and welfare during the transition from the CDS option.
The following is a discussion of the general roles and responsibilities of case management, support consultation, and financial management services.

**Case management**
Case management is provided by case managers/service coordinators and focuses on service planning. Service planning is conducted in the same manner for those who are self-directing and for those who are using traditional provider-managed personal assistance services.

Case Manager/Service Coordinator responsibilities include:

- presenting the CDS option when individuals enroll and at the annual review;
- working through consumer self-assessment to determine if the persons interested in using the CDS option would benefit from a Designated Representative or a Support Advisor;
- determining, along with individual, the need for services, including Support Consultation, service unit levels, the tasks to be performed, and the goals of the service;
- developing the service plan;
- determining the need for a back-up service plan;
- approving service back-up plans;
- facilitating transfer to the CDS option by sending the referral form, the service plan, the back-up plan, and the consumer self-assessment to the Consumer Directed Services Agency (CDSA) of the person's choosing;
- approving corrective action plans;
- receiving and reviewing quarterly reports from the CDSA;
- initiating a corrective action plan, if needed;
- conducting monitoring visits;
- approving termination from the CDS option; and
- facilitating voluntary and involuntary disenrollment from the CDSA option.

**Support Consultation**
Support consultation, provided by Support Advisors, is a service available exclusively to those who use self-direction and focuses on supporting the individual as employer in carrying out the employer functions. Support consultation is an optional service available to all individuals who choose to direct their own services.
Support Advisor responsibilities include:

- assisting, as needed, with developing the risk-planning checklist and CDS Support plan, including the service back-up plan and identified needs of additional coaching and support;
- assisting, as necessary, with the implementation of the CDS Support plan;
- providing coaching and mentoring related to being an employer; and
- assisting with completion of forms related to the hiring process.

Support Advisors do not play a role in voluntary disenrollment. Support Advisors will not monitor health and welfare, which is the responsibility of the case managers/service coordinators. However, Support Advisors are required to inform case managers/service coordinators of any health or safety issues. A Support Advisor must notify the individual’s case manager or service coordinator:

(1) when service goals have been met;
(2) if the person receiving support consultation is unable or unwilling to cooperate with service delivery; or
(3) of the progress and status of the service required by the individual’s program.

Financial Management Services

Financial Management Services are provided by Consumer Directed Services Agencies (CDSA) to individuals who serve as the common law employer of their providers.

CDSA functions include:

- providing the consumer with an initial orientation to CDS, which includes a review of rules and requirements as well as roles and responsibilities;
- providing ongoing training and support to the consumer;
- assisting with conducting required criminal history checks and other required checks, such as the Nurse Aide Registry and Employee Misconduct Registry;
- verifying citizenship status and qualifications of employees and applicants for employment;
- maintaining documentation of the appointment of a designated representative;
- approving and monitoring budgets;
• providing assistance in determining staff wages and benefits subject to State limits;
• monitoring continued eligibility of employees;
• preparing and filing applicable tax forms and reports;
• assisting with budget development;
• approving in writing budgets and budget revisions;
• paying allowable expenses incurred by the consumer;
• preparing a quarterly budget status report;
• acting as employer-agent for the consumer by handling payroll withholdings, tax deposits, reporting, timesheets, receipts and invoices and paying service providers;
• retaining copies of consumer back-up plans;
• conducting an annual satisfaction survey with the consumer;
• reporting consumer noncompliance to the state-employed caseworker;
• initiating interventions and corrective action plans; and
• recommending termination of the CDS option for consumer noncompliance.

When an individual voluntarily leaves the CDS option, the CDSA closes the employer’s payroll and payable accounts and completes all deposits and filings of required reports with governmental agencies on behalf of the individual.

After 90 days, the individual may choose to re-enroll in the CDS option.

vi. Involuntary Disenrollment

A. The circumstances under which a participant may be involuntarily disenrolled from self-directing personal assistance services, and returned to the traditional service delivery model are noted below.

Involuntary termination of the CDS option may occur when either:

(1) the individual’s case manager/service coordinator, in consultation with the Support Advisor if the individual is utilizing that support service, and the CDSA, determine that continued participation in the CDS option would not permit the individual’s health and welfare to be met; or

(2) the individual’s case manager/service coordinator, in consultation with the CDSA or DADS staff, determines that the individual or the
individual’s representative, when provided with additional support from the CDSA or Support Advisor, has not carried out employer responsibilities in accordance with requirements of the option.

Within 14 calendar days, or earlier if based on health and welfare concerns, the case manager will coordinate the transfer to the traditional provider-delivered services, as long as the individual remains eligible to receive State Plan Personal Care benefit. The case manager/service coordinator will:

1. inform the individual of the reason for terminating the CDS option;
2. inform the individual of his or her right to a fair hearing;
3. provide the individual with a choice of possible agency providers;
4. notify the provider of the individual’s choice;
5. negotiate an end date for the CDS option and a start date for the agency option with no break in service; and
6. if the individual appeals, and if the decision for termination is upheld following the fair hearing process, the case manager coordinates the termination of services.

B. The State will provide the following safeguards in place to ensure continuity of services and assure participant health and welfare during the period of transition between self-directed and traditional service delivery models.

The individual’s case manager assists the individual with changing from CDS to the traditional agency service delivery option (provider-managed service delivery) to ensure no break in service in order to maintain the individual’s health and welfare.

For individuals whose health and welfare are at risk, the case manager will facilitate an immediate transfer to a provider and ensure that CDS back-up plans are utilized until the transfer date to the agency option. If necessary, the case manager may utilize other resources to ensure health and welfare.

The CDSA closes the employer’s payroll and payable accounts and completes all deposits and filings of required reports with governmental agencies on behalf of the individual.
vii. Participant Living Arrangement

Any additional restrictions on participant living arrangements, other than homes or property owned, operated, or controlled by a provider of services, not related by blood or marriage to the participant are noted below.

The State has no additional restrictions on the individual’s living arrangement.

viii. Geographic Limitations and Comparability

A. ☑ The State elects to provide self-directed personal assistance services on a statewide basis.

B. ☐ The State elects to provide self-directed personal assistance services on a targeted geographic basis. Please describe:

C. ☑ The State elects to provide self-directed personal assistance services to all eligible populations.

D. ☐ The State elects to provide self-directed personal assistance services to targeted populations. Please describe:

E. ☑ The State elects to provide self-directed personal assistance services to an unlimited number of participants.

F. ☐ The State elects to provide self-directed personal assistance services to _________ (insert number of) participants, at any given time.

ix. Assurances

A. The State assures that there are traditional services, comparable in amount, duration, and scope, to self-directed personal assistance services.

B. The State assures that there are necessary safeguards in place to protect the health and welfare of individuals provided services under this State Plan Option, and to assure financial accountability for funds expended for self-directed personal assistance services.
C. The State assures that an evaluation will be performed of participants’ need for personal assistance services for individuals who meet the following requirements:
   i. Are entitled to medical assistance for personal care services under the Medicaid State Plan; or
   ii. Are entitled to and are receiving home and community-based services under a section 1915(c) waiver; or
   iii. May require self-directed personal assistance services; or
   iv. May be eligible for self-directed personal assistance services.

D. The State assures that individuals are informed of all options for receiving self-directed and/or traditional State Plan personal care services or personal assistance services provided under a section 1915(c) waiver, including information about self-direction opportunities that is sufficient to inform decision-making about the election of self-direction and provided on a timely basis to individuals or their representatives.

E. The State assures that individuals will be provided with a support system meeting the following criteria:
   i. Appropriately assesses and counsels individuals prior to enrollment;
   ii. Provides appropriate counseling, information, training, and assistance to ensure that participants are able to manage their services and budgets;
   iii. Offers additional counseling, information, training, or assistance, including financial management services:
   iv. At the request of the participant for any reason; or
   v. When the State has determined the participant is not effectively managing their services identified in their service plans or budgets.

F. The State assures that an annual report will be provided to CMS on the number of individuals served through this State Plan Option and total expenditures on their behalf, in the aggregate.

G. The State assures that an evaluation will be provided to CMS every 3 years, describing the overall impact of this State Plan Option on the health and welfare of participating individuals, compared to individuals not self-directing their personal assistance services.

H. The State assures that the provisions of section 1902(a)(27) of the Social Security Act, and Federal regulations 42 CFR 431.107, governing provider agreements, are met.
I. The State assures that a service plan and service budget will be developed for each individual receiving self-directed PAS. These are developed based on the assessment of needs.

J. The State assures that the methodology used to establish service budgets will meet the following criteria:
   i. Objective and evidence based, utilizing valid, reliable cost data.
   ii. Applied consistently to participants.
   iii. Open for public inspection.
   iv. Includes a calculation of the expected cost of the self-directed PAS and supports if those services and supports were not self-directed.
   v. Includes a process for any limits placed on self-directed services and supports and the basis/bases for the limits.
   vi. Includes any adjustments that will be allowed and the basis/bases for the adjustments.
   vii. Includes procedures to safeguard participants when the amount of the limit on services is insufficient to meet a participant’s needs.
   viii. Includes a method of notifying participants of the amount of any limit that applies to a participant’s self-directed PAS and supports.
   ix. Does not restrict access to other medically necessary care and services furnished under the plan and approved by the State but not included in the budget.

x. Service Plan

The State has the following safeguards in place, to permit entities providing other Medicaid State Plan services to be responsible for developing the self-directed personal assistance services service plan, to assure that the service provider’s influence on the planning process is fully disclosed to the participant and that procedures are in place to mitigate that influence.

The State does not permit entities providing other Medicaid State Plan services to be responsible for developing the individual’s self-directed personal assistance service plan.

xi. Quality Assurance and Improvement Plan

The State’s quality assurance and improvement plan is described below, including:
   i. How it will conduct activities of discovery, remediation, and quality improvement in order to ascertain whether the program meets assurances, corrects shortcomings, and pursues opportunities for improvement; and
ii. The system performance measures, outcome measures, and satisfaction measures that the State will monitor and evaluate.

Consumer Directed Services are monitored for quality assurance and improvement under the authority of the Texas Health and Human Services Commission (HHSC), the State Medicaid agency, under the auspices of its operating agency, the Texas Department of Aging and Disability Services (DADS).

The State seeks to discover areas of non-compliance related to health and welfare or financial accountability and remediate any identified issues in order to improve services. The State wants to evaluate whether:

- a participant-driven approach is used;
- choice in service delivery models is available; and
- supports for participant direction are in place and are effective for participants.

Activities of discovery, remediation, and quality improvement:
HHSC adopted rules (40 Tex. Admin. Code, Ch. 41, effective January 1, 2007) governing the CDS option. These rules define a comprehensive program to assure appropriate and effective support and oversight for individuals who choose Self-Directed Personal Assistance Services through the State's CDS option. Adherence to and enforcement of these rules, and the documentation required, provide the basis for activities of discovery, remediation, and quality improvement for system performance measures, outcome measures, and satisfaction measures. The rules address the following areas:

- enrollment and service planning;
- responsibilities of employers and designated representatives;
- enrollment and responsibilities of CDSAs;
- enrollment process, transfer, suspension, and termination;
- budgets;
- support consultation services and Support Advisor responsibilities;
- reporting allegations; and
- oversight.
Methods of discovery:
On-site monitoring of the CDSAs is conducted by the DADS contracting unit every other year. The analysis is based on a sample of 30 cases. Monitoring focuses on ensuring financial accountability and participant health and welfare and involves verification of the following:

- polices and procedures are in place and are working as they are supposed to;
- criminal background checks are completed;
- a CDSA Orientation is completed in person with each participant;
- the consumer budget was developed on the DADS-approved budget workbook;
- payroll and tax functions are carried out;
- individuals were informed of the complaint procedure and how to report abuse, neglect, and exploitation (ANE); and
- all billing can be supported with documentation.

The information obtained from the monitoring reviews is recorded and tracked using a data base.

The Participant Experience Survey (PES) is a survey instrument designed for older adults and adults with physical disabilities. The Quality Assurance and Improvement (QAI) unit at DADS uses the PES instrument every year as part of the Long Term Services (LTS) and Supports Quality Review process. Each year, QAI selects a subset of DADS programs for review through a rotating schedule of all programs. The State Plan Personal Care Services benefit will be included in reviews in even numbered years (e.g. 2010, 2112) as part of the review process. The findings are shared with program staff to determine areas for quality improvement. The results are compiled into a report that is posted on the agency's website:

State law (Government Code, Section 2114.002) requires that Texas state agencies biennially submit to the Governor's Office of Budget Planning and Policy (GOBPP) and the Legislative Budget Board (LBB) information gathered from customers on the quality of agency services. In 2006, the Texas Health and Human Services Commission (HHSC) contracted with the Survey Research Center at the University of North Texas (UNT) to conduct a mail survey of a random sample of individuals from six programs within the Texas Health and Human Services (HHS) system. The purpose of the survey is to obtain customer opinions of their interactions with Texas Health and

Up to this point, questions on the CDS option have not been included in the survey. While the survey is administered to DADS consumers, there has been no specific sampling methodology to target those who use the CDS option. The State will be redesigning the survey and the sampling approach by the end of 2011 and plans to include a focus on CDS.

Each CDSA is required to assess consumer satisfaction with Financial Management Services (FMS) annually, when participants transfer away from the CDSA, or when participants terminate the CDS option. DADS reviews these satisfaction surveys during on-site monitoring reviews.

DADS tracks complaints from participants, family members and interested other parties that come into the complaint hotline related to the CDS option. These complaints are logged in a data base.

**Activities of remediation:**
Each complaint is addressed by DADS staff by talking with the participant or family member and, if necessary, directly with the Consumer Directed Services Agencies (CDSA) as a follow up to the initial complaint.

**Activities of quality improvement:**
- follow up on corrective action plans;
- follow up on contract sanctions;
- enhance training and improve technical support;
- require additional training;
- enact policy modifications in response to consumer satisfaction surveys; and
- implement recommendations from the Consumer Direction Workgroup.

The State provides the CDSAs and Support Advisors with additional training if monitoring results indicate problems with billing, producing quarterly reports for consumer and case manager or service coordinators, criminal history check(s) were not completed, or a back-up plan was not in place. The expectation from the training of the CDSAs and Support Advisors is that they would be better able to educate and support consumers. DADS holds quarterly conference calls with the CDSAs to discuss any implementation issues.
System Performance Measures will be reviewed every other year by DADS contract monitoring staff. Measures include:

- 100 percent of CDSA reviews show compliance with the requirement to perform criminal history, Nurse Aide Registry, and Employee Misconduct Registry checks before hiring a non-licensed provider;
- 100 percent of CDSA reviews show compliance with the requirement to inform the individual and/or the designated representative about how to report allegations of abuse, neglect or exploitation;
- 100 percent of CDSA reviews indicate that participants have been informed of the complaint procedures;
- 100 percent of on-site CDSA reviews show compliance with the requirement that service providers are qualified and trained as required;
- 100 percent of CDSA reviews show that the requirement for a service back-up plan is in place;
- 100 percent of on-site CDSA reviews include evidence that quarterly budget reports were sent to individual employers and case managers or service coordinators;
- 100 percent of on-site CDSA reviews show evidence that CDSAs provided individual employers with copies of their CDS budgets; and
- 100 percent of on-site CDSA reviews show evidence that service plans were followed, time sheets were processed correctly, the employment taxes were filed and paid, and invoices were paid.

Outcome Measures will be collected and analyzed every other year through contract monitoring and the Participant Experience Survey (PES). Outcome measures include the following:

- 90 percent of participants have maximum control in selecting, managing and supervising their personal assistance services;
- 90 percent of participants have the amount of support they desire to self-direct services;
- 100 percent of participants' health and safety is not adversely affected; and
- 2 percent or fewer participants are involuntarily terminated from the CDS option.
Satisfaction Measures will be collected and analyzed annually from information collected by the CDSAs. Measures include:

- 90 percent of participants are satisfied with their choice and flexibility in managing their services;
- 90 percent of participants are satisfied with their FMS provider; and
- 90 percent of participants are satisfied with their Support Advisor.

DADS defines critical events under the CDS option as those events that:
(1) occur because of the individual's participation in the CDS option, and
(2) jeopardize the individual's health or welfare.

Complaints filed with Consumer Rights and Services, a department within the Department of Aging and Disability Services (DADS) are tracked, investigated and resolved as soon as possible. Complaint intake has an automated system for keeping track of complaints.

Complaints include any dissatisfaction expressed by a person, orally or in writing, to the DADS Consumer Rights and Services Department about any matter related to a program service. Subjects of complaints specifically related to the CDS option include:
(1) the quality of Financial Management Services (FMS) provided;
(2) failure of a CDS employer to follow CDS option rules;
(3) alleged abuse, neglect or exploitation of an individual using the CDS option by the service provider hired by the CDS employer; and
(4) failure by the provider hired by the CDS employer to respect the individual's rights.

Case managers/service coordinators have the primary responsibility for monitoring the health and welfare of all participants—those who use the CDS option and those who use traditional provider-managed services. However, Support Advisors are required to inform case managers of any health or safety issues. A Support Advisor must notify the individual's case manager or service coordinator:
(1) when service goals have been met;
(2) if the person receiving support consultation is unable or unwilling to cooperate with service delivery; or
(3) of the progress and status of the service required by the individual's program, including not meeting service goals.

The CDSAs are required to send the consumer and the case manager or service coordinator a quarterly report. This report indicates any under-
utilization or over-utilization of services by showing the amount of funds expended to date for each service category versus the projected spending amount. CDSAs also include in this report, if warranted, information about issues or concerns related to the individual’s participation in the CDS option. The quarterly reporting is the minimum requirement. Employers, Designated Representatives or case managers/service coordinators may request the report more frequently, as needed.

The CDSAs can also ask the consumer to complete a corrective action plan if the employer: hires an ineligible service provider; submits incomplete, inaccurate, or late documentation of service delivery; does not follow the budget; does not comply with program requirements related to the CDS option; does not meet service plan outcomes; or does not meet other employer responsibilities.

If requested by the case manager/service coordinator or CDSA, the participant must develop a corrective action plan, which must be approved by the case manager/service coordinator. The participant may request assistance from the Support Advisor to develop and implement the corrective action plan. If the participant has not implemented the corrective action plan, or if the corrective action plan is not working, the case manager can involuntarily terminate the participant from the CDS option. If the participant’s health and safety is in immediate jeopardy, he or she may be asked to return to the agency option for at least 90 days.

xii. Risk Management

A. The risk assessment methods used to identify potential risks to participants are described below.

As part of the initial CDS decision-making process, individuals or their legally authorized representative are required to complete a Consumer Self-Assessment, which asks the individual to identify areas related to recruiting, hiring and supervising attendants in which they may need additional support. If the individual or legally authorized representative cannot complete the assessment and chooses to use the CDS option, a designated representative, selected by the consumer or legally authorized representative, must complete the assessment and assist with employer tasks.
B. The tools or instruments used to mitigate identified risks are described below.

Risk-Planning Checklist. At the first meeting with the CDSA, individuals will be given the Risk-Planning Checklist to discuss with their Support Advisor. This instrument lists many common risk factors, ranging from physical to cognitive disabilities, and social issues such as social isolation.

CDS Support Plan. This plan includes risks that the individual will assume and strategies to mitigate any risks identified based on the Risk-Planning Checklist.

C. The State’s process for ensuring that each service plan reflects the risks that an individual is willing and able to assume, and the plan for how identified risks will be mitigated, is described below.

Information from Consumer Self-assessment Tool, in conjunction with discussion with the consumer or legally authorized representative, will be used to determine if the individual would benefit from Support Consultation and, if so, the number of hours to be authorized on the individual’s service plan. In addition, the Support Advisor uses this self-assessment as a guide to provide education and coaching to the individuals while they are using the CDS option.

CDSA orientation

Once an individual or legally authorized representative has selected the CDS option, he or she must select a CDSA that will provide financial management services such as registering as the individual’s employer-agent with the IRS and conducting payroll and tax functions. The CDSA is required to provide an in-person orientation before the individual can begin to use the CDS option. At the orientation, the CDSA explains the roles and responsibilities of using the CDS option, assists with developing the consumer budget, and reviews the requisite forms to be completed during the hiring process. Individuals may also use a designated representative (DR) to carry out employer functions. If the individual decides to use a designated representative, the individual will work with the CDSA to determine which specific employer tasks the DR will assume. To prevent over- and under-utilization, CDSAs are required to send to the individual and the case manager a quarterly report summarizing the amount of funds expended and the number of hours used.
Support Advisor training and on-going support

All individuals will have access to Support Consultation. The individual either elects to use a Support Advisor provided by the CDSA or has the opportunity to use a Support Advisor from the list of certified Support Advisors provided by the State. After meeting with the CDSA, the individual can begin to use the Support Advisor. The Support Advisor and the individual review and discuss the Risk-Planning Checklist and Consumer Self-Assessment tool to complete the CDS Support Plan, which identifies the risks the individual will assume and any needed areas of coaching and assistance. A copy of the CDS Support Plan is sent to the CDSA and the case manager/service coordinator.

Service back-up plan

In addition, individuals using the CDS option must complete a service back-up plan. This plan includes reasons for implementing the back-up plan, multiple back-up plan strategies (including informal supports), specific actions to be taken in the absence of service delivery, and contact information for each back-up strategy. Support Advisors can assist employers with the development of the back-up plan.

D. The State’s process for ensuring that the risk management plan is the result of discussion and negotiation among the persons designated by the State to develop the service plan, the participant, the participant’s representative, if any, and others from whom the participant may seek guidance, is described below.

Under the CDS option, the individual is the key driver in the development of the service plan, the CDS Support Plan and the back-up plan. The individual is responsible for completing the CDS Support Plan and the back-up plan with the assistance of the Support Advisor and approval by the case manager. The individual is responsible for ensuring that the CDSA and the case manager/service coordinator has a copy of the CDS Support Plan.
xiii. Qualifications of Providers of Personal Assistance

A. ☐ The State elects to permit participants to hire legally liable relatives as paid providers of the personal assistance services identified in the service plan and budget.

B. ☒ The State elects not to permit participants to hire legally liable relatives as paid providers of the personal assistance services identified in the service plan and budget.

xiv. Use of a Representative

A. ☒ The State elects to permit participants to appoint a representative to direct the provision of self-directed personal assistance services on their behalf.

   i. ☐ The State elects to include, as a type of representative, a State-mandated representative. Please indicate the criteria to be applied.

B. ☐ The State elects not to permit participants to appoint a representative to direct the provision of self-directed personal assistance services on their behalf.

xv. Permissible Purchases

A. ☐ The State elects to permit participants to use their service budgets to pay for items that increase a participant's independence or substitute for a participant's dependence on human assistance.

B. ☒ The State elects not to permit participants to use their service budgets to pay for items that increase a participant's independence or substitute for a participant's dependence on human assistance.

xvi. Financial Management Services

A. ☒ The State elects to employ a Financial Management Entity to provide financial management services to participants self-directing personal assistance services, with the exception of those participants utilizing the cash option and performing those functions themselves.

   i. ☐ The State elects to provide financial management services through a reporting or subagent through its fiscal
intermediary in accordance with section 3504 of the IRS Code and Revenue Procedure 80-4 and Notice 2003-70; or

ii. ☑ The State elects to provide financial management services through vendor organizations that have the capabilities to perform the required tasks in accordance with section 3504 of the IRS Code and Revenue Procedure 70-6. (When private entities furnish financial management services, the procurement method must meet the requirements set forth Federal regulations in 45 CFR section 74.40 – section 74.48.)

iii. ☐ The State elects to provide financial management services using "agency with choice" organizations that have the capabilities to perform the required tasks in accordance with the principles of self-direction and with Federal and State Medicaid rules.

B. ☐ The State elects to directly perform financial management services on behalf of participants self-directing personal assistance services, with the exception of those participants utilizing the cash option and performing those functions themselves.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT Attachment 3.1-C
MEDICAL ASSISTANCE PROGRAM

State of TEXAS

STANDARDS AND METHODS OF ASSURING HIGH QUALITY CARE

1. The state law under which Title XIX operates requires that the State agency establish and provide such methods of administration as may be necessary for the proper and efficient operation of the program.

2. Other state laws prohibit any payment to providers of service except those approved by State Standard-Setting Authorities.

3. There are State regulations requiring that only those practitioners holding a valid license in their own discipline may be authorized to treat recipients of any established program of the agency.

4. The State agency has established a Medical Care Advisory Committee. Advice is sought from this Committee in the matter of devising methods and standards for insuring high quality medical care.

5. The State agency enters into cooperative agreements with other State agencies as required by law or as may be deemed expedient by this agency. These agreements pursue the purpose of insuring high quality medical care for all of the recipients served by this agency and specifically for the recipients served under the provisions of Title XIX.

To assure sufficient incentive among providers of medical services, the following principles are applied:

a. A system of fees for medical services are established under a criteria of usual and customary fees, charges and rates.

b. A system of fees for other medical assistance is based on usual and customary fees, charges and rates. It is provided however, that if such payments are otherwise limited by Federal law, then, these fees shall be as near the usual and customary fees, charges and rates as may be permitted by law.

The State agency will provide no less in scope than the minimum required by federal law for all eligible individuals.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State: __________ TEXAS __________

SECTION 3 – SERVICES: GENERAL PROVISIONS; continued

D. Methods of Providing Transportation as an Administrative Activity in accordance with 1902(a)(4)(A) of the Act and 42 CFR § 431.53 (excluding “school based” transportation).

Provided: ☒

Not Provided: ☐

Supersedes TN No. _______ Approval Date __________ Effective Date __________
1. Non-emergency Medical Transportation

To ensure necessary transportation for clients to and from visits with enrolled Medicaid providers, the single state agency uses several types of transportation and related services that comply with federal assurance of non-emergency medical transportation (NEMT) rules and regulations, are efficient and cost effective, and meet the transportation needs of the client. The single state agency makes payment directly to provide the most effective and efficient transportation that meets the need for the client and does not endanger the client's health. These transportation and related services include the following:

(1) Demand response transportation services. These services are provided when fixed route services are either unavailable or do not meet the health care needs of clients. Services must be timely and provided by licensed, qualified, courteous, knowledgeable, and trained personnel.

(2) Mass transit tickets when determined to be the appropriate mode of transportation for the client, ensuring the client does not live more than a quarter (1/4) mile from a public fixed route stop, the appointment is not more than a quarter (1/4) mile from a public fixed route stop, and that mass transit tickets are received by the client before the client's appointment.

(3) Mileage reimbursement for Individual Transportation Participant (ITP) services. An ITP signs a participation agreement and drives a client, including himself or herself, to and from a covered health care service in a personal car; ITPs are not reimbursed for "unloaded miles," or mileage incurred when the client is not in the vehicle.

(4) Meal and lodging services for clients and an attendant when a covered health care service requires an overnight stay outside the client’s county of residence or beyond adjacent counties. Clients and attendants must receive the same quality of services provided to other guests.

(5) Transportation to and from renal dialysis services for clients enrolled in the Medicaid program who are residing in a nursing facility, as required by the Texas Human Resources Code.

(6) Advanced funds disbursed before the covered health care service to clients when a lack of transportation funds will prevent a child from traveling to the service. Advanced funds are for clients through age 20. Advanced funds may be issued to cover meals, lodging, and/or mileage.
(7) Out-of-state transport to contiguous counties or bordering counties in adjoining states (Louisiana, Arkansas, Oklahoma, and New Mexico) that are within 50 miles of the Texas border, if services are medically necessary and it is the customary or general practice of clients in a particular locality within Texas to obtain services from an out-of-state provider that is enrolled as a Texas Medicaid provider. Out-of-state transport also includes travel to states outside of the adjoining states for medically necessary medical care or other health care services that cannot be provided within the state of Texas.

(8) Commercial airline transportation services for a client and attendant to a covered health care service, when it is the most cost-effective option or when necessary to meet the client's medical needs.

(9) Transportation of an attendant, if necessary.

Transportation in Texas is provided through two models. NEMT will be provided for Medicaid recipients in managed care by managed care organizations under the authority of the 1115(a) Texas Healthcare Transformation and Quality Improvement waiver and Section 1915(a) of the Social Security Act. NEMT will be administered using a 1915(b)(4) Selective Contracting Program model for Medicaid recipients in fee-for-service.
2. Administrative Services

As an administrative activity, the following NEMT services are required to assure the availability of necessary transportation as outlined in the Medicaid regulations 42 CFR §431.53 and in addition to transportation provided as an optional Medicaid service. The following administrative NEMT services are provided by this state plan:

a. **Advanced Funds.** Transportation-related services authorized by the single state agency and provided in advance of travel and disbursed to the eligible recipient, responsible party, or Individual Transportation Participant (ITP) for the purpose of funding transportation or transportation-related services (e.g., gasoline, meals and or lodging, etc.). The State’s claim for federal financial participation in these expenditures will not be made until after the recipient has received the medical care for which the expenditures were necessary.

b. **Individual Transportation Participant - Self.** Transportation by an individual transportation participant (ITP-Self) who is the Medicaid beneficiary or parent of a Medicaid beneficiary and who is approved for mileage reimbursement at a prescribed rate to provide transportation to a prior authorized health care service.

c. **ITP-Other.** Lodging and meals, mass transit, and commercial airlines transportation services when provided by an individual or entity that is not enrolled with the State.
3. Population Served

The single state agency ensures transportation services are provided to the categorically needy and medically needy optional populations as identified in Appendix 1 to Attachment 3.1-A/B.

4. Single State Agency Responsibilities

The single state agency is responsible for determining NEMT eligibility and benefit coverage. The single state agency is responsible for ensuring that the recipient is eligible for Medicaid. The single agency ensures the following:

a. Transportation services are provided only by contracted or enrolled Medicaid transportation providers.

b. Transportation services are provided only in conjunction to a covered Medicaid service.

c. Medicaid is the payor of last resort, with certain exceptions allowed by federal regulations or law.

d. Medicaid recipient is informed about rights and responsibilities.

Exceptions to the transportation provisions contained in this plan may be authorized by the Health and Human Services Commission or its designee when, in the opinion of the Commission, circumstances of medical necessity warrant such exceptions.

5. Procurement and Purchase of Services

All transportation service providers are selected based on an assessment that includes experience, references, qualifications and credentials, resources, and costs. Additionally, the transportation service providers must ensure that transport personnel are licensed, qualified, competent, and courteous. Transportation service providers must have oversight procedures in place to monitor beneficiary access and complaints.

6. Program Limitations

Transportation and related services are limited to trips for Medicaid beneficiaries and their approved attendants to and from Medicaid-covered services.

Transportation for full-benefit dual eligible beneficiaries to obtain prescription medications covered under the Medicare Part D benefit will be provided at the same level and under the same restrictions as is offered to all Medicaid beneficiaries.
7. **Non-covered Services**

Transportation to and from services that are not medically necessary or that are not provided in compliance with Texas Medicaid Program policy and procedures.

Transportation by ambulance or nonemergency ambulance, except as described in the relevant section of the state plan.

Transportation to and from a service or facility for which the reimbursement rate structure includes transportation funds, except for transportation to and from renal dialysis services for clients who are enrolled in the Medicaid program and residing in a nursing facility.

8. **Program Monitoring and Validation**

Monitoring activities are outlined in a risk-based monitoring plan that is developed using key contract requirements, agency rules, and state and federal laws. Each element is weighted based on the level of risk to program operations, agency business needs, and cost containment. HHSC conducts monitoring activities to determine a performing provider’s compliance with contract requirements, including adherence to the contract provisions that relate to quality and service standards. The State ensures performing provider contract compliance through the following activities:

- Annual and random field audits.
- Targeted field and desk audits in response to client complaints, complaint trends, and incident and accident trends.
- Monthly desk reviews of vehicle credentialing records, including annual inspection and vehicle registration.
- Monthly desk reviews of driver records and training requirements, including validation of driver's license and driver records, drug and substance abuse checks, and criminal history checks.
- Federal and state screening requirements for driver: U.S. Department of Health and Human Services-Office of Inspector General’s List of Excluded Individuals and Entities (LEIE) (applies to TNCs and their drivers); HHSC Inspector General exclusion list, Excluded Parties List System (EPLS) on the System for Award Management (SAM) (applies to TNCs and their drivers), Texas Comptroller of Public Accounts’ Vendor Debarment List, and Social Security Administration’s Death Master File.
- Monthly review and reconciliation of payment requests, including reviews of prior authorization approvals for submitted claims and comparison of driver logs to covered healthcare services.
- Auditing performance improvement plans initiated in response to corrective action plans put in place to address performance deficiencies.
- Matching transportation services against a covered healthcare service using a logic developed by HHSC and its claims administrator.
- Call center metrics are reviewed monthly to ensure compliance with Frew measures in areas subject to these requirements.
- Client satisfaction surveys conducted by the external quality review organization (EQRO).

The level of transportation capacity is reviewed by HHSC and adjusted accordingly to ensure clients are receiving timely and safe transportation services. Monitoring is ongoing and additional monitoring will be done principally through monitoring of complaints. HHSC uses an accelerated monitoring activity when complaint information analysis suggests that there is a decrease in the quality of service provided to eligible clients. HHSC performs monitoring through ride-alongs and on-site observations to ensure that clients are transported safely, comfortably, and in the manner that best suits their medical needs. HHSC also monitors quality of services including timely service delivery by reviewing vehicles, driver logs and reviewing complaints.

The State attests that all minimum requirements outlined in 1902(a)(87) of the Social Security Act are met.
Exclusion of Transportation by a Prescribed Pediatric Extended Care Center (PPECC)

Transportation provided by a prescribed pediatric extended care center (PPECC) is not included as a non-emergency transportation service.
Medical Transportation Program (continued)

Exclusion of Transportation by a Prescribed Pediatric Extended Care Center (PPECC)

Transportation provided by a prescribed pediatric extended care center (PPECC) is not included as a non-emergency transportation service.
STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES

Subject to the specifications, conditions, and limitations established by the state Single State Agency, organ transplant services are covered as follows:

a. Coverage is limited to those transplant services that are determined to be reasonable, medically necessary, and standard medical procedures as approved by the Single State Agency.

b. Coverage includes solid and nonsolid organ procurement (including acquiring/harvesting, processing, preserving, storing, distributing, and tissue typing). Nonsolid organs include bone marrow, peripheral stem cell, or cornea. If a hospital obtains an organ outside of the hospital, the hospital must obtain it from an organ procurement organization designated by the secretary of the Department of Health and Human Services. Coverage does not include donor expenses.

c. Coverage of each type of solid organ transplant is limited to an initial transplant and one subsequent transplant because of rejection as a lifetime benefit.

As specified by the Single State Agency or its designee, certain organ transplant services must be prior authorized. If a covered organ transplant has been prior authorized as medically necessary by the Single State Agency or its designee because of an emergent, life-threatening situation, a maximum of 30 days of inpatient hospital services during a Title XIX spell of illness may be covered beginning with the actual first day of the transplant. This coverage is in addition to covered inpatient hospital days described elsewhere in this state plan and provided before the actual first day of the transplant. This 30-day period is considered a separate inpatient hospital admission for reimbursement purposes.

If expenditures for a single inpatient hospital admission exceed the $200,000 limit on hospitalization-related services described elsewhere in this state plan, expenditures for that admission are excluded in calculating expenditures toward the limit. This policy only applies to an inpatient hospital admission to perform a covered organ transplant procedure determined to be medically necessary because of an emergent, life-threatening situation.
STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES

The criteria for determining reasonableness and medical necessity, including prior authorization requirements, are contained in the Medical Policy Manual, Texas Medicaid Provider Procedures Manual, or Medicaid Bulletins prepared by the Single State Agency's designee.

For purposes of this attachment, the term "organ" means a human heart, kidney, liver, cornea, lung, heart/lung, peripheral stem cell, or bone marrow, and any other human organ or tissue specified by the Single State Agency.

To be reimbursed for transplant services, a hospital must meet the requirements contained in Section 1138 of the Social Security Act.

Benefits do not extend to any experimental or investigational services, supplies, or procedures as may be determined by the U.S. Public Health Service or the Single State Agency.
The State of Texas enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (managed care organization (MCOs) and/or primary care case managers (PCCMs)) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230). This authority may not be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries who are Medicare eligible, who are Indians (unless they would be enrolled in certain plans—see D.2.ii. below), or who meet certain categories of "special needs" beneficiaries (see D.2.iii. -vii. below)

B. General Description of the Program and Public Process.

For B.1 and B.2, place a check mark on any or all that apply.

1. The State will contract with an
   i. MCO
   ii. PCCM (including capitated PCCMs that qualify as PAHPs)
   iii. Both

   The state operates the PCCM through an administrative contractor. PCCM primary care providers and hospitals sign agreements with the state to provide services to PCCM recipients. PCCM does not operate under capitated or risk contracts.

2. The payment method to the contracting entity will be:
   i. fee for service;
   ii. capitation;
   iii. a case management fee;
   iv. a bonus/incentive payment;
   v. a supplemental payment, or
   vi. other. (Please provide a description below).

3. For states that pay a PCCM on a fee-for-service basis, incentive
4. Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. (Example: public meeting, advisory groups.)

Beginning with the original PCCM implementation in 1993 approved under federal waiver, the Texas Medicaid Program was in compliance with the federal and state requirements related to public input in the Medicaid managed care program. The Medicaid Program will continue to be in compliance with those requirements.

Preliminary public involvement for the expansion of PCCM occurred during the month of March 2004. The Texas Medicaid Program held 16 public meetings in rural/border areas and two state-level stakeholder meetings to present the proposed plan for expansion of PCCM managed care. Comments and questions were recorded and responded to; no significant opposition to the expansion was received. Comments regarding simplification of administrative
requirements and other issues were incorporated into the PCCM program design.

Information about policy processes for state-level and regional public input will continue in the PCCM service areas. The State Medicaid Program convenes regular public forums, regional managed care advisory committee meetings, and the Medical Care Advisory Committee meetings in order to include the public in the development and review of Medicaid policy and operation.

5. The state plan program will _X_ implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory _X_ / voluntary ____ enrollment will be implemented in the following county/area(s):

All counties listed below will have mandatory enrollment. Populations exempt from mandatory enrollment, as noted in Section D.2., will be offered voluntary enrollment. Only one health plan will operate in these counties, PCCM.

i. county/counties (mandatory) __County list attached __

ii. county/counties (voluntary) 

iii. area/areas (mandatory)

iv. area/areas (voluntary)

C. State Assurances and Compliance with the Statute and Regulations.

If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.

1. _NA_ The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>42 CFR 438.50(c)(1)</td>
<td>2. <em>X</em> The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.</td>
</tr>
<tr>
<td>1932(a)(1)(A)(i)(I) 1905(t) 42 CFR 438.50(c)(2) 1902(a)(23)(A)</td>
<td>3. <em>X</em> The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities will be met.</td>
</tr>
<tr>
<td>1932(a)(1)(A) 42 CFR 438.50(c)(3)</td>
<td>4. <em>X</em> The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.</td>
</tr>
<tr>
<td>1932(a)(1)(A) 42 CFR 431.51 1905(a)(4)(C)</td>
<td>5. <em>X</em> The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs and PCCMs will be met.</td>
</tr>
<tr>
<td>1932(a)(1)(A) 42 CFR 438 42 CFR 438.50(c)(4) 1903(m)</td>
<td>6. <em>NA</em> The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met.</td>
</tr>
<tr>
<td>1932(a)(1)(A) 42 CFR 438.6(c) 42 CFR 438.50(c)(6)</td>
<td>7. <em>X</em> The state assures that all applicable requirements of 42 CFR 447.362 payments under any nonrisk contracts will be met.</td>
</tr>
<tr>
<td>1932(a)(1)(A) for 42 CFR 447.362 42 CFR 438.50(c)(6)</td>
<td>8. <em>X</em> The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.</td>
</tr>
</tbody>
</table>

D. Eligible groups

1. List all eligible groups that will be enrolled on a mandatory basis.

Section 1931 Children and Related Poverty Level Populations (TANF)
Section 1931 Adults and Related Poverty Level Populations, including pregnant women (TANF)
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1932(a)(2)(B) 42 CFR 438(d)(1)</td>
<td>Blind/Disabled Adults and Related Populations (SSI) 21 years of age and older, except in counties where 1915(b) and (c) waiver programs operate.</td>
</tr>
<tr>
<td>1932(a)(2)(C) 42 CFR 438(d)(2)</td>
<td></td>
</tr>
<tr>
<td>1932(a)(2)(A)(i) 42 CFR 438.50(d)(3)(i)</td>
<td>i. Recipients who are also eligible for Medicare.</td>
</tr>
<tr>
<td>1932(a)(2)(A)(iii) 42 CFR 438.50(d)(3)(iii)</td>
<td>ii. Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.</td>
</tr>
<tr>
<td>1932(a)(2)(A)(iv) 42 CFR 438.50(d)(3)(iv)</td>
<td></td>
</tr>
<tr>
<td>1932(a)(2)(A)(v) 42 CFR 438.50(d)(3)(v)</td>
<td></td>
</tr>
</tbody>
</table>


Use a check mark to affirm if there is voluntary enrollment any of the following mandatory exempt groups.

i. ___________Recipients who are also eligible for Medicare.

If enrollment is voluntary, describe the circumstances of enrollment.

(Example: Recipients who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service.)

ii. _______ Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.

iii. _______ Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under title XVI.

iv. _______ Children under the age of 19 years who are eligible under 1902(e)(3) of the Act.

v. _______ Children under the age of 19 years who are in foster care or other out-of-the-home placement.

vi. _______ Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E.

vii. _______ Children under the age of 19 years who are receiving services through a...
Citation | Condition or Requirement
---|---
42 CFR 438.50(3)(v) | family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the state in terms of either program participation or special health care needs.

E. Identification of Mandatory Exempt Groups

1932(a)(2) 42 CFR 438.50(d)

1. Describe how the state defines children who receive services that are funded under section 501(a)(1)(D) of title V. (Examples: children receiving services at a specific clinic or enrolled in a particular program.)

Children under the age of 21 who have applied for and meet the eligibility criteria for the Children with Special Health Care Needs Services Program administered by the Department of State Health Services.

1932(a)(2) 42 CFR 438.50(d)

2. Place a check mark to affirm if the state’s definition of title V children is determined by:

- i. program participation,
- ii. special health care needs, or
- X iii. both

1932(a)(2) 42 CFR 438.50(d)

3. Place a check mark to affirm if the scope of these title V services is received through a family-centered, community-based, coordinated care system.

- X i. yes
- ii. no

1932(a)(2) 42 CFR 438.50 (d)

4. Describe how the state identifies the following groups of children who are exempt from mandatory enrollment: (Examples: eligibility database, self-identification)

i. Children under 19 years of age who are eligible for SSI under title XVI;

An indicator in the Medicaid eligibility system identifies children under 19 years of age who are eligible for SSI under Title XVI. These children are offered voluntary enrollment in PCCM.

TN No. 04-25
Supersedes
TN No.

Approval Date 8-2-05
Effective Date 9-1-05
### Condition or Requirement

<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>ii. 1932(a)(2)</td>
<td>Children under 19 years of age who are eligible under section 1902(e)(3) of the Act;</td>
</tr>
<tr>
<td>42 CFR 438.50(d)</td>
<td>An indicator in the Medicaid eligibility system identifies children under 19 years of age who are eligible under section 1902(e)(3) of the Act. These children are never enrolled in PCCM.</td>
</tr>
<tr>
<td>iii. 1932(a)(2)</td>
<td>Children under 19 years of age who are in foster care or other out-of-home placement;</td>
</tr>
<tr>
<td>42 CFR 438.50(d)</td>
<td>An indicator in the Medicaid eligibility system identifies children under 19 years of age who are in foster care or other out-of-home placement. These children are never enrolled in PCCM.</td>
</tr>
<tr>
<td>iv. 1932(a)(2)</td>
<td>Children under 19 years of age who are receiving foster care or adoption assistance.</td>
</tr>
<tr>
<td>42 CFR 438.50(d)</td>
<td>An indicator in the Medicaid eligibility system identifies children under 19 years of age who are receiving foster care or adoption assistance. These children are never enrolled in PCCM.</td>
</tr>
</tbody>
</table>

5. Describe the state’s process for allowing children to request an exemption from mandatory enrollment based on the special needs criteria as defined in the state plan if they are not initially identified as exempt. *(Example: self-identification)*

Parents or caregivers with children who are enrolled in the Children with Special Health Care Needs Program self-identify on the Medicaid application. An indicator in the Medicaid eligibility system identifies these children.

6. Describe how the state identifies the following groups who are exempt from mandatory enrollment into managed care: *(Examples: usage of aid codes in the eligibility system, self-identification)*

i. Recipients who are also eligible for Medicare.

---

**Supersedes**

<table>
<thead>
<tr>
<th>TN No.</th>
<th>Approval Date</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>04-25</strong></td>
<td>8-2-05</td>
<td>9-1-05</td>
</tr>
</tbody>
</table>

**Supersedes:** NONE. NEW PAGE.
Recipients who are also eligible for Medicare are identified by an indicator in the State's Medicaid eligibility system. These recipients are never enrolled in PCCM.

ii. Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.

Indians who are members of Federally recognized Tribes self-identify on the Medicaid application. An indicator is used in the State's Medicaid eligibility system to identify these recipients. These recipients are offered voluntary enrollment in PCCM.

Other groups exempt from mandatory enrollment: Medically Needy; emergency services-only recipients; adults in waiver programs; children in waiver programs; recipients in institutions. These recipients are never enrolled in PCCM.

None

An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state
## Condition or Requirement

<table>
<thead>
<tr>
<th>Citation</th>
<th>records of previous managed care enrollment or fee-for-service experience, or through contact with the recipient.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1932(a)(4)</td>
<td>i. A provider is considered to have &quot;traditionally served&quot; Medicaid recipients if it has experience in serving the Medicaid population.</td>
</tr>
<tr>
<td>42 CFR 438.50</td>
<td>2. State process for enrollment by default.</td>
</tr>
<tr>
<td></td>
<td>Describe how the state’s default enrollment process will preserve:</td>
</tr>
<tr>
<td></td>
<td>i. the existing provider-recipient relationship (as defined in H.1.i).</td>
</tr>
<tr>
<td></td>
<td>When assignment (default) to a primary care provider is necessary, the default methodology begins by identifying the most recent or primary Medicaid provider of record for that enrollee during the previous year. This ensures that existing provider-recipient relationships remain intact. If no record exists, geographical proximity is used to assign the primary care provider. These geographical assignments are made on a “rotation” basis to ensure that all primary care providers have an equal chance to act as primary care providers.</td>
</tr>
<tr>
<td></td>
<td>ii. the relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.i).</td>
</tr>
<tr>
<td></td>
<td>Any willing Medicaid provider, including specialty providers and providers who have traditionally served Medicaid recipients, can enroll as a PCCM primary care provider. Any Medicaid specialist may provide specialty care to PCCM recipients with a referral from the primary care provider. When a provider who has traditionally served Medicaid clients chooses not to enroll as a primary care provider, Medicaid recipients may continue to access that provider through a referral from their primary care provider.</td>
</tr>
<tr>
<td></td>
<td>iii. the equitable distribution of Medicaid recipients among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702(a)(4)); and disenrollment for cause in accordance with 42 CFR 438.56 (d)(2). (Example: No auto-assignments will be made if MCO meets a certain percentage of capacity.)</td>
</tr>
</tbody>
</table>
There is only one health plan, PCCM.

3. As part of the state's discussion on the default enrollment process, include the following information:

i. The state will _/will not_X use a lock-in for managed care.

ii. The time frame for recipients to choose a health plan before being auto-assigned will be NA-all counties are PCCM-only _.

iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment. (Example: state generated correspondence.)

Recipients are notified of enrollment into PCCM on the state generated Medicaid identification letter. Recipients also receive a welcome letter from the PCCM administrator.

iv. Describe the state's process for notifying the Medicaid recipients who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment. (Examples: state generated correspondence, HMO enrollment packets etc.)

There is only one health plan, PCCM.

v. Describe the default assignment algorithm used for auto-assignment. (Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)

There is only one health plan, PCCM.
vi. Describe how the state will monitor any changes in the rate of default assignment. *(Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker)*

There is only one health plan, PCCM.

1932(a)(4) 42 CFR 438.50

I. State assurances on the enrollment process

Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

1. **X**. The state assures it has an enrollment system that allows recipients who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program.

2. **X**. The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid recipients enrolled in either an MCO or PCCM model will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3).

3. **X**. The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs.

The rural exception to the choice requirement applies to all PCCM counties included on the county list for B.5.i. Recipients may choose from at least two Medicaid enrolled physicians or other primary care providers and may obtain services from any other Medicaid provider who is the main source of a service to the recipient with a referral from the primary care provider. Emergency services and family planning services do not require a referral.

**This provision is not applicable to this 1932 State Plan Amendment.**

4. **_**. The state limits enrollment into a single Health Insuring Organization (HIO), if and only if the HIO is one of the entities described in section 1932(a)(3)(C) of
the Act; and the recipient has a choice of at least two primary care providers within the entity. (California only.)

_X_ This provision is not applicable to this 1932 State Plan Amendment.

5. _X_ The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.

_This provision is not applicable to this 1932 State Plan Amendment.

1932(a)(4) 42 CFR 438.50

J. Disenrollment

1. The state will_/will not_X_ use lock-in for managed care.

2. The lock-in will apply for ___ months (up to 12 months).

3. Place a check mark to affirm state compliance.

_X_ The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c).

4. Describe any additional circumstances of “cause” for disenrollment (if any).

K. Information requirements for beneficiaries

Place a check mark to affirm state compliance.

1932(a)(5) 42 CFR 438.50 42 CFR 438.10

_X_ The state assures that its state plan program is in compliance with 42 CFR 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.)

1932(a)(5)(D) 1905(t)

L. List all services that are excluded for each model (MCO & PCCM)

Any services not included in the scope of services for the Medicaid Program as specified in the State Plan.

Approval Date _8-2-05_ Effective Date _9-1-05_
M. Selective contracting under a 1932 state plan option

To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.

1. The state will __/will not _X_ intentionally limit the number of entities it contracts under a 1932 state plan option.

2. _____ The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.

3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. (Example: a limited number of providers and/or enrollees.)

4. __X__ The selective contracting provision in not applicable to this state plan.
1915(i) State plan Home and Community-Based Services

Administration and Operation

The state implements the optional 1915(i) State plan Home and Community-Based Services (HCBS) benefit for elderly and disabled individuals as set forth below.

1. Services. (Specify the state’s service title(s) for the HCBS defined under “Services” and listed in Attachment 4.19-B):

   Transition Assistance Services (TAS);
   HCBS Psychosocial Rehabilitation Services;
   Adaptive Aids;
   Employment Services;
   Transportation;
   Community Psychiatric Supports and Treatment (CPST);
   Peer Support;
   Host Home/Companion Care;
   Supervised Living Services;
   Assisted Living Services;
   Supported Home Living;
   Respite Care;
   Home Delivered Meals;
   Minor Home Modifications;
   Nursing;
   Substance Use Disorder (SUD) Services;
   Home and Community-Based Services - Adult Mental Health (HCBS-AMH) - Recovery Management

2. Concurrent Operation with Other Programs. (Indicate whether this benefit will operate concurrently with another Medicaid authority):

   Select one:
   - ☑ Not applicable
   - ☐ Applicable

Check the applicable authority or authorities:

☐ Services furnished under the provisions of §1915(a)(1)(a) of the Act. The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of 1915(i) State plan HCBS. Participants may voluntarily elect to receive waiver and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. Specify:
   (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1);
   (b) the geographic areas served by these plans;
   (c) the specific 1915(i) State plan HCBS furnished by these plans;
   (d) how payments are made to the health plans; and
   (e) whether the 1915(a) contract has been submitted or previously approved.
<table>
<thead>
<tr>
<th>Waiver(s) authorized under §1915(b) of the Act.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:</td>
</tr>
</tbody>
</table>

Specify the §1915(b) authorities under which this program operates (check each that applies):

- ☐ §1915(b)(1) (mandated enrollment to managed care)
- ☐ §1915(b)(2) (central broker)
- ☐ §1915(b)(3) (employ cost savings to furnish additional services)
- ☐ §1915(b)(4) (selective contracting/limit number of providers)

<table>
<thead>
<tr>
<th>A program operated under §1932(a) of the Act.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A program authorized under §1115 of the Act.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specify the program:</td>
</tr>
</tbody>
</table>

State: Texas

TN: 20-0003

Effective: September 1, 2020

Approved: 8/31/2020

Supersedes: TN 14-0014

§1915(i) State plan HCBS

State plan Attachment 3.1–i: Page 2
3. **State Medicaid Agency (SMA) Line of Authority for Operating the State plan HCBS. Benefit** *(Select one)*:

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>The State plan HCBS benefit is operated by the SMA. Specify the SMA division/unit that has line authority for the operation of the program <em>(select one)</em>:</td>
</tr>
<tr>
<td>☐</td>
<td>The Medical Assistance Unit <em>(name of unit)</em>:</td>
</tr>
</tbody>
</table>
| ☐ | Another division/unit within the SMA that is separate from the Medical Assistance Unit *(name of division/unit)*:  
This includes administrations/divisions under the umbrella agency that have been identified as the Single State Medicaid Agency. |
| ☐ | Health and Human Services Commission Intellectual and Developmental Disability and Behavioral Health Services Department |
| ☐ | The State plan HCBS benefit is operated by *(name of agency)*: |
| ☐ | a separate agency of the state that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the State plan HCBS benefit and issues policies, rules and regulations related to the State plan HCBS benefit. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this delegation of authority is available through the Medicaid agency to CMS upon request. |
4. Distribution of State plan HCBS Operational and Administrative Functions.

- (By checking this box the state assures that): When the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency. When a function is performed by an agency/entity other than the Medicaid agency, the agency/entity performing that function does not substitute its own judgment for that of the Medicaid agency with respect to the application of policies, rules and regulations. Furthermore, the Medicaid Agency assures that it maintains accountability for the performance of any operational, contractual, or local regional entities. In the following table, specify the entity or entities that have responsibility for conducting each of the operational and administrative functions listed (check each that applies):

<table>
<thead>
<tr>
<th>Function</th>
<th>Medicaid Agency</th>
<th>Other State Operating Agency</th>
<th>Contracted Entity</th>
<th>Local Non-State Entity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Individual State plan HCBS enrollment</td>
<td>☑</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2 Eligibility evaluation</td>
<td>☑</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>3 Review of participant service plans</td>
<td>☑</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>4 Prior authorization of State plan HCBS</td>
<td>☑</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>5 Utilization management</td>
<td>☑</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>6 Qualified provider enrollment</td>
<td>☑</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>7 Execution of Medicaid provider agreement</td>
<td>☑</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>8 Establishment of a consistent rate methodology for each State plan HCBS</td>
<td>☑</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>9 Rules, policies, procedures, and information development governing the State plan HCBS benefit</td>
<td>☑</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>10 Quality assurance and quality improvement activities</td>
<td>☑</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

(Specify, as numbered above, the agencies/entities (other than the SMA) that perform each function):
5. **Conflict of Interest Standards.** The state assures the independence of persons performing evaluations, assessments, and plans of care. Written conflict of interest standards ensure, at a minimum, that persons performing these functions are not:

- related by blood or marriage to the individual, or any paid caregiver of the individual
- financially responsible for the individual
- empowered to make financial or health-related decisions on behalf of the individual
- providers of State plan HCBS for the individual, or those who have interest in or are employed by a provider of State plan HCBS; except, at the option of the state, when providers are given responsibility to perform assessments and plans of care because such individuals are the only willing and qualified entity in a geographic area, and the state devises conflict of interest protections. *(If the state chooses this option, specify the conflict of interest protections the state will implement):*

HHSC ensures that conflicts of interest do not occur. The individuals performing the independent assessments, reassessments, and Person Centered Service Plans (AKA Individual Recovery Plans) (IRP)s cannot also be providers of HCBS-AMH on the IRP or under the administrative control of a provider of HCBS-AMH on the IRP unless the provider is the only willing and qualified entity in a geographic area who can be responsible for assessments and person-centered service plan development.

The individuals performing the assessments and IRPs are HHSC employees or contractors who are delegated this responsibility. Contractors must have the requisite experience and skill to perform assessments and/or IRPs. For assessments and person-centered service plan development, the contractors may be public or private sector entities, but may not be HCBS-AMH providers, unless they are the only willing and qualified entity in a geographic area who can be responsible for assessments and person-centered service plan development. The needs-based assessments are reviewed by HHSC staff pursuant to the 1915(i) Quality Improvement Strategy (QIS) requirements listed later in this state plan. HHSC will biennially review contractors who complete assessments and IRPs to ensure that they do not have an interest in or are under the control of a provider on the IRP. Contractors delegated the responsibility to perform assessments who are an HCBS-AMH provider of last resort will have a higher level of scrutiny.

IRPs will be completed by recovery managers. Recovery management may only be provided by agencies and individuals employed by agencies who are not providers of other HCBS-AMH services for the individual, or those who have interest in or are employed by a provider of HCBS-AMH on the IRP. On occasion the State anticipates exceptions may be necessary in which the recovery management provider for the individual is employed by a provider of other HCBS-AMH services on the IRP as the provider of last resort. Recovery management may only be provided by the provider of last resort when they are the only willing and qualified entity in a geographic area who can be responsible for the development of the person-centered service plan. Recovery management will only be provided by the provider of last resort when there is no other willing and qualified non-provider entity to perform these functions.

Texas anticipates that some service areas may not have separate Provider Agencies and Recovery Management Entities, who develop the person-centered service plans that meet requirements of the program and provider agreement. HHSC will enroll HCBS-AMH Provider Agencies and Recovery Management entities through separate Open Enrollments and will actively recruit both types of entities with consideration for counties where Recovery Management Providers are serving as the recovery management provider of last resort. The state anticipates the provision of recovery management by recovery management provider of last resort and instances in which contractors delegated the responsibility to perform assessments are an HCBS-AMH provider of last resort will occur in health manpower shortage areas, combined with rural and frontier counties.

- Health manpower shortage area designations can be found at: http://hpsafind.hrsa.gov/
- Rural county designations can be found at: http://www.dshs.texas.gov/chs/hprc/counties.shtm
- Frontier and Remote Area Codes as identified by the Economic Research Service of the United States Department of Agriculture can be found at: https://www.ers.usda.gov/data-products/frontier-and-remote-area-codes/
In lieu of denying an individual residence in his/her community of choice due to lack of available Provider Agencies and Recovery Management Entities, the State foresees that in this circumstance an HCBS provider of last resort may also provide recovery management services with certain conflict of interest protections in place.

When an HCBS provider of last resort also provides recovery management services, HHSC will require a clear separation of provider and recovery management functions. The distinct individual staff providing recovery management must be administratively separate from other HCBS-AMH provider functions and any related utilization review units and functions. Recovery Managers who work for provider agencies that are providing other HCBS-AMH services as the provider of last resort will not be providers of any other HCBS-AMH service on the IRP. HHSC reviews the administrative structure of the HCBS-AMH agency to ensure that there is a clear administrative separation of recovery management and HCBS-AMH provider staff/functions before approving a provider to serve as a recovery manager, and periodically reviews (including unannounced site-reviews) the individuals performing recovery management to ensure that they are not providers of HCBS-AMH and not under the administrative control of units providing HCBS-AMH services. HHSC will also review resulting IRPs to ensure that there is no conflict of interest.

The following conflict mitigation strategies are utilized by HHSC:

- Individual staff performing the assessments shall not be under the same administrative authority of staff providing HCBS-AMH or developing the IRP.
- Restricting the entity that develops the person-centered service plan from providing services without the direct approval of the state.
- Requiring the recovery management entity that develops the IRP to be administratively separate the plan development function from the direct service provider functions.
- Assuring that individuals can advocate for themselves or have an advocate present in planning meetings.
- Full disclosure to participants and assurance that participants are supported in exercising their right to free choice of providers and are provided information about the full range of HCBS-AMH services, not just the services furnished by the recovery management entity that is responsible for development of the IRP.
- Having clear, well-known, and easily accessible means for individuals to make grievances and/or appeals to the State for assistance regarding concerns about choice, quality, and outcomes. This includes a consumer bill of rights for mental health; published rules on consumer rights; a toll-free line staffed by dedicated Consumer Rights representatives who can answer questions about rights and assist the individual in resolving issues with mental health HCBS services or with filing a complaint regarding services. HHSC’s client ombudsman office is also available via toll-free line to assist consumers in resolving issues with Medicaid providers or services. Information on these rights and grievance/appeal processes will be provided in writing to each individual enrolled in the HCBS program.
- Documenting the number and types of appeals and the decisions regarding grievances and/or appeals.
- Conducting biennial on-site reviews, desk reviews, and analysis of aggregate and individual data.
- Documenting consumer experiences with measures that capture the quality of IRP development.

6. Fair Hearings and Appeals. The state assures that individuals have opportunities for fair hearings and appeals in accordance with 42 CFR 431 Subpart E.

7. No FFP for Room and Board. The state has methodology to prevent claims for Federal financial participation for room and board in State plan HCBS.

8. Non-duplication of services. State plan HCBS will not be provided to an individual at the same time as another service that is the same in nature and scope regardless of source, including Federal, state, local, and private entities. For habilitation services, the state includes within the record of each individual an explanation that these services do not include special education and related services defined in the Individuals with Disabilities Education Improvement Act of 2004 that otherwise are available to the individual through a local education agency, or vocational rehabilitation services that otherwise are available to the individual through a program funded under §110 of the Rehabilitation Act of 1973.
1. **Projected Number of Unduplicated Individuals To Be Served Annually.** 
   *(Specify for year one. Years 2-5 optional):*

<table>
<thead>
<tr>
<th>Annual Period</th>
<th>From</th>
<th>To</th>
<th>Projected Number of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>09/01/2020</td>
<td>08/31/2021</td>
<td>266</td>
</tr>
<tr>
<td>Year 2</td>
<td>09/01/2021</td>
<td>08/31/2022</td>
<td>344</td>
</tr>
<tr>
<td>Year 3</td>
<td>09/01/2022</td>
<td>08/31/2023</td>
<td>420</td>
</tr>
<tr>
<td>Year 4</td>
<td>09/01/2023</td>
<td>08/31/2024</td>
<td>496</td>
</tr>
<tr>
<td>Year 5</td>
<td>09/01/2024</td>
<td>08/31/2025</td>
<td>571</td>
</tr>
</tbody>
</table>

2. **Annual Reporting.** *(By checking this box the state agrees to):* annually report the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

---

### Financial Eligibility

1. **Medicaid Eligible.** *(By checking this box the state assures that):* Individuals receiving State plan HCBS are included in an eligibility group that is covered under the State’s Medicaid Plan and have income that does not exceed 150% of the Federal Poverty Line (FPL). (This election does not include the optional categorically needy eligibility group specified at §1902(a)(10)(A)(ii)(XXII) of the Social Security Act. States that want to adopt the §1902(a)(10)(A)(ii)(XXII) eligibility category make the election in Attachment 2.2-A of the state Medicaid plan.)

2. **Medically Needy (Select one):**

   - [ ] The State does not provide State plan HCBS to the medically needy.
   - [ ] The State provides State plan HCBS to the medically needy. *(Select one):*
     - [ ] The state elects to disregard the requirements section of 1902(a)(10)(C)(i)(III) of the Social Security Act relating to community income and resource rules for the medically needy. When a state makes this election, individuals who qualify as medically needy on the basis of this election receive only 1915(i) services.
     - [ ] The state does not elect to disregard the requirements at section 1902(a)(10)(C)(i)(III) of the Social Security Act.
Evaluation/Reevaluation of Eligibility

1. **Responsibility for Performing Evaluations / Reevaluations.** Eligibility for the State plan HCBS benefit must be determined through an independent evaluation of each individual. Independent evaluations/reevaluations to determine whether applicants are eligible for the State plan HCBS benefit are performed (Select one):

   - [ ] Directly by the Medicaid agency
   - [ ] By Other (specify State agency or entity under contract with the State Medicaid agency):

2. **Qualifications of Individuals Performing Evaluation/Reevaluation.** The independent evaluation is performed by an agent that is independent and qualified. There are qualifications (that are reasonably related to performing evaluations) for the individual responsible for evaluation/reevaluation of needs-based eligibility for State plan HCBS. *(Specify qualifications):*

   Licensed Practitioner of the Healing Arts (LPHA) preferred, not required. Bachelor’s degree, masters preferred, from a U.S. accredited college or university with specialization in health services, business administration, human services, public policy, social work or related areas.

   and

   Has received HHSC-approved training in evaluating individuals for HCBS-AMH.

3. **Process for Performing Evaluation/Reevaluation.** Describe the process for evaluating whether individuals meet the needs-based State plan HCBS eligibility criteria and any instrument(s) used to make this determination. If the reevaluation process differs from the evaluation process, describe the differences:

   The evaluation / reevaluation is conducted using the Adult Needs and Strengths Assessment (ANSA) to identify functional needs and determine whether an individual meets the needs-based HCBS eligibility criteria. Criteria evaluated using the ANSA include behavioral health needs, life domain functioning (including assessment of ADLs and IADLs), and functional needs / strengths. Evaluations and reevaluations of eligibility for HCBS will be conducted by HHSC staff.
4. **Reevaluation Schedule.** *(By checking this box the state assures that):* Needs-based eligibility reevaluations are conducted at least every twelve months.

5. **Needs-based HCBS Eligibility Criteria.** *(By checking this box the state assures that):* Needs-based criteria are used to evaluate and reevaluate whether an individual is eligible for State plan HCBS.

The criteria take into account the individual’s support needs, and may include other risk factors: *(Specify the needs-based criteria):*

<table>
<thead>
<tr>
<th>For needs:</th>
</tr>
</thead>
<tbody>
<tr>
<td>0= No evidence</td>
</tr>
<tr>
<td>1= Watchful waiting/prevention</td>
</tr>
<tr>
<td>2= Action</td>
</tr>
<tr>
<td>3= Immediate/Intensive Action</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>For strengths:</th>
</tr>
</thead>
<tbody>
<tr>
<td>0= Centerpiece strength</td>
</tr>
<tr>
<td>1= Strength that you can use in planning</td>
</tr>
<tr>
<td>2= Strength has been identified-must be built</td>
</tr>
<tr>
<td>3= No strength identified</td>
</tr>
</tbody>
</table>

Individuals must have a level of functional need (ANSA score of 2 or higher) that indicates a need for intervention provided by HCBS-AMH services that is identified by items in one of the following domains assessed by the ANSA: behavioral health, life domain functioning (including ADLs and IADLs), or functional needs and strengths.

Inpatient psychiatric criteria, which require that the individual be acutely ill and in need of 24-hour observation, stabilization and intervention, including active supervision by a psychiatrist, are more stringent than HCBS needs-based criteria.

Need is also evidenced by meeting one of the following risk categories:

1) A history of extended or repeated stay(s) in an inpatient psychiatric hospital (i.e., three years or more of consecutive or cumulative inpatient psychiatric hospitalization during the five years prior to initial enrollment in HCBS-AMH).

Or

2) In the three years prior to initial enrollment in HCBS-AMH two or more psychiatric crises (i.e., inpatient psychiatric hospitalizations and/or outpatient psychiatric crisis that meets inpatient psychiatric criteria) and four or more repeated discharges from correctional facilities.

Or

3) In the three years prior to initial enrollment in HCBS-AMH two or more psychiatric crises (i.e., inpatient psychiatric hospitalizations and/or outpatient psychiatric crisis that meets inpatient psychiatric criteria) and fifteen or more total emergency department (ED) visits.
6. **Needs-based Institutional and Waiver Criteria.** (By checking this box the state assures that): There are needs-based criteria for receipt of institutional services and participation in certain waivers that are more stringent than the criteria above for receipt of State plan HCBS. If the state has revised institutional level of care to reflect more stringent needs-based criteria, individuals receiving institutional services and participating in certain waivers on the date that more stringent criteria become effective are exempt from the new criteria until such time as they no longer require that level of care. *(Complete chart below to summarize the needs-based criteria for State Plan HCBS and corresponding more-stringent criteria for each of the following institutions):*

<table>
<thead>
<tr>
<th>State plan HCBS needs-based eligibility criteria</th>
<th>NF (NF LOC** &amp; ICF/IID LOC waivers)</th>
<th>ICF/IID (&amp; ICF/IID LOC waivers)</th>
<th>Applicable Hospital* (Hospital LOC waivers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The individual must:</td>
<td>The individual must:</td>
<td>The individual must:</td>
<td>The individual must:</td>
</tr>
</tbody>
</table>
| 1. Require HCBS-AMH services to improve or maintain functioning, prevent relapse to a lower level of functioning, and maintain residence in the community; demonstrated by a level of functional need (ANSA score of 2 or higher) that indicates a need for intervention provided by HCBS-AMH services that is identified in one of the following domains assessed by the ANSA: behavioral health, life domain functioning (including ADLs and IADLs), or functional needs and strengths;  
And  
2. Meet one of the following risk categories:  
a. Demonstrate a history of extended or repeated stay(s) in an inpatient psychiatric hospital (i.e., three years or more of consecutive or cumulative inpatient psychiatric hospitalization during the five years prior to initial enrollment in HCBS-AMH);  
b. Demonstrate in the three years prior to initial enrollment in HCBS-AMH two or more psychiatric crises (i.e., inpatient psychiatric | Live in a Medicaid-certified NF for 30 consecutive days or live in the community (for NF LOC waivers) and meet medical necessity requirements (see below)  
According to Texas rules (40 Tex. Admin. Code §19.2401), an individual must meet both of the following criteria for medical necessity:  
1. The individual must demonstrate a medical condition that:  
   * is of sufficient seriousness that the individual's needs exceed the routine care which may be given by an untrained person; and  
* requires licensed nurses' supervision, assessment, planning, and intervention that is available only in an institution.  
AND  
2. The individual must require medical or nursing services that:  
   * are ordered by a physician;  
   * are dependent upon the individual's documented medical conditions;  
   * has documented reasons why the service(s) are medically necessary;  
* is of sufficient seriousness that the individual's needs exceed the routine care which may be given by an untrained person; and  
* is attributable to a mental or physical impairment or combination of mental and physical impairments;  
* is manifested before the individual attains age 22;  
* is likely to continue indefinitely;  
* results in substantial functional limitations in 3 or more of the following areas of major life activity:  
  (i) Self-care.  
  (ii) Receptive and expressive language.  
  (iii) Learning.  
  (iv) Mobility.  
  (v) Self-direction.  
  (vi) Capacity for independent living.  
  (vii) Economic self-sufficiency; and  
| Live in a Medicaid-certified Intermediate Care Facility for Individuals with Intellectual or Developmental Disabilities (ICF-IID) for 30 consecutive days or live in the community (for ICF/IID waivers) and meet medical necessity requirements (see below)  
1. Have a diagnosed developmental disability.  
The term "developmental disability" means a severe, chronic disability of an individual that:  
   * is attributable to a mental or physical impairment or combination of mental and physical impairments;  
   * is manifested before the individual attains age 22;  
   * is likely to continue indefinitely;  
   * results in substantial functional limitations in 3 or more of the following areas of major life activity:  
     (i) Self-care.  
     (ii) Receptive and expressive language.  
     (iii) Learning.  
     (iv) Mobility.  
     (v) Self-direction.  
     (vi) Capacity for independent living.  
     (vii) Economic self-sufficiency; and  
| 1. Have a valid diagnosis as listed in the current version of the ICD as the principal admitting diagnosis and one of the following:  
a. Outpatient therapy or partial hospitalization has been attempted and failed  
b. A psychiatrist has documented reasons why an inpatient level of care is required.  
AND  
2. The individual must meet at least one of the following criteria:  
a. The individual is presently a danger to self, demonstrated by at least one of the following:  
   (i) Recent suicide attempt or active suicidal threats with a deadly plan, and there is an absence of appropriate supervision or structure to prevent suicide.  
   (ii) Recent self-mutilative behavior or active threats of same with likelihood of acting on the threat, and there is an absence of appropriate supervision or structure to prevent self-mutilation (i.e., intentionally cutting/burning self).  
   (iii) Active hallucinations or delusions directing or likely to lead to serious self-harm or debilitating psychomotor agitation or...
hospitalizations and/or outpatient psychiatric crisis that meets inpatient psychiatric criteria) four or more repeated discharges from correctional facilities;

c. Demonstrate in the three years prior to initial enrollment in HCBS-AMH two or more psychiatric hospitalizations (i.e., inpatient psychiatric hospitalizations and/or outpatient psychiatric crisis that meets inpatient psychiatric criteria) and fifteen or more total emergency department (ED) visits.

Note: Individuals in HCBS-AMH are not required to demonstrate the need for services that require 24-hour-a-day medical observation, supervision, and intervention.

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Medical necessity and level of institutional need is determined by assessing the individual’s functioning using the Minimum Data Set (MDS), version 3.0.</th>
<th>intellectual disability resulting in a significant inability to care for self.</th>
</tr>
</thead>
<tbody>
<tr>
<td>* require the skills of a registered or licensed vocational nurse;</td>
<td>* reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.</td>
<td>(iv) Significant inability to comply with prescribed medical health regimens due to concurrent psychiatric illness and such failure to comply is potentially hazardous to the life of the individual.</td>
</tr>
<tr>
<td>* are provided either directly by or under the supervision of a licensed nurse in an institutional setting; and</td>
<td>* are required on a regular basis.</td>
<td>b. The individual is a danger to others. This behavior must be attributable to the individual’s specific diagnosis that can be adequately treated only in a hospital setting. This danger is demonstrated by one of the following: (i) Recent life-threatening action or active homicidal threats of same with a deadly plan, and availability of means to accomplish the plan, with likelihood of acting on the threat. (ii) Recent serious assaultive or sadistic behavior or active threats of same with likelihood of acting on the threat, and there is an absence of appropriate supervision or structure to prevent assaultive behavior. (iii) Active hallucinations or delusions directing or likely to lead to serious harm of others.</td>
</tr>
<tr>
<td>* are required on a regular basis.</td>
<td></td>
<td>c. The individual exhibits acute onset of psychosis or severe thought disorganization, or there is significant clinical deterioration in the condition of someone with a chronic psychosis, rendering the individual unmanageable and unable to cooperate in treatment, and the individual is in need of assessment and</td>
</tr>
</tbody>
</table>

AND

2. Require active treatment in an institutional setting specifically designed for treatment of intellectual and developmental disabilities.
treatment in a safe and therapeutic setting.

d. The individual has a severe eating or substance abuse disorder that requires 24-hour-a-day medical observation, supervision, and intervention.

e. The individual exhibits severe disorientation of person, place, or time.

f. The individual’s evaluation and treatment cannot be carried out safely or effectively in other settings due to severely disruptive behaviors and other behaviors, which may also include physical, psychological, or sexual abuse.

g. The individual requires medication therapy or complex diagnostic evaluation where the individual’s level of functioning precludes cooperation with the treatment regimen.

h. The individual is involved in the legal system, manifests psychiatric symptoms, and is ordered by a court to undergo a comprehensive assessment in a hospital setting to clarify diagnosis and treatment needs.

AND

3. The proposed treatment or therapy requires 24-hour-a-day medical observation, supervision, and intervention and must include all of the following:
<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
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<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Active supervision by a psychiatrist with the appropriate credentials, as determined by the Texas Medical Board (TMB) or other appropriate entity;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td>Implementation of an individualized treatment plan;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c.</td>
<td>Provision of services that can reasonably be expected to improve the client’s condition or prevent further regression so that a lesser level of care can be implemented;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>d.</td>
<td>Proper treatment of the client’s psychiatric condition requires services on an inpatient basis under the direction of a psychiatrist and is being provided in the least restrictive environment available, and ambulatory care resources available in the community do not meet the client’s needs.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>e.</td>
<td>A history of inpatient admission, repeated discharges from correctional facilities, psychiatric crisis, or ED visits is not sufficient to admit an individual to a psychiatric facility.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Long Term Care/Chronic Care Hospital

**LOC= level of care**
7. **Target Group(s).** The state elects to target this 1915(i) State plan HCBS benefit to a specific population based on age, disability, diagnosis, and/or eligibility group. With this election, the state will operate this program for a period of 5 years. At least 180 days prior to the end of this 5 year period, the state may request CMS renewal of this benefit for additional 5-year terms in accordance with 1915(i)(7)(C) and 42 CFR 441.710(c)(2). *(Specify target group(s)):

An adult over the age of 18 who meets the following criteria is eligible to receive State Plan HCBS:

**Serious mental illness (SMI)**—An illness, disease, disorder, or condition (other than a sole diagnosis of epilepsy, dementia, substance use disorder, or intellectual or developmental disability) that:

(A) substantially impairs an individual’s thought, perception of reality, emotional process, development, or judgment; or

(B) grossly impairs an individual’s behavior as demonstrated by recent disturbed behavior.

**Option for Phase-in of Services and Eligibility.** If the state elects to target this 1915(i) State plan HCBS benefit, it may limit the enrollment of individuals or the provision of services to enrolled individuals in accordance with 1915(i)(7)(B)(ii) and 42 CFR 441.745(a)(2)(ii) based upon criteria described in a phase-in plan, subject to CMS approval. At a minimum, the phase-in plan must describe: (1) the criteria used to limit enrollment or service delivery; (2) the rationale for phasing-in services and/or eligibility; and (3) timelines and benchmarks to ensure that the benefit is available statewide to all eligible individuals within the initial 5-year approval. *(Specify the phase-in plan):

(By checking the following box the State assures that):

8. **Adjustment Authority.** The state will notify CMS and the public at least 60 days before exercising the option to modify needs-based eligibility criteria in accord with 1915(i)(1)(D)(ii).

9. **Reasonable Indication of Need for Services.** In order for an individual to be determined to need the 1915(i) State plan HCBS benefit, an individual must require: (a) the provision of at least one 1915(i) service, as documented in the person-centered service plan, and (b) the provision of 1915(i) services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the person-centered service plan. Specify the state’s policies concerning the reasonable indication of the need for 1915(i) State plan HCBS:

<table>
<thead>
<tr>
<th>i.</th>
<th>Minimum number of services.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The minimum number of 1915(i) State plan services (one or more) that an individual must require in order to be determined to need the 1915(i) State plan HCBS benefit is:</td>
</tr>
<tr>
<td></td>
<td>One</td>
</tr>
</tbody>
</table>

| ii. | Frequency of services. The state requires (select one): |
|     | The provision of 1915(i) services at least monthly |
|     | Monthly monitoring of the individual when services are furnished on a less than monthly basis |

If the state also requires a minimum frequency for the provision of 1915(i) services other than monthly (e.g., quarterly), specify the frequency:
Home and Community-Based Settings

(By checking the following box the State assures that):

1. ☑ Home and Community-Based Settings. The State plan HCBS benefit will be furnished to individuals who reside and receive HCBS in their home or in the community, not in an institution. (Explain how residential and non-residential settings in this SPA comply with Federal home and community-based settings requirements at 42 CFR 441.710(a)(1)-(2) and associated CMS guidance. Include a description of the settings where individuals will reside and where individuals will receive HCBS, and how these settings meet the Federal home and community-based settings requirements, at the time of submission and in the future):

(Note: In the Quality Improvement Strategy (QIS) portion of this SPA, the state will be prompted to include how the state Medicaid agency will monitor to ensure that all settings meet federal home and community-based settings requirements, at the time of this submission and ongoing.)

Texas assures the settings included with this state plan amendment (SPA) renewal will be subject to any provisions or requirements included in Texas' approved statewide transition plan. Texas will implement any required changes upon approval of the statewide transition plan and will make conforming changes to its HCBS state plan when it submits the next amendment or renewal.

Individuals will receive HCBS services in the following settings.
- Host Home/Companion Care
- Community
- Own home/family home
- Assisted Living
- Supervised Living
(By checking the following boxes the state assures that):

1. ☐ There is an independent assessment of individuals determined to be eligible for the State plan HCBS benefit. The assessment meets federal requirements at 42 CFR §441.720.

2. ☐ Based on the independent assessment, there is a person-centered service plan for each individual determined to be eligible for the State plan HCBS benefit. The person-centered service plan is developed using a person-centered service planning process in accordance with 42 CFR §441.725(a), and the written person-centered service plan meets federal requirements at 42 CFR §441.725(b).

3. ☐ The person-centered service plan is reviewed, and revised upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the individual’s circumstances or needs change significantly, and at the request of the individual.

4. **Responsibility for Face-to-Face Assessment of an Individual’s Support Needs and Capabilities.**
   There are educational/professional qualifications (that are reasonably related to performing assessments) of the individuals who will be responsible for conducting the independent assessment, including specific training in assessment of individuals with need for HCBS. *(Specify qualifications):*

   (A) The agent performing the assessment is independent and qualified as defined in § 441.730 and meets the provider qualifications defined by the State as listed:

   1) Qualified Mental Health Professional -- a person who has demonstrated and documented competency in the work to be performed and:
      (A) has a bachelor's degree from an accredited college or university with a minimum number of hours that is equivalent to a major in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education, or early childhood intervention (as determined by the LMHA or MCO in accordance with 26 TAC, Part 1, Chapter 301, Subchapter G §301.331 (relating to Competency and Credentialing));
      (B) is a registered nurse; or
      (C) completes an alternative credentialing process identified by HHSC.
   or

   2) Licensed Practitioner of the Healing Arts:
      (A) a physician;
      (B) a licensed professional counselor;
      (C) a licensed clinical social worker;
      (D) a psychologist;
      (E) an advanced practice registered nurse recognized by the Texas Board of Nursing as a clinical nurse specialist in psychiatry/mental health or nurse practitioner in psychiatry/mental health; or
      (F) A licensed marriage and family therapist.

   and

   Has received HHSC-approved training in evaluating individuals for HCBS-AMH.

   (B) The individual receives appropriate support during the assessment, including the use of any necessary on-site support-staff.
   (C) The agent performing the assessment provides informed consent for this type of assessment.
5. **Responsibility for Development of Person-Centered Service Plan.** There are qualifications (that are reasonably related to developing service plans) for persons responsible for the development of the individualized, person-centered service plan. *(Specify qualifications):*

   Individual providers of recovery management who develop the person-centered service plan must:
   - Have at least 2 years of experience working with people with severe mental illness;
   - Have a master’s degree in human services or a related field (the requirement to have a master’s degree may be waived by HHSC if HHSC determines that waiver is necessary to provide access to care to Medicaid recipients);
   - Demonstrate knowledge of issues affecting people with severe mental illness and community-based interventions/resources for this population; and
   - Complete HHSC-required training in the HCBS-AMH program.

6. **Supporting the Participant in Development of Person-Centered Service Plan.** Supports and information are made available to the participant (and/or the additional parties specified, as appropriate) to direct and be actively engaged in the person-centered service plan development process. *(Specify: (a) the supports and information made available, and (b) the participant’s authority to determine who is included in the process):*

   Individuals will be afforded the services of an independent Recovery Manager, trained and competent in person-centered planning who will support the individual in all aspects of their recovery process, including assisting the creation of the IRP, helping the individual gain access to needed services and other resources, making informed choices according to individual needs and preferences; resolving issues impeding recovery; and developing strategies/resources to promote recovery. The IRP addresses the individual’s personal preferences, choices, and goals.

   It is directed by the individual and involves the interdisciplinary team (IDT), which includes participants whom the individual has freely chosen including the individual, recovery manager, legally authorized representative, and others, such as natural supports, advocates and service providers.

   The IRP is based on information from the independent needs-based assessment, which is conducted by HHSC staff or contractors. The individual and team identify the individual’s strengths, needs, preferences, and desired outcomes to determine the nature, amount, and scope of Medicaid and non-Medicaid services required. The resulting IRP incorporates the individual’s goals and preferences, including those related to community participation in the most integrated setting, employment, income and savings, health care and wellness, education, and others. The IRP also takes into account the participant’s social, treatment, and service history.

7. **Informed Choice of Providers.** *(Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the 1915(i) services in the person-centered service plan):*

   Each individual will be afforded the services of an independent Recovery Manager. The Recovery Manager will support the individual in all aspects of their recovery process including assisting the individual in gaining access to needed services and other resources, making informed choice of services and providers according to individual needs and preferences, resolving issues impeding recovery, and developing strategies/resources to promote recovery. The HCBS-AMH Recovery Manager will inform the individual and IDT of qualified provider options when IRPs are developed and revised. Documentation regarding provider choice is included in the individual’s record and updates to that record.
8. Process for Making Person-Centered Service Plan Subject to the Approval of the Medicaid Agency. (Describe the process by which the person-centered service plan is made subject to the approval of the Medicaid agency):

The person-centered service plan (Individual Recovery Plan – IRP) will be developed by the individual’s recovery manager, with full participation of the individual and significant others in a person-centered planning process that is based on the individual’s preferences, needs, and personal goals. HHSC will review and authorize the IRPs. Individual plan data will include, at a minimum, the type, amount, and duration of services to be provided; effective dates of service; and individual goals. HHSC will collect and maintain individual recovery plan (IRP) data and provide aggregate reporting on utilization review findings.

HHSC will use an electronic data system to collect clinical information and authorize service plans/requests. The HHSC Clinical Management for Behavioral Health Services (CMBHS) system will provide a platform for HHSC employees and providers to electronically submit data. The CMBHS system will interface with the MMIS to allow service authorization and claims payment. This system will ensure that authorizations for services are in place ensuring correct claims payment to certified Medicaid providers. Until the MMIS is modified, HHSC will authorize individual recovery plans and pay claims manually. All claims will be subject to final review and approval by the single state Medicaid agency.

HHSC will perform first-level review of 100 percent of person-centered service plans, referred to as the Individual Recovery Plans (IRPs), consistent with operating procedures approved by HHSC. HHSC will collect and maintain aggregate performance data. In addition, HHSC will collect and maintain individual IRP data. Individual IRP data includes the IRPs, any supporting documentation, and claims/utilization records related to implementation of the IRPs. HHSC will retain final review and approval authority over the IRPs.

Services must be planned for and provided in home and community-based settings and provided in the least restrictive manner possible. Individuals are free to participate in services on their IRP or refuse these services. Restraint is used only as last resort after less restrictive measures have been found to be ineffective or are judged unlikely to protect the individual or others from harm. Other forms of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ other aversive methods to modify behavior are not allowable. Individuals must provide informed consent regarding the potential use of restrictive intervention. This potential use must be included on the individual’s safety plan on the IRP, which must also confirm that the individual understands his/her rights and how to report abuse, neglect, and exploitation.

The use of restraints is prohibited except in a behavioral emergency. A behavioral emergency is a situation involving an individual who is behaving in a violent or self-destructive manner and in which preventive, de-escalative, or verbal techniques have been determined to be ineffective and it is immediately necessary to restrain the individual to prevent:

• imminent probable death or substantial bodily harm to the individual because the individual is attempting to commit suicide or inflict serious bodily harm; or
• imminent physical harm to others because of acts the individual is currently committing.

Restrictive intervention is used for the shortest period possible and terminated as soon as the individual demonstrates safe behaviors.

The use of any restrictive intervention must be reported to HHSC as a critical incident by the provider. All critical incidents are reviewed by HHSC.

Direct staff shall:

• Respect and preserve the rights of an individual during restrictive interventions;
• Provide an environment that is protected and private from other individuals and that safeguards the personal dignity and well-being of an individual placed in restrictive interventions;
• Ensure that undue physical discomfort, harm, or pain to the individual does not occur when initiating or using restrictive interventions;
• Use only the amount of physical force that is reasonable and necessary to implement a particular restrictive intervention.
The use of restrictive interventions is permissible on the provider’s property or for transportation of an individual only if implemented:
• In accordance with state law regarding interventions in mental health services;
• When less restrictive interventions (such as those listed in the individual’s safety plan) are determined ineffective to protect other individuals, the individual, staff members, or others from harm;
• In connection with applicable evaluation and monitoring;
• In accordance with any alternative strategies and special considerations documented in the IRP;
• When the type or technique of restrictive intervention used is the least restrictive intervention that will be effective to protect the other individuals, the individual, staff members, or others from harm; and
• Is discontinued at the earliest possible time.

The HCBS-AMH provider must take into consideration information that could contraindicate or otherwise affect the use of personal restraint, including information obtained during the assessment. This information includes, but is not limited to:
• Techniques, methods, or tools that would help the individual effectively cope with his or her environment;
• Pre-existing medical conditions or any physical disabilities and limitations, including substance use disorders, that would place the individual at greater risk during restraint;
• Any history of sexual or physical abuse that would place the individual at greater psychological risk during restraint; and
• Any history that would contraindicate restraint.

An individual held in restraint shall be under continuous direct observation. The HCBS-AMH provider shall ensure adequate respiration and circulation during restraint.

The use of planned restrictive interventions is reflected on the individuals IRP, which is submitted to HHSC for approval. The use of physical restraints must be documented as a critical incident by the HCBS-AMH provider and reported to HHSC. Unauthorized use of restrictive interventions will be detected by record review and through complaints. The oversight of personal restraint for HCBS-AMH providers is accomplished through the quarterly risk assessment conducted by HHSC.

The HCBS-AMH provider shall record the following information in the clinical record:
• The circumstances leading to the use of personal restraint;
• The specific behavior necessitating the restraint and the behavior required for release;
• Less restrictive interventions that were tried before restraint began;
• The names of the direct service staff who implemented the restraint;
• The date and time the restraint began and ended; and
• The individual’s response.

The recovery manager shall convene the individual’s IDT and document alternative strategies for dealing with behaviors in each of the following circumstances and update the IRP and safety plan accordingly:
• In any case in which behaviors have necessitated the use of restrictive interventions for the same individual more than two times during any 30-day period; and
• When two or more separate episodes of restrictive interventions of any duration have occurred within the same 12 hour period.

The use of chemical restraints and mechanical restraints by HCBS-AMH providers is prohibited. The use of seclusion is prohibited.

Restraint shall not be used:
• As a means of discipline, retaliation, punishment, or coercion;
• For the purpose of convenience of staff members or other individuals; or
• As a substitute for effective treatment or habilitation.

Restraints that do any of the following are prohibited:
• Obstruct the individual's airway, including a procedure that places anything in, on, or over the individual's
A prone or supine hold shall not be used during a personal restraint. Should an individual become prone or supine during a restraint, then any provider involved in administering the restraint shall immediately transition the individual to a side-lying or other appropriate position.

Providers shall ensure that direct service members are informed of their roles and responsibilities and are trained and demonstrate competence accordingly.

Before assuming job duties involving direct care responsibilities, and at least annually thereafter, direct service staff must receive training and demonstrate competence in at least the following knowledge and applied skills that shall be specific and appropriate to the target population of HCBS-AMH:

- The use of restraint, including how to perform the restraint;
- Identifying the causes of aggressive or threatening behaviors of individuals who need mental health services, including behavior that may be related to an individual's non-psychiatric medical condition;
- Identifying underlying cognitive functioning and medical, physical, and emotional conditions;
- Identifying medications and their potential effects;
- Identifying how age, weight, cognitive functioning, developmental level or functioning, gender, culture, ethnicity, and elements of trauma-informed care, including history of abuse or trauma and prior experience with restraint or seclusion, may influence behavioral emergencies and affect the individual's response to physical contact and behavioral interventions;
- Explaining how the psychological consequences of restraint and the behavior of staff members can affect an individual's behavior, and how the behavior of individuals can affect a staff member;
- Applying knowledge and effective use of communication strategies and a range of early intervention, de-escalation, mediation, problem-solving, and other non-physical interventions, such as clinical timeout and quiet time; and Recognizing and appropriately responding to signs of physical distress in individuals who are restrained or secluded, including the risks of asphyxiation, aspiration, and trauma.

Before any direct service staff may initiate any restraint, direct service staff shall receive training and demonstrate competence in:

- Safe and appropriate initiation and use of restraint as a last resort in a behavioral emergency;
- Safe and appropriate initiation and application, and use of personal restraint as a last resort in a behavioral emergency;
- Safe and appropriate initiation and application, and use of restraint as a last resort in a behavioral emergency or as a protective or supportive device.
- Management of emergency medical conditions in accordance with the provider's policies and procedures and other applicable requirements for:
  - obtaining emergency medical assistance; and
  - obtaining training in and using techniques for cardiopulmonary respiration and removal of airway obstructions.

Before assuming job duties, and at least annually thereafter, a registered nurse or a physician assistant who is authorized to:

- Perform assessments of individuals who are in restraint shall receive training, which shall include a demonstration of competence in:
  - monitoring cardiac and respiratory status and interpreting their relevance to the physical safety of the individual in restraint;
  - recognizing and responding to nutritional and hydration needs; o checking circulation in, and range of motion of, the extremities;
  - providing for hygiene and elimination;
  - identifying and responding to physical and psychological status and comfort, including signs of
distress;
  o assisting individuals in de-escalating, including through identification and removal of stimuli, that meet the criteria for a behavioral emergency if known;
  o recognizing when continuation of restraint is no longer justified by a behavioral emergency; and
  o recognizing when to contact emergency medical services to evaluate and/or treat an individual for an emergency medical condition.

- Conduct evaluations of individuals, including face-to-face evaluations relating to initiation of restraint or in a behavioral emergency of individuals who are in restraint, shall receive training, which shall include a demonstration of competence in:
  o identifying restraints that are permitted by the provider and by applicable law;
  o identifying stimuli that trigger behaviors;
  o identifying medical contraindications to restraint;
  o recognizing psychological factors to be considered when using restraint, such as sexual abuse, physical abuse, neglect, and trauma.

Before assuming job duties, and at least annually thereafter, providers who are authorized to monitor, under the supervision of a registered nurse, individuals during restraint shall receive training, which shall include a demonstration of competence in:

- Monitoring respiratory status;
- Recognizing nutritional and hydration needs;
- Checking circulation, and range of motion of, the extremities;
- Providing for hygiene and elimination;
- Addressing physical and psychological status and comfort, including signs of distress;
- Assisting individuals in de-escalating, including through identification and removal of stimuli, if known.
- Recognizing when continuation of restraint is no longer justified by a behavioral emergency; and
- Recognizing when to contact a registered nurse.

HHSC is responsible for overseeing the use of restrictive interventions with individuals enrolled in HCBS-AMH. The use of restrictive interventions, including personal restraints, are reported as critical incidents and managed as part of the contract oversight process by HHSC. HHSC’s oversight of the use of personal restraints by HCBS-AMH providers is accomplished through annual risk assessment conducted by HHSC. Unauthorized use of restraint will be detected by record review, site review, and through complaints.

HHSC is responsible for overseeing the reporting of and response to critical incidents that affect individuals enrolled in HCBS-AMH. Critical incidents are managed as part of the contract oversight process by HHSC. The State utilizes Critical Event or Incident Reporting and Management Processes that enable the State to collect information on sentinel events that occur. Critical incidents are situations that threaten the health and safety of the individual or the community or pose a significant change in the individual’s status or environment. HCBS-AMH providers shall be responsible for implementing a procedure which ensures the reporting of all critical incidences. Incidences may include, but are not limited to, the following:

- Abuse, neglect, or exploitation of an HCBS-AMH participant;
- Hospital admission and discharge;
- Nursing home placement other than for the provision of respite;
- Incarceration;
- Restraint of an HCBS-AMH participant;
- A slip or fall, medication error, or medical complication; or
- Incidents caused by the individual such as verbal and/or physical abuse of providers or other participants, destruction or damage of property, contraband, and member self-abuse;
- Eviction from primary residence;
- The individual poses an immediate health or safety risk to self or others; or
- Serious injury or death.

In the case of critical incidents, HCBS-AMH providers are expected to take immediate action to resolve, when feasible, and to report to the appropriate state and/or law enforcement entities. Providers shall submit to HHSC the Critical Incident Report Form within 72 hours of notification of outcome of the incident with any updated information.

During HHSC site review of HCBS-AMH providers, HHSC reviews critical incident reports to ensure compliance.
The HCBS-AMH provider will cooperate with and assist HHSC, HHSC, and any state or federal agency charged with the duty of identifying, investigating, sanctioning or prosecuting suspected fraud and abuse, including the Office of Inspector General at HHSC.

The Department of Family and Protective Services (DFPS) is responsible for investigating abuse, neglect and exploitation and providing services to adults who are over age 65 or have a disabling condition such as a mental, physical, or developmental disability that substantially impairs their ability to live on their own or provide for their own self-care or protection.

The Department of Family and Protective Services (DFPS) will provide HHSC copies of each investigation of ANE allegations involving an individual enrolled in the HCBS-AMH. Regardless of the investigation findings, HHSC reviews each investigative report.

HHSC regulates assisted living facilities and associated complaints of abuse by providers of HCBS-AMH services in assisted living facilities and HCBS-AMH providers of respite in nursing home settings.

HHSC notifies individuals of his/her rights prior to enrollment into the HCBS-AMH Program. HHSC verifies notification of the individual of his/her rights through the individual or LAR’s signature on the Notification of Participant Rights Form as part of the enrollment process. The Notification of Participant Rights Form:

- Informs the individual of the contact information for DFPS and the Office of the Ombudsman;
- Informs the individual of his/her right to a Fair Hearing regarding the HCBS-AMH Program; and
- Informs the individual of the process for reporting allegations of ANE and the toll free number for DFPS.

HCBS-AMH providers and recovery managers must also provide information to the individual and LAR regarding the participant’s rights and how the participant or LAR can notify appropriate authorities or entities when the participant has experienced ANE. This information must be provided by recovery managers and providers when the individual and/or LAR request it, and when the provider or recovery manager identify a need to provide the information.

The name, telephone number, and mailing address of the HCBS-AMH provider’s rights protection officer must be prominently posted in every area that is frequented by HCBS-AMH participants. Individuals desiring to contact the rights protection officer must be allowed access to the HCBS-AMH Provider’s telephones to do so.

The method used to communicate the information will be designed for effective communication, tailored to meet each person’s ability to comprehend, and responsive to any visual or hearing impairment. Oral communications of rights will be documented on the Notification of Participant Rights Form bearing the date and signatures of the individual enrolled in HCBS-AMH and/or LAR and the staff person who explained the rights. The Notification of Participant Rights Form will be filed in the individual’s clinical record.

HCBS-AMH Providers are responsible for monitoring participant medication regimens, including the administration of medications to individuals enrolled in HCBS-AMH who cannot self-administer and/or the oversight of individuals enrolled in HCBS-AMH who self-administer medications.

- At least annually, the HCBS-AMH Provider must assure that staff administering medications be qualified under their scope of practice.
- The HCBS-AMH provider must assure that staff who have been delegated the authority to administer medications or delegated oversight of individuals who self-administer medications receive instruction in medication administration and monitoring from a practitioner with delegation authority before assuming their duties and as indicated by changes in the client’s condition or medication regimen. The staff delegated to administer the medications will be trained and have knowledge of each medication, what it is prescribed for, and the adverse reactions and side effects.
- The HCBS-AMH provider must monitor staff who have been delegated authority to administer medications or delegated oversight of individuals who self-administer medications. The frequency and monitoring is based on the individual’s condition, medication regimen, and changes to the medication regimen.
- If applicable, the LAR must sign an authorization for the HCBS-AMH provider to administer each medication according to label directions.
- The medication must be in the original container labeled with the expiration date and the individual’s full name.
9. **Maintenance of Person-Centered Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following (check each that applies):

<table>
<thead>
<tr>
<th></th>
<th>Medicaid agency</th>
<th></th>
<th>Operating agency</th>
<th></th>
<th>Case manager</th>
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<tbody>
<tr>
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<td>Other (<em>specify</em>):</td>
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</table>

- The HCBS-AMH provider must administer the medication according to the label directions or as amended by a physician.
- The HCBS-AMH provider must administer the medication only to the individual for whom it is intended.
- The HCBS-AMH provider must not administer the medication after its expiration date.
- If applicable, the HCBS-AMH provider may provide non-prescription medications if the HCBS-AMH provider obtains LAR consent prior to administration of the medication. Consent may be given over the phone and documented as such by the HCBS-AMH provider.
- At least quarterly, or more frequently if indicated by the individual’s condition, medication regimen or changes to the regimen, HCBS-AMH providers shall review medication administration records to ensure that medications are correctly administered.

HHSC includes medication management review as part of its biennial review of contracted HCBS-AMH providers. HHSC is responsible for monitoring the performance of providers administering medications to the individual. HHSC enforces requirements through biennial review and review of critical incidents.
1. **State plan HCBS.** *(Complete the following table for each service. Copy table as needed):*

<table>
<thead>
<tr>
<th>Service Specifications <em>(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):</em></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service Title:</strong> Transition Assistance Services (TAS)</td>
</tr>
<tr>
<td><strong>Service Definition (Scope):</strong></td>
</tr>
<tr>
<td>TAS pays set-up expenses for individuals transitioning from institutions into community settings. Allowable expenses are those necessary to enable individuals to establish basic households and may include: security deposits for leases on apartments or homes; essential household furnishings and expenses required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed and bath linens; set-up fees or deposits for utility or service access, including telephone, electricity, gas, and water; and services necessary for an individual's health and welfare, such as pest eradication and one-time cleaning prior to occupancy.</td>
</tr>
<tr>
<td>TAS may also include services necessary for an individual's health and welfare, such as pest eradication and one-time cleaning prior to occupancy, and activities to assess need, arrange for, and procure needed resources (limited to up to 180 consecutive days prior to discharge).</td>
</tr>
<tr>
<td>Providers may only bill Medicaid for TAS on or after the date that the individual is enrolled in the state plan benefit, on or after the date of discharge from the facility, and pursuant to the IRP. Room and board are not allowable TAS expenses. TAS are furnished only to the extent that the expense is reasonable and necessary, as determined through the individual recovery plan development process, and is clearly identified in the individual recovery plan. The IRP must document that individuals are unable to meet such expenses or the services cannot be obtained from other sources.</td>
</tr>
<tr>
<td>TAS does not include: monthly rental or mortgage expenses, food, regular utility charges, major household appliances, or items that are intended for purely recreational purposes. TAS excludes shared expenses, such as furniture and appliances, covered under provider owned or operated residential options.</td>
</tr>
</tbody>
</table>

**Additional needs-based criteria for receiving the service, if applicable (specify):**

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. *(Choose each that applies):*

- **Categorically needy (specify limits):**
  - There is a $2,500 cost cap per participant for the transition event into his/her own home, including settings with supported home living and companion care arrangements. Individuals transitioning to their own home (not a provider-owned or operated setting) have a need to purchase and arrange for essential household furnishings and expenses required to occupy and use a community domicile. There is a $1,000 cost cap per participant for the transition event into a host home, supervised living, or assisted living arrangement. This cost cap reflects that, while the individual will need items to personalize their living space, other items such as furniture are provided by the residential setting.  

- **Medically needy (specify limits):**
  - N/A

| Provider Qualifications *(For each type of provider. Copy rows as needed):* |
|-----------------------------|-----------------|-----------------|-----------------|
| Provider Type *(Specify):*  | License *(Specify):* | Certification *(Specify):* | Other Standard *(Specify):* |
HCBS Provider Agency that meets the minimum eligibility and standards for HCBS-AMH provider enrollment.

<table>
<thead>
<tr>
<th>Provider Type (Specify):</th>
<th>Entity Responsible for Verification (Specify):</th>
<th>Frequency of Verification (Specify):</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCBS Provider Agency that meets the minimum eligibility and standards for HCBS-AMH provider enrollment.</td>
<td>HHSC</td>
<td>Biennial</td>
</tr>
</tbody>
</table>

Before entering into a provider agreement with the provider agency, HHSC verifies the providers’ compliance with these qualifications through a credentialing process. Contracted providers are obligated to verify on an ongoing basis that these qualifications are achieved, maintained, and documented. HHSC will conduct biennial review to verify these requirements continue to be met after the provider and HHSC enter into an agreement.

Individual providers of TAS must be 18 years of age or older, pass criminal background check, demonstrate knowledge and/or experience in managing transitions to home and community-based settings.

Service Delivery Method. (Check each that applies):

- [ ] Participant-directed
- [✓] Provider managed

Service Specifications (Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):

| Service Title: | HCBS Psychosocial Rehabilitation Services |
HCBS Psychosocial Rehabilitation services are evidence-based or evidence-informed interventions which support the individual’s recovery by helping the individual develop, refine, and/or maintain the skills needed to function successfully in the community to the fullest extent possible. Skills include but are not limited to: illness/recovery management, self-care, activities of daily living, and instrumental activities of daily living. The modality(ies) used must be approved by HHSC. A variety of evidence-based practices may be used as appropriate to individual needs, interests and goals. Activities included must be intended to achieve the identified goals or objectives as set forth in the individual’s IRP. Rehabilitative services are in-person, audio-visual, or audio-only interventions with the individual present. Services may be provided individually or in a group setting. Audio-only is not allowed for group setting interventions. Audio-visual or audio-only option will not be available 100% of the time. All HCBS-AMH participants will receive at least on in-person visit during each IRP period this restriction will support utilization of telehealth delivery of services while supporting community integration. HIPAA compliance remains the responsibility of the provider delivering the services. In order to ensure the privacy of individuals is respected, HCBS-AMH providers will be required to sign and submit an attestation form that will be developed by HHSC that ensures service will be in a private space. In addition, contracted providers will ensure each participant is in a private location where they feel safe to openly discuss their health. HHSC’s HIPAA Compliance officer has approved the telehealth methodology. Cameras may never be used for any reason in private spaces such as bedrooms, bathrooms, and areas for private phone calls or telehealth delivery of services. Cameras are only allowed outside and in common areas, and with the use of consent from each person living in the home.

Telehealth delivery of services enhances community integration by providing more flexibility for participation in community activities. Telehealth delivery of services can connect participants to a broad range of services and community resources by removing barriers related to physical distance and expanding provider options thereby increasing participant choice. Telehealth delivery of services serves to promote independence and improve patient/provider relationships as services can be provided in individualized preferred settings and provides participants ownership to their own treatment of care, thereby increasing opportunities for engagement on their own schedule. Allowing telehealth delivery of services supports community integration by increasing choice and access to multiple providers and community resources in the setting of participants choosing and affording participants equal opportunity to telehealth delivery of services as other individuals in the community. Whenever possible, HHSC encourages in person delivery of services. HCBS-AMH providers must document in the Individual Recovery Plan the reason(s) why telehealth delivery of services was delivered in person delivery. HCBS-AMH was included in Texas’s HCBS ARPA spending plan to provide funding to purchase technology equipment to increase access to the remote delivery of mental health services. HCBS-AMH shall provide initial, ongoing, and ad hoc technical assistance and training to providers in need of assistance with using technology to better ensure participants are well supported in the use of devices to access telehealth delivery of services.

HHSC is responsible for monitoring the provision of telehealth delivery of services and enforces compliance of service delivery restrictions, participant privacy, and use of adaptive aids through biennial onsite or desk reviews. HCBS-AMH providers shall also establish internal escalation protocols that dictate when a participant receiving telehealth delivery of services should be transitioned to urgent in-person follow-up care, crisis care or intervention, or even to receiving emergency services. HCBS-AMH providers shall also immediately report cases of suspected abuse neglect or exploitation (ANE) to the appropriate investigative authority.

The provider must incorporate research-based approaches pertinent to the needs of the target population.
Approaches used must be approved by HHSC. Examples of specific research-based approaches that could be used for various sub-populations of clients include, but are not limited to:

Cognitive Adaptation Training (CAT): An evidence-based practice which provides assistance and environmental modifications to help individuals establish daily routines, organize their environment, and build social skills, with the ultimate goal of increasing independence. CAT compensates for cognitive deficits from mental illness (such as psychomotor speed, attention, and memory) by providing visual clues, signage, and organization of the individual’s environment, which results in increased independent functioning. CAT improves the individual’s ability to perform activities of daily living such as dressing, hygiene, social skills and communication, medication management, toileting, leisure skills, and transportation.

Illness Management and Recovery (IMR): IMR gives individuals information about mental illnesses and coping skills to help them manage their illnesses, develop goals, and make informed decisions about their treatment. IMR practitioners help individuals define recovery for themselves and identify personally meaningful recovery goals. In IMR, education about mental illnesses is the foundation of informed decision-making. Practitioners help individuals build social networks and engage supporters in activities that promote recovery. Individuals learn to identify early warning signs and plan steps that they can take to prevent relapses. They also learn strategies to help them manage their symptoms, cope with stress, and significantly improve their lives.

Seeking Safety: Present-focused therapy to help people attain safety from trauma, post-traumatic stress disorder, and substance abuse. This therapy was developed by Lisa M. Najavits at Harvard Medical School/McLean Hospital in 1992.

Rehabilitation services are provided by practitioners working under the direction of the HCBS-AMH Provider Agency and supervision of clinicians who are credentialed or qualified in the specific evidence-based practices.

Additional needs-based criteria for receiving the service, if applicable (specify):

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

- ✓ Categorically needy (specify limits):
  - HCBS-AMH rehabilitation services cannot be delivered at the same time as State Plan mental health rehabilitative services. Individuals will receive State Plan mental health rehabilitative services if the individual so desires and those services are appropriate for the individual.

  Services are subject to prior approval by HHSC and may be subject to periodic reviews to ensure fidelity with evidence-based practice. Service plans for HCBS Psychosocial Rehabilitation must be developed with a practitioner credentialed in the evidence-based practices (EBP). The activities included under HCBS Psychosocial Rehabilitation services must be intended to achieve identified IRP goals or objectives and must be reviewed at least annually with the individual and significant others as part of the IRP process to determine whether the services are meeting related IRP goals and objectives, and may be adjusted as needed to reflect the individual’s needs, preferences and progress.

  As outlined in the IRP, services may be provided at an office of the provider, in the community, or in the individual’s place of residence. Rehabilitative services are not intended to substitute for personal assistance services.

- □ Medically needy (specify limits):
  - N/A

Provider Qualifications (For each type of provider. Copy rows as needed):

| Provider Type (Specify): | License (Specify): | Certification (Specify): | Other Standard (Specify): |
HCBS Provider Agency that meets the minimum eligibility and standards for HCBS-AMH provider enrollment.

HCBS provider agency enrolled and contracted with HHSC to provide HCBS-AMH services, which employs or has a contract with the HCBS Psychosocial Rehabilitation practitioner.

Before entering into a provider agreement with the provider agency, HHSC verifies the providers’ compliance with these qualifications through a credentialing process. Contracted providers are obligated to verify on an ongoing basis that these qualifications are achieved, maintained, and documented in personnel files. HHSC will conduct annual review to verify these requirements continue to be met after the provider and HHSC enter into an agreement.

Individual providers must be qualified and demonstrate competency and fidelity to the evidence-based practices (EBPs) used. Individual providers must have the level of education and experience required by the evidence-based modality employed. An individual provider must, at a minimum, have a bachelor’s degree in psychology or a related field. HHSC-approved training and/or certification in the evidence-based practice(s) employed and must be supervised by a licensed clinician trained and competent in the EBP.

### Verification of Provider Qualifications

<table>
<thead>
<tr>
<th>Provider Type (Specify):</th>
<th>Entity Responsible for Verification (Specify):</th>
<th>Frequency of Verification (Specify):</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCBS Provider Agency that meets the minimum eligibility and standards for HCBS-AMH provider enrollment.</td>
<td>HHSC</td>
<td>Annual</td>
</tr>
</tbody>
</table>

### Service Delivery Method

- □ Participant-directed
- ✔ Provider managed

### Service Specifications

<table>
<thead>
<tr>
<th>Service Title:</th>
<th>Adaptive aids</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Definition (Scope):</td>
<td></td>
</tr>
</tbody>
</table>
HCBS-AMH allows the use of adaptive aid services to enhance all HCBS-AMH service delivery; telehealth delivery may require additional use of adaptive aids to ensure access for individuals requiring hands on assistance. This may include the purchase of specialized equipment to aid the access of telehealth delivery of services and promoting reasonable accommodations as needed. This may with prior approval from HHSC include communication aids, computers and appropriate accessories, appropriate software, computer evaluations, specifications and training, computer literacy training to educate individuals in use of adaptive software necessary to perform activities, webcam, screen readers, visual aids, headphones.

Specialized equipment and supplies including devices, controls and appliances that enable individuals to increase their abilities to perform activities of daily living; to perceive, control, or communicate with the environment in which they live; allow the individual to integrate more fully into the community; or to ensure the health, welfare and safety of the individual.

Adaptive aids include vehicle adaptations or modifications, environmental adaptations, and aids for daily living, such as reachers, adapted utensils, certain types of lifts, pill keepers, reminder devices, signs, calendars, planners, and storage devices.

Vehicle adaptations or modifications that are specified on the IRP may be made to a vehicle that is not owned by the provider and is the individual’s primary means of transportation in order to accommodate the identified needs of the individual. Vehicle adaptations or modifications do not include the following: (1) adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the individual; (2) purchase or lease of a vehicle; and (3) regularly scheduled upkeep and maintenance of a vehicle, except upkeep and maintenance of the modifications.

Adaptive aids also include service animals and items associated with equipping, training, and maintaining the health and safety of a service animal. (These items include veterinary care; travel benefits associated with obtaining and training an animal; and the provision, maintenance, and replacement of items and supplies required for the animal to perform the tasks necessary to assist individuals. The cost effectiveness of medical interventions outside of routine veterinary care is to be determined on an individual basis.) Other items may be included if specifically required to realize a goal specified in the IRP and prior approved by HHSC.

Items reimbursed are in addition to any supports furnished under the State Plan and do not include those items which are not of direct benefit to the individual. All items must meet applicable standards of manufacture, design, and installation.

Service animals must be provided in accordance with the IRP and documented as necessary for the individual to remain in the community.

This 1915(i) service is only provided to individuals age 21 and over. All medically necessary adaptive aid services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.

Additional needs-based criteria for receiving the service, if applicable (specify):

Individual items costing over $500.00 must be recommended in writing by a licensed practitioner of the healing arts (Physician, Advanced Practice Registered Nurse, Psychologist, Licensed Professional Counselor, Licensed Clinical Social Worker or Licensed Marriage and Family Therapist qualified to assess the individual’s need for the specific adaptive aid and be approved by HHSC.

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

- Categorically needy (specify limits):
The annual cap is $10,000 per individual, per year. Should an individual require adaptive aids after the cost limit has been reached, the recovery manager assists the individual/family to access any other resources or alternate funding sources.
Adaptive aids are available only after benefits available through Medicare, other Medicaid benefits, or other third party resources have been documented as exhausted.
Adaptive aids are limited to those categories specified in the state plan amendment.

Medically needy (specify limits):
- N/A

### Provider Qualifications
(For each type of provider. Copy rows as needed):

<table>
<thead>
<tr>
<th>Provider Type (Specify):</th>
<th>License (Specify):</th>
<th>Certification (Specify):</th>
<th>Other Standard (Specify):</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCBS Provider Agency that meets the minimum eligibility and standards for HCBS-AMH provider enrollment.</td>
<td></td>
<td></td>
<td>HCBS provider agency enrolled and contracted with HHSC to provide HCBS services, which employs or has contracts with adaptive aid providers. Before entering into a provider agreement with the provider agency, HHSC verifies the providers’ compliance with these qualifications through a credentialing process. Contracted providers are obligated to verify on an ongoing basis that these qualifications are achieved, maintained, and documented in personnel files. HHSC will conduct annual review to verify these requirements continue to be met after the provider and HHSC enter into an agreement. Adaptive aid providers and their employees must comply with all applicable laws and regulations for the provision of adaptive aids.</td>
</tr>
</tbody>
</table>

### Verification of Provider Qualifications
(For each provider type listed above. Copy rows as needed):

<table>
<thead>
<tr>
<th>Provider Type (Specify):</th>
<th>Entity Responsible for Verification (Specify):</th>
<th>Frequency of Verification (Specify):</th>
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</thead>
<tbody>
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<td>HHSC</td>
<td>Annual</td>
</tr>
</tbody>
</table>

### Service Delivery Method
(Check each that applies):
- Participant-directed
- Provider managed
## Employment Services

### Service Definition (Scope):

Employment services help people with severe mental illness work at regular jobs of their choosing and to achieve goals meaningful to them, such as increasing their economic security. Services must follow evidence-based or evidence-informed practices approved by HHSC. Employment services:

- focus on the individual’s strengths and preferences;
- promote recovery and wellness by enabling individuals to engage in work which is meaningful to them and compensated at a level equal to or greater than individuals without severe mental illness or other disabilities (competitive employment);
- collaborate with and do not supplant existing resources, such as state vocational rehabilitation programs available to the individual;
- use a multidisciplinary team approach;
- are individualized and extended as needed to assist the individual attain and maintain meaningful work;
- are provided based on individual preference and choice without exclusions based on readiness, diagnoses, symptoms, substance use history, psychiatric hospitalizations, level of disability, or legal system involvement;
- are coordinated with mental health services provided to the individual, such as rehabilitation;
- help individuals obtain personalized, understandable, and accurate information about their Social Security, Medicaid, and other government entitlements in relation to work.
Specialized equipment and supplies including devices, controls and appliances that enable individuals to increase their abilities to perform activities of daily living; to perceive, control, or communicate with the environment in which they live; allow the individual to integrate more fully into the community; or to ensure the health, welfare and safety of the individual.

Adaptive aids include vehicle adaptations or modifications, environmental adaptations, and aids for daily living, such as reachers, adapted utensils, certain types of lifts, pill keepers, reminder devices, signs, calendars, planners, and storage devices.

Vehicle adaptations or modifications that are specified on the IRP may be made to a vehicle that is not owned by the provider and is the individual’s primary means of transportation in order to accommodate the identified needs of the individual. Vehicle adaptations or modifications do not include the following: (1) adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the individual; (2) purchase or lease of a vehicle; and (3) regularly scheduled upkeep and maintenance of a vehicle, except upkeep and maintenance of the modifications.

Adaptive aids also include service animals and items associated with equipping, training, and maintaining the health and safety of a service animal. (These items include veterinary care; travel benefits associated with obtaining and training an animal; and the provision, maintenance, and replacement of items and supplies required for the animal to perform the tasks necessary to assist individuals. The cost effectiveness of medical interventions outside of routine veterinary care is to be determined on an individual basis.) Other items may be included if specifically required to realize a goal specified in the IRP and prior approved by HHSC.

Items reimbursed are in addition to any supports furnished under the State Plan and do not include those items which are not of direct benefit to the individual. All items must meet applicable standards of manufacture, design, and installation.

Service animals must be provided in accordance with the IRP and documented as necessary for the individual to remain in the community.

This 1915(i) service is only provided to individuals age 21 and over. All medically necessary adaptive aid services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.

Additional needs-based criteria for receiving the service, if applicable (specify):

- Individual items costing over $500.00 must be recommended in writing by a licensed practitioner of the healing arts (Physician, Advanced Practice Registered Nurse, Psychologist, Licensed Professional Counselor, Licensed Clinical Social Worker or Licensed Marriage and Family Therapist qualified to assess the individual’s need for the specificadaptive aid and be approved by HHSC.

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

- Categorically needy (specify limits):
  - The annual cap is $10,000 per individual, per year. Should an individual require adaptive aids after the cost limit has been reached, the recovery manager assists the individual/family to access any other resources or alternate funding sources. Adaptive aids are available only after benefits available through Medicare, other Medicaid benefits, or other third party resources have been documented as exhausted. Adaptive aids are limited to those categories specified in the state plan amendment.

- Medically needy (specify limits):
  - N/A

Provider Qualifications (For each type of provider. Copy rows as needed):

| Provider Type (Specify): | License (Specify): | Certification (Specify): | Other Standard (Specify): |
HCBS Provider Agency that meets the minimum eligibility and standards for HCBS-AMH provider enrollment.

HCBS provider agency enrolled and contracted with HHSC to provide HCBS services, which employs or has contracts with adaptive aid providers.

Before entering into a provider agreement with the provider agency, HHSC verifies the providers’ compliance with these qualifications through a credentialing process. Contracted providers are obligated to verify on an ongoing basis that these qualifications are achieved, maintained, and documented in personnel files. HHSC will conduct biennial review to verify these requirements continue to be met after the provider and HHSC enter into an agreement.

Adaptive aid providers and their employees must comply with all applicable laws and regulations for the provision of adaptive aids.

Verification of Provider Qualifications *(For each provider type listed above. Copy rows as needed)*:

<table>
<thead>
<tr>
<th>Provider Type <em>(Specify)</em></th>
<th>Entity Responsible for Verification <em>(Specify)</em></th>
<th>Frequency of Verification <em>(Specify)</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>HCBS Provider Agency that meets the minimum eligibility and standards for HCBS-AMH provider enrollment.</td>
<td>HHSC</td>
<td>Biennial</td>
</tr>
</tbody>
</table>

Service Delivery Method. *(Check each that applies)*:

- Participant-directed
- Provider managed

Service Specifications *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover)*:

**Service Title:** Employment Services

**Service Definition (Scope):**

Employment services help people with severe mental illness work at regular jobs of their choosing and to achieve goals meaningful to them, such as increasing their economic security. Services must follow evidence-based or evidence-informed practices approved by HHSC. Employment services:

- focus on the individual's strengths and preferences;
- promote recovery and wellness by enabling individuals to engage in work which is meaningful to them and compensated at a level equal to or greater than individuals without severe mental illness or other disabilities (competitive employment);
- collaborate with and do not supplant existing resources, such as state vocational rehabilitation programs available to the individual;
- use a multidisciplinary team approach;
- are individualized and extended as needed to assist the individual attain and maintain meaningful work;
- are provided based on individual preference and choice without exclusions based on readiness, diagnoses, symptoms, substance use history, psychiatric hospitalizations, level of disability, or legal system involvement;
- are coordinated with mental health services provided to the individual, such as rehabilitation;
- help individuals obtain personalized, understandable, and accurate information about their Social Security, Medicaid, and other government entitlements in relation to work;
• help individuals obtain jobs directly, rather than mandating lengthy pre-employment assessment, training, and counseling;
• include systematic job development based on individuals’ interests, developing relationships with local employers by making systematic contacts; and
• provide time-unlimited and individualized support for as long the individual wants and needs support.

**Supported Employment**

Supported Employment provides individualized services to sustain individuals in paid jobs in regular work settings, who, because of disability, require support to be self-employed, work from home, or perform in a work setting at which individuals without disabilities are employed. Supported Employment includes adaptations, assistance, and training essential for individuals to sustain paid employment at or above the minimum wages and benefits provided to non-disabled workers performing similar jobs. Transporting an individual to support the individual to be self-employed, work from home, or perform in a community-based work setting is billable within the service. Components include:

• on-the-job training and skills development;
• assisting the individual with development of natural supports in the workplace;
• helping individuals attend school and providing academic supports, when that is their preference;
• coordinating with employers or employees, coworkers and customers, as necessary. (Note: Coordinating with employers and other employees is done only if the individual prefers to have her or his mental illness disclosed and gives permission);
• providing work incentives planning prior to or during the process of job placement. Work incentives planning involves helping the person review her or his options for working (number of hours per week, etc.), given the hourly pay the person is being offered, or is likely to be offered, the person's current income needs, and the rules concerning how SSA benefits, medical benefits, medical subsidies, and other subsidies (housing, food stamps, etc.) change based on income from paid employment. Work incentives planning allows individuals to make informed decisions about how many hours per week to work, as well as their preferred timing in moving from part-time to full-time work. Individuals also are given information and assistance about reporting earnings to various sources of entitlements/benefits;
• assisting individuals in making informed decisions about whether to disclose their mental illness condition to employers and co-workers; and
• providing follow-along services for as long as the individual needs and desires them to help the individual maintain employment. Follow-along may include periodic reminders of effective workplace practices and reinforcement of skills.

**Employment Assistance**

Employment Assistance helps the individual locate and maintain paid employment in the community and may include activities on behalf of the individual to assist in maintaining employment. Components include:

• identifying an individual’s employment preferences, job skills, and requirements for a work setting and work conditions;
• engaging the individual in identifying a career direction and developing a plan for achieving competitive, integrated employment at or above the state’s minimum wage. The outcome of this activity is documentation of the individual’s stated career objective and a career plan used to guide individual employment assistance;
• providing support to establish or maintain home-based or self-employment, when identified as a goal by the individual;
• locating prospective employers offering employment compatible with the individual’s identified preferences, skills, and requirements;
• contacting a prospective employer on behalf of an individual and negotiating the individual’s job development/employment;
• developing customized employment options with the individual to meet the individual’s needs and preferences; and
• transporting the individual to help the individual locate paid employment in the community.

Additional needs-based criteria for receiving the service, if applicable (specify):
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

<table>
<thead>
<tr>
<th>Categorically needy (specify limits):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services do not include payment for the supervisory activities rendered as a normal part of the business setting.</td>
</tr>
<tr>
<td>Services do not include payment for supervision, training, support, and adaptations typically available to other non-disabled workers filling similar positions in the business.</td>
</tr>
<tr>
<td>Services do not include adaptations, assistance, and training used to meet an employer’s responsibility to fulfill requirements for reasonable accommodations under the Americans with Disabilities Act.</td>
</tr>
<tr>
<td>Transportation to and from the work site may be a component of - and the cost of this transportation may be included in - the rate paid to providers, unless the individual can access public transportation or has other means of transportation available to them. If public transportation is available, then it should be utilized by the individual, if at all possible.</td>
</tr>
<tr>
<td>Employment Services may be used for an individual to gain work-related experience considered crucial for job, placement (e.g., unpaid internship), only if such experience is vital to the person to achieve his or her vocational goal.</td>
</tr>
<tr>
<td>Documentation must be maintained for each individual receiving this service that the service is not available under a program funded under Section 110 of the Rehabilitation Act of 1973, relating to vocational rehabilitation services, or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.), relating to special education.</td>
</tr>
<tr>
<td>Services may not be for job placements paying below minimum wage.</td>
</tr>
<tr>
<td>Services must be delivered in a manner that supports and respects the individual’s communication needs including translation services, assistance with, and use of communication devices.</td>
</tr>
<tr>
<td>Services may not be provided on the same day and at the same time as services that contain elements integral to the delivery of Employment Services (e.g., rehabilitation).</td>
</tr>
<tr>
<td>Services must be provided in regular integrated settings and do not include sheltered work or other types of vocational services in specialized facilities, or incentive payments, subsidies, or unrelated vocational training expenses such as the following:</td>
</tr>
<tr>
<td>• Incentive payments made to an employer to encourage hiring the individual;</td>
</tr>
<tr>
<td>• Payments that are passed through to the individual;</td>
</tr>
<tr>
<td>o Payments for supervision, training, support and adaptations typically available to other workers without disabilities filling similar positions in the business; or</td>
</tr>
<tr>
<td>o Payments used to defray the expenses associated with starting up or operating a business.</td>
</tr>
</tbody>
</table>

The documentation of employment services must be available to HHSC and to the Recovery Manager for monitoring at all times on an ongoing basis. The Recovery Manager will monitor on a quarterly basis to see if the objectives and outcomes are being met.

<table>
<thead>
<tr>
<th>Medically needy (specify limits):</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
</tr>
</tbody>
</table>

**Provider Qualifications (For each type of provider. Copy rows as needed):**

<table>
<thead>
<tr>
<th>Provider Type (Specify):</th>
<th>License (Specify):</th>
<th>Certification (Specify):</th>
<th>Other Standard (Specify):</th>
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</thead>
<tbody>
<tr>
<td>HCBS Provider agency that meets the minimum eligibility and standards for HCBS-AMH provider enrollment</td>
<td></td>
<td></td>
<td>HCBS provider agency enrolled and contracted with HHSC to provide HCBS services, which employs or has agreements with employment practitioners with training/certification in evidence-based or evidence-informed employment services.</td>
</tr>
<tr>
<td>The individual provider of employment</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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services must be at least 18 years of age and meet one of the following qualifications:
• have a bachelor's degree in rehabilitation, business, marketing, or a related human services field, and one year's paid or unpaid experience providing employment services to people with disabilities;
• have an associate degree in rehabilitation, business, marketing, or a related human services field, and two years paid or unpaid experience providing employment services to people with disabilities; or
• have a high school diploma or Certificate of High School Equivalency (GED credentials), and three years paid or unpaid experience providing employment services to people with disabilities.

The individual provider must complete training required by HHSC.

Before entering into a provider agreement with the provider agency, HHSC verifies the providers' compliance with these qualifications through a credentialing process. Contracted providers are obligated to verify on an ongoing basis that these qualifications are achieved, maintained, and documented in personnel files. HHSC will conduct biennial review to verify these requirements continue to be met after the provider and HHSC enter into an agreement.

### Verification of Provider Qualifications

(For each provider type listed above. Copy rows as needed):

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<td>HHSC</td>
<td>Biennial</td>
</tr>
</tbody>
</table>

### Service Delivery Method

(Click each that applies):

- [ ] Participant-directed
- [✓] Provider managed

### Service Specifications

( Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):

<table>
<thead>
<tr>
<th>Service Title</th>
<th>Service Definition (Scope)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transportation</td>
<td>Transportation is offered in order to enable individuals served to gain access to services, activities, and resources, as specified in the IRP. This service is offered in addition to medical transportation required under 42 C.F.R. § 431.53 and transportation services under the State Plan, defined at 42 C.F.R. § 440.170(a) (if applicable), and will not replace them. Transportation services are offered in accordance with the individual's recovery plan. Whenever possible, family,</td>
</tr>
</tbody>
</table>


neighbors, friends, or community agencies that can provide this service without charge will be utilized. This service does not duplicate transportation provided as part of other services or under the State Plan medical transportation benefit.

HCBS-AMH Transportation Services are for non-medical transportation needs related to goals identified on the IRP and are mutually exclusive of State Plan medical transportation services. Contracted providers are required to provide and document service provision of HCBS-AMH in accordance with program policies and procedures and billing guidelines. HCBS-AMH documentation requirements for HCBS-AMH Transportation include date of contact; mileage log with start and stop time; printed name of service provider; location of origination and destination; and signature and credentials of service provider.

Documentation must support that claims for HCBS-AMH transportation are not duplicative or inclusive of transportation provided as part of another service, including other state plan transportation benefits.

- System edits will be in place to prevent duplicative billing.
- All Medicaid transportation services will be coordinated by the individual’s recovery manager and the relevant full-risk broker or managed transportation organization in the client’s area.
- The state Medicaid authority has final authority over approval of claims.
- The state will perform periodic review of claims data to check for duplicative claims.
- Where duplicative claims are found, the State will recoup claims payment.

HCBS-AMH Providers and direct service staff may not bill for Transportation Services when the transportation is related to or a part of another HCBS-AMH service such as Supported Home Living or Employment Services. Transportation activities associated with Supported Home Living and Employment Services shall be billed in accordance with the requirements of those services, respectively.

This 1915(i) service is only provided to individuals age 21 and over. All medically necessary non-emergency medical transportation services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.

Additional needs-based criteria for receiving the service, if applicable (specify):

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

☑️ Categorically needy (specify limits):

There is a limit of $2000 per individual per year for this service.

☐ Medically needy (specify limits):

N/A

Provider Qualifications (For each type of provider. Copy rows as needed):

<table>
<thead>
<tr>
<th>Provider Type (Specify):</th>
<th>License (Specify):</th>
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</thead>
<tbody>
<tr>
<td>HCBS provider agency that meets the minimum eligibility and standards for HCBS-AMH provider enrollment.</td>
<td></td>
<td></td>
<td>HCBS provider agency enrolled and contracted with HHSC to provide HCBS services, which employs or contracts with transportation vendors.</td>
</tr>
</tbody>
</table>

Individual transportation providers must be 18 years of age or older, pass a criminal background check, and have a valid driver’s license and proof of insurance.

Clients may also use specialized transport,
Verification of Provider Qualifications (For each provider type listed above. Copy rows as needed):

<table>
<thead>
<tr>
<th>Provider Type (Specify):</th>
<th>Entity Responsible for Verification (Specify):</th>
<th>Frequency of Verification (Specify):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transportation</td>
<td>HHSC</td>
<td>Biennial</td>
</tr>
</tbody>
</table>

Service Delivery Method. (Check each that applies):

- [ ] Participant-directed
- [✓] Provider managed

Service Specifications (Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):

<table>
<thead>
<tr>
<th>Service Title:</th>
<th>Community Psychiatric Supports and Treatment (CPST)</th>
</tr>
</thead>
</table>

Service Definition (Scope):

CPST are goal-directed supports and solution-focused interventions intended to achieve identified goals or objectives as set forth in the individual’s IRP. CPST is a face-to-face intervention with the individual present; however, family or other persons significant to the individual may also be involved. This service may include the following components:

- Assist the individual and family members or other collaterals to identify strategies or treatment options associated with the individual’s mental illness and/or substance use disorder, with the goal of minimizing the negative effects of symptoms, emotional disturbances, or associated environmental stressors which interfere with the individual’s daily living, financial management, housing, academic and/or employment progress, personal recovery or resilience, family and/or interpersonal relationships, and community integration.

- Provide individual supportive counseling, solution-focused interventions, emotional and behavioral management support, and behavioral analysis with the individual, with the goal of assisting the individual with developing and implementing social, interpersonal, self-care, daily living, and independent living skills to restore stability, support functional gains, and adapt to community living.

- Facilitate participation in and utilization of strengths based planning and treatments which include assisting the individual and family members or other collaterals with identifying strengths and needs, resources, natural supports, and developing goals and objectives to utilize personal strengths, resources, and natural supports to address functional deficits associated with their mental illness and/or substance use disorder.

- Assist the individual with effectively responding to or avoiding identified precursors or triggers that would risk their remaining in a natural community location, including assisting the individual and family members or other collaterals with identifying a potential psychiatric or personal crisis, developing a crisis management plan, and/or seeking other supports to restore stability and functioning, as appropriate.

- CPST addresses specific individual needs with evidence-based and evidence-informed psychotherapeutic practices designed specifically to meet those needs. Examples include, but are not limited to:
  - Cognitive Behavioral Therapy (CBT): CBT is an empirically supported treatment that focuses on maladaptive patterns of thinking and the beliefs that underlie such thinking. This includes variations of CBT specific to the needs of an individual, such as Cognitive Processing Therapy.
  - Dialectical Behavior Therapy (DBT): DBT is a form of CBT directed at individuals with borderline personality disorder or other disorders with chronic suicidal ideation and unstable relationships. It is a manual treatment program that provides support in managing chronic crisis and stress to keep individuals in outpatient treatment settings. It requires specialized training by the original developer or other entity approved by original developer (Marsha Linehan). The treatment program includes individual and group therapy sessions and requires homework by the individual. These therapies are provided by licensed therapists working under the direction of the HCBS provider agency.
This service may include the following components:

Assist the individual and family members or other collaterals to identify strategies or treatment options associated with the individual’s mental illness and/or substance use disorder, with the goal of minimizing the negative effects of symptoms, emotional disturbances, or associated environmental stressors which interfere with the individual’s daily living, financial management, housing, academic and/or employment progress, personal recovery or resilience, family and/or interpersonal relationships, and community integration.

Provide individual supportive counseling, solution-focused interventions, emotional and behavioral management support, and behavioral analysis with the individual, with the goal of assisting the individual with developing and implementing social, interpersonal, self-care, daily living, and independent living skills to restore stability, support functional gains, and adapt to community living.

Facilitate participation in and utilization of strengths based planning and treatments which include assisting the individual and family members or other collaterals with identifying strengths and needs, resources, natural supports, and developing goals and objectives to utilize personal strengths, resources, and natural supports to address functional deficits associated with their mental illness and/or substance use disorder.

Assist the individual with effectively responding to or avoiding identified precursors or triggers that would risk their remaining in a natural community location, including assisting the individual and family members or other collaterals with identifying a potential psychiatric or personal crisis, developing a crisis management plan, and/or seeking other supports to restore stability and functioning, as appropriate.

CPST addresses specific individual needs with evidence-based and evidence-informed psychotherapeutic practices designed specifically to meet those needs. Examples include, but are not limited to:

Cognitive Behavioral Therapy (CBT): CBT is an empirically supported treatment that focuses on maladaptive patterns of thinking and the beliefs that underlie such thinking. This includes variations of CBT specific to the needs of an individual, such as Cognitive Processing Therapy.

Dialectical Behavior Therapy (DBT): DBT is a form of CBT directed at individuals with borderline personality disorder or other disorders with chronic suicidal ideation and unstable relationships. It is a manual treatment program that provides support in managing chronic crisis and stress to keep individuals in outpatient treatment settings. It requires specialized training by the original developer or other entity approved by original developer (Marsha Linehan). The treatment program includes individual and group therapy sessions and requires homework by the individual. These therapies are provided by licensed therapists working under the direction of the HCBS provider agency.
Additional needs-based criteria for receiving the service, if applicable (specify):

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

✔ Categorically needy (specify limits):

Community Psychiatric Support and Treatment (CPST) services are provided as part of a comprehensive specialized psychiatric program available to all Medicaid eligible adults with significant functional impairments meeting the need levels in the 1915(i).

Medical necessity for these treatment services must be determined by a licensed behavioral health practitioner (LBHP) or physician who is acting within the scope of his/her professional license and applicable state law and furnished by or under the direction of a licensed practitioner to promote the maximum reduction of symptoms and/or restoration of an individual to his/her best age-appropriate functional level. The LBHP or physician may conduct an assessment consistent with state law, regulation, and policy. A unit of service is defined according to the HCPCS approved code set unless otherwise specified. If the determination of medical necessity for CPST requires additional assessment, this assessment may be conducted as part of the service up to one unit of the service.

This service may not be provided on the same day and at the same time as services that contain elements integral to the delivery of this service.

☐ Medically needy (specify limits):

N/A

Provider Qualifications (For each type of provider. Copy rows as needed):

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>License</th>
<th>Certification</th>
<th>Other Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCBS Provider agency</td>
<td>LPC, LMFT, LCSW, PhD psychologist, RN or MD (for individual therapists), Licensure candidates may provide services as part of a graduate education program under the direct supervision of an appropriately licensed professional.</td>
<td></td>
<td>HCBS provider agency enrolled and contracted with HHSC to provide HCBS services, which employs or contracts with licensed practitioners with demonstrated competence in specialized mental health therapies. Direct-care therapists must be trained, credentialed, and demonstrate competence in the specialized psychotherapy practice used. Individual service providers must be determined to be a clinician under State regulations, meaning a person with a doctoral or master’s degree in psychology, counseling, social work, nursing, rehabilitation, or related field from an accredited college or university (or a registered nurse with a certificate in mental health nursing from the American Nurses Association).</td>
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</tbody>
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Verification of Provider Qualifications (For each provider type listed above. Copy rows as needed):

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Entity Responsible for Verification</th>
<th>Frequency of Verification</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCBS Provider agency that meets</td>
<td>HHSC</td>
<td>Biennial</td>
</tr>
</tbody>
</table>
Service Delivery Method. (Check each that applies):

- [ ] Participant-directed
- [x] Provider managed

Service Specifications (Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):

Service Title: Peer Support

Service Definition (Scope):

Peer support services are provided by self-identified consumers who are in recovery from mental illness and/or substance use disorders. Peer support specialists use their own experiences with mental illness, substance use disorder (SUD), and/or another co-occurring disorders (such as a chronic health condition), to help individuals reach their recovery goals. Peer support providers are supervised by mental health professionals or licensed SUD treatment providers, working under the direction of the HCBS provider agency, and are trained to deliver peer services. The services are coordinated within the context of a comprehensive, individual recovery plan that includes specific individualized goals and delineates activities intended to achieve the identified goals.

Peer Support services promote coping skills, facilitate use of natural resources/supports, and enhance recovery-oriented attributes such as hope and self-efficacy. The activities provided by this service emphasize the opportunity for consumers to support each other in the restoration and expansion of the skills and strategies necessary to move forward in recovery.

Additional needs-based criteria for receiving the service, if applicable (specify):

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

- [x] Categorically needy (specify limits):
  Peer Support is available daily, limited to no more than four hours per day for an individual client. Progress notes document the individual’s progress relative to goals identified in the IRP.
  Peer services are not a substitute for or adjunct to other HCBS services such as HCBS Psychosocial Rehabilitation or Community Psychiatric Supports and Treatment.

- [ ] Medically needy (specify limits):
  N/A

Provider Qualifications (For each type of provider. Copy rows as needed):

<table>
<thead>
<tr>
<th>Provider Type (Specify):</th>
<th>License (Specify):</th>
<th>Certification (Specify):</th>
<th>Other Standard (Specify):</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCBS Provider Agency that meets the minimum eligibility and standards for HCBS-AMH provider enrollment.</td>
<td>Peer Specialists must be recognized under a HHSC-approved process for MH or SUD peers.</td>
<td>HCBS provider agency enrolled and contracted with HHSC to provide HCBS services, which employs or has agreements with recognized Peer Specialists.</td>
<td>Individual providers must maintain a HHSC-approved certification to be mental health or substance use disorder peer specialists. At</td>
</tr>
</tbody>
</table>
minimum, individuals must also be 18 years of age or older and have common life experiences with the individual, such as having a mental health or substance use condition, using services or supports for mental health and substance use conditions and being in a recovery process.

Verification of Provider Qualifications (For each provider type listed above. Copy rows as needed):

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<thead>
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<td>HCBS Provider Agency that meets the minimum eligibility and standards for HCBS-AMH provider enrollment.</td>
<td>HHSC</td>
<td>Biennial</td>
</tr>
</tbody>
</table>

Service Delivery Method. (Check each that applies):
- [ ] Participant-directed
- ✔ Provider managed

Service Specifications (Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):

<table>
<thead>
<tr>
<th>Service Title:</th>
<th>Host Home/Companion Care</th>
</tr>
</thead>
</table>

Service Definition (Scope):

Host Home/Companion Care services are supportive and health-related residential services provided to individuals in the individual’s own home or in settings licensed or approved by the State of Texas. Host Home/Companion Care services are necessary, as specified in the individual’s person-directed IRP, to enable the individual to remain integrated in the community and ensure the health, welfare, and safety of the individual in accordance with 42 C.F.R. § 441.710. (Refer to Section 9 “Home and Community-Based Settings” for HCBS-AMH settings requirements.) Community-based residential services include personal care and supportive services (homemaker, chores, attendant services, and meal preparation) that are furnished to individuals who reside in homelike, non-institutional, integrated settings. In addition, they include 24-hour onsite response capability to meet scheduled and unscheduled or unpredictable resident needs and to provide supervision and safety. Services also include social and recreational programming and medication assistance (to the extent permitted under state law).

Home and Community-Based Settings must:
- Be integrated in and support full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
- Be selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting.
- Ensure rights of privacy, dignity and respect, and freedom from coercion and restraint.
- Optimize, but not regiment, individual initiative, autonomy, and independence in making life choices, daily activities, physical environment, and with whom to interact.
- Facilitate individual choice regarding services and supports, and who provides them.

Host home/companion care services promote recovery by supporting individual recovery goals, using natural supports and typical community services available to all people, enabling social interaction and participation in leisure activities, and helping the individual develop daily living and functional living skills. This service also fosters the individual’s recovery and independence by providing personal assistance with activities of daily living (grooming, eating, bathing, dressing, and personal hygiene) and functional living tasks; assistance with planning and preparing meals; transportation or assistance in securing transportation; assistance with ambulation and mobility; reinforcement of specialized rehabilitative, habilitative, or psychosocial therapies/activities; assistance with medications based upon the results of an RN assessment and the performance of tasks delegated by a RN in...
accordance with the Texas Board of Nursing rules as defined by Title 22 of the Texas Administrative Code, Part 11, Chapter 225; and supervision of the individual’s safety and security. Host home/companion care is provided in a private residence meeting HCBS requirements by a host home or companion care provider who lives in the residence. In a host home arrangement, the host home provider owns or leases the residence. In a companion care arrangement, the residence may be owned or leased by the companion care provider or may be owned or leased by the individual. Transportation costs are included in the rate. Type and frequency of supervision is determined on an individual basis based on the level of need for each individual.

The HCBS-AMH provider agency will be encouraged to hire providers to deliver personal care services separate from those who provide rehabilitation services, if there is more than one provider on-site at the residence during normal hours who can provide personal care services. This will ensure that the clinical boundary issues that would otherwise complicate rehabilitation services (if the same staff were also delivering personal care services) will be mitigated.

The individual receiving Host Home/Companion Care services has a right to privacy. Sleeping and individual living units may be locked at the discretion of the individual, with keys available only to appropriate providers or landlords. Provider access to living units will be documented in the IRP. The IRP will identify when persons other than the individual have access, what types of persons have access, and under what circumstances staff will be allowed to access an individual’s unit. In order to justify a modification of person-centered residence requirements, the IRP must document: a specific and individualized assessed need; the positive interventions and supports used prior to any modifications; less intrusive methods of meeting the need that have been tried but did not work; a clear description of the condition that is directly proportionate to the specific assessed need; regular collection and review of data to measure the ongoing effectiveness of the modification; established time limits for periodic reviews to determine if the modification is still necessary or can be terminated; informed consent of the individual; and assurance that interventions and supports will cause no harm to the individual.

Individuals have the freedom and support to control their own schedules and activities, and have access to food and visitors of their choosing at any time, and have the freedom to furnish and decorate units. Settings facilitate individual choice regarding services and supports and who provide them.

Each living unit is separate and distinct from each other. The individual retains the right to assume risk, tempered only by the individual’s ability to assume responsibility for that risk. Services must be furnished in a way that fosters the independence of each individual to facilitate recovery. Routines of service delivery must be individual-driven to the maximum extent possible and each individual must be treated with dignity and respect. The IRP will document any planned intervention which could potentially impinge on individual autonomy. Documentation will include informed consent of the individual to the intervention; the specific need for the intervention in supporting the individual to achieve his/her goals; assurance that the intervention is the most inclusive and person-centered option; time limits for the intervention, periodic reviews of the intervention to determine if it is still needed, and assurance that the intervention will cause no harm to the individual.

This service will be provided to meet the individual’s needs as determined by an individualized assessment performed in accordance HHSC requirements and as outlined in the individual’s IRP.

Host Home/Companion Care services are available to individuals as they are determined necessary, based upon a quarterly assessment documented in the IRP and approved by HHSC.

HHSC will review the authorized residential service on an ongoing basis to ensure that it is community-based, inclusive, and meets federal and state HCBS setting requirements. HHSC staff will conduct biennial reviews of residential services in all settings, and will conduct unannounced site visits to provider owned or operated settings. If the monitoring suggests that a change in service is needed, an independent re-assessment will be conducted by HHSC or its designee to re-evaluate the participant to determine the appropriateness of the service in accordance with HHSC requirements.

The HCBS-AMH provider agency must implement and maintain a plan for initial and periodic training of staff members and service providers that ensures staff members and service providers are qualified to deliver services as required by the current needs and characteristics of the individuals to whom they deliver services and are knowledgeable of acts that constitute abuse, neglect, or exploitation of an individual and methods to prevent the occurrence of abuse, neglect, and exploitation.

Periodic training is delivered by the HCBS-AMH provider agency, as needed, to ensure service providers are
qualified to provide HCBS-AMH services in accordance with state and federal laws and regulations; and to ensure the individual’s safety and security.

Periodic training is delivered by the HCBS-AMH provider agency, as needed, to ensure service providers are qualified to provide HCBS-AMH services in accordance with state and federal laws and regulations; and to ensure the individual’s safety and security.

Additional needs-based criteria for receiving the service, if applicable (specify):

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services. (Choose each that applies):

✔ Categorically needy (specify limits):
  Payments for Host-home/Companion Care are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep, and improvement. An individual may receive only one type of residential assistance (Host-home/Companion Care, Assisted Living, Supervised Living, or Supported Home Living) at a time.

  Separate payments will not be made for respite, personal assistance, home-delivered meals, minor home modifications, non-medical transportation, or transition assistance services for individuals who receive Host-Home/Companion Care in provider owned or operated settings.

  Individuals receiving adult foster care or Department of Family and Protective Services foster care services may not also receive Host Home/Companion Care services.

  Texas ensures duplication of services does not occur by prohibiting payment for services without authorization. Two entities may not be paid for providing the same service to the same individual during the same time period.

  Individuals are responsible for their room and board costs.

  This service may not be provided on the same day and at the same time as services that contain elements integral to the delivery of this service.

  Services that are provided by third parties must be coordinated with the Host Home/Companion Care provider and through the recovery manager, including community-based rehabilitative services provided outside of the residence.

  Host Home/Companion Care services should be provided only in settings within Texas, which meet home and community-based characteristic requirements for the type of residential support provided. Residential services cannot be provided in or on the grounds of the following settings:
  • Nursing facilities;
  • Institutions for mental disease;
  • Intermediate care facilities for individuals with Intellectual or Developmental Disabilities;
  • Inpatient hospitals; or
  • Any other location that has qualities of an institutional setting.

☐ Medically needy (specify limits):
  N/A

Provider Qualifications (For each type of provider. Copy rows as needed):

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<td>HCBS Provider agency that meets</td>
<td></td>
<td></td>
<td>HCBS provider agency enrolled and contracted with HHSC to provide HCBS</td>
</tr>
</tbody>
</table>
services, which employs or has agreements with Host Home/Companion Care Providers.

Residential settings must meet relevant state and local requirements.

Individual direct service providers must be at least 18 years of age. The employee provider must have a high school diploma or Certificate of High School Equivalency (GED credentials) or documentation of a proficiency evaluation of experience and competence to perform job tasks including ability to provide the required services as needed by the individual to be served as demonstrated through a written competency-based assessment. The individual provider must pass a criminal background check and also have at least three personal references from persons not related within three degrees of consanguinity that evidence the ability to provide a safe and healthy environment for the individual(s) to be served.

Transportation of individuals must be provided in accordance with applicable state laws. Individuals transporting individuals must be 18 years of age or older; pass a criminal background check; and must have a valid driver's license and proof of insurance.

Assisting with tasks delegated by an RN must be in accordance with state law.

Individual providers of Host Home/Companion Care must complete initial and periodic training provided by HCBS provider agency which includes HHSC-required training in the HCBS-AMH program.

Before entering into a provider agreement with the provider agency, HHSC verifies the providers’ compliance with these qualifications through a credentialing process. Contracted providers are obligated to verify on an ongoing basis that these qualifications are achieved, maintained, and documented in personnel files. HHSC will conduct biennial review to verify these requirements continue to be met after the provider and HHSC enter into an agreement.

### Verification of Provider Qualifications

*For each provider type listed above. Copy rows as needed:*

<table>
<thead>
<tr>
<th>Provider Type (Specify):</th>
<th>Entity Responsible for Verification (Specify):</th>
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<tbody>
<tr>
<td>HCBS Provider Agency that meets</td>
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<td>Biennial</td>
</tr>
</tbody>
</table>
Service Delivery Method. (Check each that applies):

- [ ] Participant-directed
- [x] Provider managed

Service Specifications (Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):

<table>
<thead>
<tr>
<th>Service Title</th>
<th>Supervised Living Services</th>
</tr>
</thead>
</table>

Service Definition (Scope):

Supervised Living Services are supportive and health-related residential services provided to individuals in settings licensed or approved by the State of Texas. Residential services are necessary, as specified in the individual’s person-directed IRP, to enable the individual to remain integrated in the community and ensure the health, welfare, and safety of the individual in accordance with 42 C.F.R. § 441.710. (Refer to Section 9 “Home and Community-Based Settings” for HCBS-AMH settings requirements.) Supervised Living Services include personal care and supportive services (homemaker, chores, attendant services, and meal preparation) that are furnished to individuals who reside in homelike, non-institutional, integrated settings. In addition, they include 24-hour onsite response capability to meet scheduled and unscheduled or unpredictable resident needs and to provide supervision and safety. Services also include social and recreational programming and medication assistance (to the extent permitted under state law).

Home and Community-Based Settings must:
- Be integrated in and support full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
- Be selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting.
- Ensure rights of privacy, dignity and respect, and freedom from coercion and restraint.
- Optimize, but not regiment, individual initiative, autonomy, and independence in making life choices, daily activities, physical environment, and with whom to interact.
- Facilitate individual choice regarding services and supports, and who provides them

Supervised Living Services promote recovery by supporting individual recovery goals, using natural supports and typical community services available to all people, enabling social interaction and participation in leisure activities, and helping the individual develop daily living and functional living skills. Supervised living also fosters recovery and independence by providing individuals with personal assistance with activities of daily living (grooming, eating, bathing, dressing, and personal hygiene) and functional living tasks; assistance with planning and preparing meals; transportation or assistance in securing transportation; assistance with ambulation and mobility; reinforcement of specialized rehabilitative, habilitative or psychosocial therapies; assistance with medications based upon the results of an RN assessment; the performance of tasks delegated by a RN in accordance with the Texas Board of Nursing rules as defined by Title 22 of the Texas Administrative Code, Part 11, Chapter 225; and supervision of the individual’s safety and security. Transportation costs included in the rate for the supervised living service are for providing transportation to the participant and not provider staff.

Supervised living provides residential assistance as needed by individuals who live in residences in which the HCBS provider holds a property interest and that meet program certification standards. This service may be provided to individuals in one of two modalities:
- By providers who are not awake during normal sleep hours but are present in the residence and able to respond to the needs of individuals during normal sleeping hours; or
- By providers assigned on a shift schedule that includes at least one complete change of staff each day.

Transportation costs are included in the rate. Type and frequency of supervision is determined on an individual basis based on the level of need for each individual.

The individual receiving supervised living services has a right to privacy. Sleeping and individual living units may be locked at the discretion of the individual, with keys available only to appropriate staff or landlords. Staff...
access to living units will be documented in the IRP. The IRP will identify when staff members have access, what types of staff have access, and under what circumstances staff will be allowed to access an individual’s unit. In order to justify a modification of person-centered residence requirements, the IRP must document: a specific and individualized assessed need; the positive interventions and supports used prior to any modifications; less intrusive methods of meeting the need that have been tried but did not work; a clear description of the condition that is directly proportionate to the specific assessed need; regular collection and review of data to measure the ongoing effectiveness of the modification; established time limits for periodic reviews to determine if the modification is still necessary or can be terminated; informed consent of the individual; and assurance that interventions and supports will cause no harm to the individual.

Individuals have the freedom and support to control their own schedules and activities, and have access to food and visitors of their choosing at any time, and have the freedom to furnish and decorate units. Settings facilitate individual choice regarding services and supports and who provide them.

Each living unit is separate and distinct from each other. The individual retains the right to assume risk, tempered only by the individual’s ability to assume responsibility for that risk. Services must be furnished in a way that fosters the independence of each individual to facilitate recovery. Routines of service delivery must be individual-driven to the maximum extent possible and each individual must be treated with dignity and respect. The IRP will document any planned intervention which could potentially impinge on individual autonomy. Documentation will include informed consent of the individual to the intervention; the specific need for the intervention in supporting the individual to achieve his/her goals; assurance that the intervention is the most inclusive and person-centered option; time limits for the intervention, periodic reviews of the intervention to determine if it is still needed, and assurance that the intervention will cause no harm to the individual.

The HCBS AMHI provider agency will be encouraged to hire providers to deliver personal care services separate from those who provide rehabilitation services, if there is more than one provider on-site at the residence during normal hours who can provide personal care services. This will ensure that the clinical boundary issues that would otherwise complicate rehabilitation services (if the same staff were also delivering personal care services) will be mitigated.

This service will be provided to meet the individual’s needs as determined by an individualized assessment performed in accordance HHSC requirements and as outlined in the individual’s IRP.

Supervised Living Services are available to individuals as they are determined necessary, based upon a quarterly assessment documented in the IRP and approved by HHSC.

HHSC will review the authorized residential service on an ongoing basis to ensure that it is community-based, inclusive, and meets federal and state HCBS setting requirements. HHSC staff will conduct biennial reviews of residential services in all settings, and will conduct unannounced site visits to provider owned or operated settings. HHSC conducts biennial on-site reviews of community-based settings to ensure that settings do not have the qualities of an institutional setting, meet HCBS setting requirements, and promote choice and community inclusion. If the monitoring suggests that a change in service is needed, an independent re-assessment will be conducted by HHSC or its designee to re-evaluate the participant to determine the appropriateness of the service in accordance with HHSC requirements.

The HCBS-AMHI provider agency must implement and maintain a plan for initial and periodic training of staff members and service providers that ensures staff members and service providers are qualified to deliver services as required by the current needs and characteristics of the individuals to whom they deliver services and are knowledgeable of acts that constitute abuse, neglect, or exploitation of an individual and methods to prevent the occurrence of abuse, neglect, and exploitation.

Periodic training is delivered by the HCBS-AMHI provider agency, as needed, to ensure service providers are qualified to provide HCBS-AMHI services in accordance with state and federal laws and regulations; and to ensure the individual’s safety and security.

Additional needs-based criteria for receiving the service, if applicable (specify):
Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

*(Choose each that applies):*

**Categorically needy (specify limits):**

- Supervised living services can only be provided in settings approved by HHSC or in licensed assisted living facilities with no more than 4 beds. HHSC approved settings with more than four beds must maintain a staffing ratio of 4:1.

  Payments for Supervised Living are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep, and improvement. An individual may receive only one type of residential assistance (Host-home/Companion Care, Assisted Living, Supervised Living, or Supported Home Living) at a time.

  Separate payments will not be made for respite, personal assistance, home-delivered meals, minor home modifications, non-medical transportation, or transition assistance services for individuals who receive Supervised Living in provider owned or operated settings.

  Individuals receiving adult foster care or Department of Family and Protective Services foster care services may not also receive Supervised Living Services.

  Texas ensures duplication of services does not occur by prohibiting payment for services without authorization. Two entities may not be paid for providing the same service to the same individual during the same time period.

  Individuals are responsible for their room and board costs.

  This service may not be provided on the same day and at the same time as services that contain elements integral to the delivery of this service.

  Services that are provided by third parties must be coordinated with the Supervised Living Services provider and through the recovery manager, including community-based rehabilitative services provided outside of the residence.

  Supervised Living Services should be provided only in settings within Texas, which meet home and community-based characteristic requirements for the type of residential support provided. Supervised Living Services cannot be provided in or on the grounds of the following settings:

  - Nursing facilities;
  - Institutions for mental disease;
  - Intermediate care facilities for individuals with Intellectual or Developmental Disabilities;
  - Inpatient hospitals; or
  - Any other location that has qualities of an institutional setting.

**Medically needy (specify limits):**

- N/A

**Provider Qualifications (For each type of provider. Copy rows as needed):**

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<td></td>
<td>HCBS provider agency enrolled and contracted with HHSC to provide HCBS services, which employs or has agreements with Supervised Living Services Providers. Residential settings must meet relevant state and local requirements.</td>
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</tbody>
</table>
Individual direct service providers must be at least 18 years of age. The employee provider must have a high school diploma or Certificate of High School Equivalency (GED credentials) or documentation of a proficiency evaluation of experience and competence to perform job tasks including ability to provide the required services as needed by the individual to be served as demonstrated through a written competency-based assessment. The individual provider must pass a criminal background check and also have at least three personal references from persons not related within three degrees of consanguinity that evidence the ability to provide a safe and healthy environment for the individual(s) to be served.

Transportation of individuals must be provided in accordance with applicable state laws. Individuals transporting individuals must be 18 years of age or older; pass a criminal background check; and must have a valid driver's license and proof of insurance.

Assisting with tasks delegated by an RN must be in accordance with state law.

Individual providers of Supervised Living Services must complete initial and periodic training provided by HCBS provider agency which includes HHSC-required training in the HCBS-AMH program.

Before entering into a provider agreement with the provider agency, HHSC verifies the providers' compliance with these qualifications through a credentialing process. Contracted providers are obligated to verify on an ongoing basis that these qualifications are achieved, maintained, and documented in personnel files. HHSC will conduct annual review to verify these requirements continue to be met after the provider and HHSC enter into an agreement.

**Verification of Provider Qualifications** *(For each provider type listed above. Copy rows as needed):*

<table>
<thead>
<tr>
<th>Provider Type <em>(Specify):</em></th>
<th>Entity Responsible for Verification <em>(Specify):</em></th>
<th>Frequency of Verification <em>(Specify):</em></th>
</tr>
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<tr>
<td>HCBS Provider Agency that meets the minimum eligibility and standards for HCBS-AMH provider enrollment.</td>
<td>HHSC</td>
<td>Annual</td>
</tr>
</tbody>
</table>

**Service Delivery Method.** *(Check each that applies):*
## Service Specifications

(*Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover:*)

<table>
<thead>
<tr>
<th>Service Title:</th>
<th>Assisted Living Services</th>
</tr>
</thead>
</table>

### Service Definition (Scope):

Assisted Living Services are supportive and health-related residential services provided to individuals in settings licensed or approved by the State of Texas. Residential services are necessary, as specified in the individual’s person-directed IRP, to enable the individual to remain integrated in the community and ensure the health, welfare, and safety of the individual in accordance with 42 C.F.R. § 441.710. (Refer to Section 9 “Home and Community-Based Settings” for HCBS-AMH settings requirements.) Assisted Living Services include personal care and supportive services (homemaker, chores, attendant services, and meal preparation) that are furnished to individuals who reside in homelike, non-institutional, integrated settings. In addition, they include 24-hour onsite response capability to meet scheduled and unscheduled or unpredictable resident needs and to provide supervision and safety. Services also include social and recreational programming and medication assistance (to the extent permitted under state law).

### Home and Community-Based Settings must:

- Be integrated in and support full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
- Be selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting.
- Ensure rights of privacy, dignity and respect, and freedom from coercion and restraint.
- Optimize, but not regiment, individual initiative, autonomy, and independence in making life choices, daily activities, physical environment, and with whom to interact.
- Facilitate individual choice regarding services and supports, and who provides them.

Assisted Living Services are personal care, homemaker, and chore services; medication oversight; and therapeutic, social, and recreational programming provided in a home-like environment in a licensed community setting in conjunction with residing in the assisted living setting. This service includes 24-hour on-site response staff to meet scheduled or unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety, and security. Other individuals or agencies may also furnish care directly or under arrangement with the community setting, but the services provided by these other entities supplement that provided by the community setting and do not supplant it. Assisted living is furnished to individuals who reside in their own living units/bedrooms, which may include dually-occupied units when both occupants consent to the arrangement, that contain toilet facilities, and may or may not include kitchenette and/or living rooms. The assisted living setting must have a central dining room; living room or parlor; and/or common activity center(s) (which may also serve as living rooms or dining rooms). Individuals have the freedom and support to control their own schedules and activities, have access to food and visitors of their choosing at any time, have access at any time to the common/shared areas (including kitchens, living rooms, and activity centers), and have the freedom to furnish and decorate units. Individuals in assisted living settings, where units do not have a private kitchen/kitchenette and/or living room or parlor, have full access to a shared kitchen with cooking facilities and comfortable seating in the shared areas for private visits with family and friends.

The HCBS AMH provider agency will be encouraged to hire providers to deliver personal care services separate from those who provide rehabilitation services, if there is more than one provider on-site at the residence during normal hours who can provide personal care services. This will ensure that the clinical boundary issues that would otherwise complicate rehabilitation services (if the same staff were also delivering personal care services) will be mitigated.

This service will be provided to meet the individual’s needs as determined by an individualized assessment performed in accordance HHSC requirements and as outlined in the individual’s IRP.

Assisted Living Services are available to individuals as they are determined necessary, based upon a quarterly assessment documented in the IRP and approved by HHSC.
The individual receiving Assisted Living Services has a right to privacy. Sleeping and individual living units may be locked at the discretion of the individual, with keys available only to appropriate staff or landlords. Staff access to living units will be documented in the IRP. The IRP will identify when staff members have access, what types of staff have access, and under what circumstances staff will be allowed to access an individual’s unit. In order to justify a modification of person-centered residence requirements the IRP must document: a specific and individualized assessed need; the positive interventions and supports used prior to any modifications; less intrusive methods of meeting the need that have been tried but did not work; a clear description of the condition that is directly proportionate to the specific assessed need; regular collection and review of data to measure the ongoing effectiveness of the modification; established time limits for periodic reviews to determine if the modification is still necessary or can be terminated; informed consent of the individual; and assurance that interventions and supports will cause no harm to the individual. Settings facilitate individual choice regarding services and supports and who provides them.

Each living unit is separate and distinct from each other. The individual retains the right to assume risk, tempered only by the individual’s ability to assume responsibility for that risk. Services must be furnished in a way that fosters the independence of each individual to facilitate recovery. Routines of service delivery must be individual-driven to the maximum extent possible and each individual must be treated with dignity and respect. The IRP will document any planned intervention which could potentially impinge on individual autonomy. Documentation will include informed consent of the individual to the intervention; the specific need for the intervention in supporting the individual to achieve his/her goals; assurance that the intervention is the most inclusive and person-centered option; time limits for the intervention, periodic reviews of the intervention to determine if it is still needed, and assurance that the intervention will cause no harm to the individual.

HHSC will review the authorized residential service on an ongoing basis to ensure that it is community-based, inclusive, and meets federal and state HCBS setting requirements. HHSC staff will conduct biennial reviews of residential services in all settings, and will conduct unannounced site visits to provider owned or operated settings. HHSC conducts biennial on-site reviews of community-based settings to ensure that settings do not have the qualities of an institutional setting, meet HCBS setting requirements, and promote choice and community inclusion. If the monitoring suggests that a change in service is needed, an independent re-assessment will be conducted by HHSC or its designee to re-evaluate the participant to determine the appropriateness of the service in accordance with HHSC requirements.

The HCBS-AMH provider agency must implement and maintain a plan for initial and periodic training of staff members and service providers that ensures staff members and service providers are qualified to deliver services as required by the current needs and characteristics of the individuals to whom they deliver services and are knowledgeable of acts that constitute abuse, neglect, or exploitation of an individual and methods to prevent the occurrence of abuse, neglect, and exploitation.

Periodic training is delivered by the HCBS-AMH provider agency, as needed, to ensure service providers are qualified to provide HCBS-AMH services in accordance with state and federal laws and regulations); and to ensure the individual’s safety and security.

Additional needs-based criteria for receiving the service, if applicable (specify):

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

- **Categorically needy (specify limits):**
  - Payments for Assisted Living are not made for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep, and improvement. An individual may receive only one type of residential assistance (Host-home/Companion Care, Assisted Living, Supervised Living, or Supported Home Living) at a time.
  - Separate payments will not be made for respite, personal assistance, home-delivered meals, minor home modifications, non-medical transportation, or transition assistance services for individuals who receive
Assisted Living.

Individuals receiving adult foster care or Department of Family and Protective Services foster care services may not also receive Assisted Living Services.

Nursing and skilled therapy services (except periodic nursing evaluations) are incidental, rather than integral to providing assisted living services. Payment will not be made for 24-hour skilled care.

Texas ensures duplication of services does not occur by prohibiting payment for services without authorization. Two entities may not be paid for providing the same service to the same individual during the same time period.

Individuals are responsible for their room and board costs.

This service may not be provided on the same day and at the same time as services that contain elements integral to the delivery of this service.

Services that are provided by third parties must be coordinated with the Assisted Living Services provider and through the recovery manager, including community-based rehabilitative services provided outside of the residence.

Assisted Living Services should be provided only in settings within Texas, which meet home and community-based characteristic requirements for the type of residential support provided. Assisted Living Services cannot be provided in or on the grounds of the following settings:

- Nursing facilities;
- Institutions for mental disease;
- Intermediate care facilities for individuals with Intellectual or Developmental Disabilities;
- Inpatient hospitals; or
- Any other location that has qualities of an institutional setting.

Medically needy (specify limits):

Provider Qualifications (For each type of provider. Copy rows as needed):

<table>
<thead>
<tr>
<th>Provider Type (Specify)</th>
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<td></td>
<td>HCBS provider agency enrolled and contracted with HHSC to provide HCBS services, which employs or has agreements with Assisted Living Services Providers.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Residential settings must meet relevant state and local requirements.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Individual direct service providers must be at least 18 years of age. The provider must have a high school diploma or Certificate of High School Equivalency (GED credentials) or documentation of a proficiency evaluation of experience and competence to perform job tasks including ability to provide the required services as needed by the individual to be served as demonstrated through a written competency-based assessment. The individual provider must pass a criminal background check and also have at least three personal references from persons not related within three degrees of consanguinity that evidence the ability to provide a safe and healthy</td>
</tr>
</tbody>
</table>
environment for the individual(s) to be served.

Transportation of individuals must be provided in accordance with applicable state laws. Individuals transporting individuals must be 18 years of age or older; pass a criminal background check; and must have a valid driver's license and proof of insurance.

Assisting with tasks delegated by an RN must be in accordance with state law.

Individual providers of Assisted Living Services must complete initial and periodic training provided by HCBS provider agency which includes HHSC-required training in the HCBS-AMH program.

Before entering into a provider agreement with the provider agency, HHSC verifies the providers’ compliance with these qualifications through a credentialing process. Contracted providers are obligated to verify on an ongoing basis that these qualifications are achieved, maintained, and documented in personnel files. HHSC will conduct annual review to verify these requirements continue to be met after the provider and HHSC enter into an agreement.

### Verification of Provider Qualifications

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<td>HHSC</td>
<td>Annual</td>
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</table>

### Service Delivery Method. (Check each that applies):

- [x] Participant-directed
- [ ] Provider managed

### Service Specifications

*(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover)*:

<table>
<thead>
<tr>
<th>Service Title:</th>
<th>Supported Home Living</th>
</tr>
</thead>
</table>

**Service Definition (Scope):**

Supported Home Living services are supportive and health-related residential services provided to individuals in their own home or family home or in a setting licensed or approved by the State of Texas. Residential services are necessary, as specified in the individuals person-directed IRP, to enable the individual to remain integrated in the community and ensure the health, welfare, and safety of the individual in accordance with 42 CFR § 441.710. (Refer to Section 9 “Home and Community-Based Settings” for HCBS-AMH settings requirements.) Supported Home Living services include personal care and supportive services (homemaker, chores, attendant services, and meal preparation) that are
furnished to individuals who reside in homelike, non-institutional, integrated settings. Services also include social and recreational programming and medication assistance (to the extent permitted under state law).

Home and Community-Based Settings must:
Be integrated in and support full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community, to the same degree of access as individuals not receiving Medicaid HCBS.
Be selected by the individual from among setting options including non-disability specific settings and an option for a private unit in a residential setting.
Ensure rights of privacy, dignity and respect, and freedom from coercion and restraint.
Optimize, but not regiment, individual initiative, autonomy, and independence in making life choices, daily activities, physical environment, and with whom to interact.
Facilitate individual choice regarding services and supports, and who provides them

Supported Home Living services assist individuals living in community-based residences. Supported home living promotes individual recovery and community inclusion by providing individuals with direct personal assistance with activities of daily living (grooming, eating, bathing, dressing, and personal hygiene) and functional living tasks; assistance with planning and preparing meals; transportation or assistance in securing transportation; assistance with ambulation and mobility; reinforcement specialized rehabilitative, habilitative, or psychosocial mental health therapies/activities; assistance with medications and the performance of tasks delegated by a registered nurse in accordance with the Texas Board of Nursing rules as defined by Title 22 of the Texas Administrative Code, Part 11, Chapter 225; and supervision as needed to ensure the individual’s health and safety; and supervision of the individual’s safety and security. This service includes activities that facilitate the individual’s inclusion in community activities, use of natural supports and typical community services available to all people, social interaction, and participation in leisure activities, and development of socially valued behaviors and daily living and functional living skills.

Services must be furnished in a way that fosters the independence of each individual to facilitate recovery. Routines of service delivery must be individual-driven to the maximum extent possible and each individual must be treated with dignity and respect. The IRP will document any planned intervention which could potentially impinge on individual autonomy. Documentation will include informed consent of the individual to the intervention; the specific need for the intervention in supporting the individual to achieve his/her goals; assurance that the intervention is the most inclusive and person-centered option; time limits for the intervention, periodic reviews of the intervention to determine if it is still needed, and assurance that the intervention will cause no harm to the individual.

The individual receiving supported home living has a right to privacy. Sleeping and individual living units may be locked at the discretion of the individual, with keys available only to landlords or appropriate service providers. Service providers with access to living units will be documented in the IRP. The IRP will identify when service providers have access, what types of service providers have access, and under what circumstances service providers will be allowed to access an individual’s unit. In order to justify a modification of person-centered residence requirements, the IRP must document: a specific and individualized assessed need; the positive interventions and supports used prior to any modifications; less intrusive methods of meeting the need that have been tried but did not work; a clear description of the condition that is directly proportionate to the specific assessed need; regular collection and review of data to measure the ongoing effectiveness of the modification; established time limits for periodic reviews to determine if the modification is still necessary or can be terminated; informed consent of the individual; and assurance that interventions and supports will cause no harm to the individual.

Supported Home Living services can be provided to individuals residing in their own or family
residence. When supported home living is provided to individuals residing with their family members, it is designed to support rather than supplant the family and natural supports. Individuals residing in their own homes receive supported home living as necessary, based on the individual’s IRP, to support them in their independent residence.

Transportation provided to individuals in accordance with HHSC guidelines is a billable supported home living service. Transportation costs which are not billable, but which are incurred to provide the supported home living service, are included in the indirect portion of the rate.

This service will be provided to meet the individual’s needs as determined by an individualized assessment performed in accordance HHSC requirements and as outlined in the individual’s IRP.

Supported home living services are available to individuals as they are determined necessary, based upon a quarterly assessment documented in the IRP and approved by HHSC. HHSC will review the authorized residential service on an ongoing basis to ensure that it is community-based, inclusive, and meets federal and state HCBS setting requirements. HHSC staff will conduct biennial reviews of residential services in all settings, and will conduct unannounced site visits to provider owned or operated settings. HHSC conducts biennial on-site reviews of community-based settings to ensure that settings do not have the qualities of an institutional setting, meet HCB setting requirements, and promote choice and community inclusion. If the monitoring suggests that a change in service is needed, an independent re-assessment will be conducted by HHSC or its designee to re-evaluate the participant to determine the appropriateness of the service in accordance with HHSC requirements.

The HCBS-AMH provider agency must implement and maintain a plan for initial and periodic training of staff members and service providers that ensures staff members and service providers are qualified to deliver services as required by the current needs and characteristics of the individuals to whom they deliver services and are knowledgeable of acts that constitute abuse, neglect, or exploitation of an individual and methods to prevent the occurrence of abuse, neglect, and exploitation.

Periodic training is delivered by the HCBS-AMH provider agency, as needed, to ensure service providers are qualified to provide HCBS-AMH services in accordance with state and federal laws and regulations; and to ensure the individual’s safety and security.

Electronic Visit Verification System. The state will demonstrate compliance with the Electronic Visit Verification System (EVV) requirements for personal care services (PCS) on or before January 1, 2021 and compliance with home health services by January 1, 2023 in accordance with section 12006 of the 21st Century CURES Act.

**Additional needs-based criteria for receiving the service, if applicable:**

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

**Choose each that applies:**

<table>
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<tr>
<th>Yes</th>
<th>Categorically needy (specify limits):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Individuals receiving adult foster care or Department of Family and Protective Services foster care services may not also receive Supported Home Living services.</td>
</tr>
<tr>
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<td>Texas ensures duplication of services does not occur by prohibiting payment for services without authorization. Two entities may not be paid for providing the same service to the same individual during the same time period.</td>
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integral to the delivery of this service.

Services that are provided by third parties must be coordinated with the Supported Home Living provider and through the recovery manager, including community-based rehabilitative services provided outside of the residence.

Supported Home Living services should be provided only in settings within Texas, which meet home and community-based characteristic requirements for the type of residential support provided. Supported Home Living services cannot be provided in or on the grounds of the following settings:

- Nursing facilities;
- Institutions for mental disease;
- Intermediate care facilities for individuals with Intellectual or Developmental Disabilities;
- Inpatient hospitals; or
- Any other location that has qualities of an institutional setting.

Medically needy *(specify limits):*

N/A

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<td>HCBS Provider agency that meets the minimum eligibility and standards for HCBS-AMH provider enrollment.</td>
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<td></td>
<td>HCBS provider agency enrolled and contracted with HHSC to provide HCBS services, which employs or has agreements with Supported Home Living Providers. Residential settings must meet relevant state and local requirements. Individual direct service providers must be at least 18 years of age. The employee provider must have a high school diploma or Certificate of High School Equivalency (GED credentials) or documentation of a proficiency evaluation of experience and competence to perform job tasks including ability to provide the required services as needed by the individual to be served as demonstrated through a written competency-based assessment. The individual provider must pass a criminal background check and also have at least three personal references from persons not related within three degrees of consanguinity that evidence the ability to provide a safe and healthy environment for the individual(s) to be served. Transportation of individuals must be provided in accordance with applicable state laws. Individuals transporting individuals must be 18 years of age or older; pass a criminal background check; and must have a valid driver's license and proof of insurance. Assisting with tasks delegated by an RN must be in accordance with state law. Individual providers of Supported Home Living services must complete initial and periodic training provided by HCBS provider.</td>
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agency which includes HHSC-required training in the HCBS-AMH program.

Before entering into a provider agreement with the provider agency, HHSC verifies the providers’ compliance with these qualifications through a credentialing process. Contracted providers are obligated to verify on an ongoing basis that these qualifications are achieved, maintained, and documented in personnel files. HHSC will conduct annual review to verify these requirements continue to be met after the provider and HHSC enter into an agreement.

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**Service Delivery Method. (Check each that applies):**

- [ ] Participant-directed
- [✓] Provider managed

**Service Specifications** (Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):

Service Title: Respite Care

Service Definition (Scope):

Respite is a service that provides temporary relief from care giving to the primary caregiver of an individual during times when the individual's primary caregiver would normally provide care.

In-home respite will be provided in the individual’s home or place of residence, or in the home of a family member or friend.

Electronic Visit Verification System. The state will demonstrate compliance with the Electronic Visit Verification System (EVV) requirements for personal care services (PCS) on or before January 1, 2021 and compliance with home health services by January 1, 2023 in accordance with section 12006 of the 21st Century CURES Act.

Respite is provided for the planned or emergency short-term relief for natural, unpaid caregivers. Respite is provided intermittently when the natural caregiver is temporarily unavailable to provide supports. This service provides an individual with personal assistance with activities of daily living (grooming, eating, bathing, dressing, and personal hygiene) and functional living tasks; assistance with planning and preparing meals; transportation or assistance in securing transportation; assistance with ambulation and mobility; reinforcement of rehabilitation or specialized therapies; assisting an individual with administration of certain medications or with supervision of self-medication in accordance with the Texas Board of Nursing rules as defined the Texas Administrative Code; and supervision as needed to ensure the individual’s health and safety.

This service includes activities that facilitate the individual’s inclusion in community activities, use of natural supports and typical community services available to all people, social interaction, and participation in leisure activities, and development of socially valued behaviors and daily living and functional living skills. Respite is provided in the residence of the individual or in other locations, including residences in which supervised living or residential support is provided or in a respite facility that meets HHSC requirements and afford an environment
that ensures the health, safety, comfort, and welfare of the individual. The provider of respite must ensure that respite is provided in accordance with the individual's recovery plan.

Transportation costs associated with the respite service are included in the respite rate. Transportation to and from the respite service site is not a billable service for the respite service but is included in the billable service for supported home living.

Out-of-home respite can be provided in the following locations:
- Adult foster care home;
- 24-hour residential habilitation home;
- Licensed assisted living facilities;
- Licensed Nursing Facilities.

Additional needs-based criteria for receiving the service, if applicable (specify):

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

- **Categorically needy (specify limits):**
  
  Reimbursement for respite is limited to 30 days annually of any combination of in-home or out-of-home respite.

  Other services indicated on the individual's recovery plan may be provided during the period of respite, if they are not duplicative of or integral to services which can be reimbursable as respite. Respite is not a reimbursable service for individuals receiving community-based residential supports in provider owned or operated settings, including host home/companion care, supervised living or assisted living; to relieve paid caregivers and providers or to supplant natural supports. Payment of the cost of room and board is the responsibility of the individual except when the individual is receiving out-of-home respite services under HCBS-AMH. Room and board is included in the rate for out-of-home respite services.

- **Medically needy (specify limits):**
  
  N/A

### Provider Qualifications (For each type of provider. Copy rows as needed):

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<thead>
<tr>
<th>Provider Type (Specify):</th>
<th>License (Specify):</th>
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<th>Other Standard (Specify):</th>
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</thead>
<tbody>
<tr>
<td>HCBS Provider Agency that meets the minimum eligibility and standards for HCBS-AMH provider enrollment.</td>
<td></td>
<td></td>
<td>HCBS provider agency enrolled and contracted with HHSC to provide HCBS services, which employs or contracts with individual respite workers.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Respite settings must meet appropriate state and local licensure or certification requirements.</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Individual direct service workers must be 18 years of age or older; trained in CPR/first-aid; pass criminal history checks; not be on list of Employee Misconduct Registry or Nurse Aide Registry; maintain current Texas driver's license and proof of automobile insurance if transporting individuals; and be familiar with client-specific competencies.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
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with the provider agency, HHSC verifies the providers’ compliance with these qualifications through a credentialing process. Contracted providers are obligated to verify on an ongoing basis that these qualifications are achieved, maintained, and documented in personnel files. HHSC will conduct biennial review to verify these requirements continue to be met after the provider and HHSC enter into an agreement.

### Verification of Provider Qualifications

**Verification of Provider Qualifications** *(For each provider type listed above. Copy rows as needed)*:

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<tbody>
<tr>
<td>HCBS Provider Agency</td>
<td>HHSC</td>
<td>Biennial</td>
</tr>
</tbody>
</table>

### Service Delivery Method

**Service Delivery Method.** *(Check each that applies):*

- [ ] Participant-directed
- [x] Provider managed

### Service Specifications

**Service Specifications** *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

**Service Title:** Home Delivered Meals

**Service Definition (Scope):**

Home delivered meals services provide a nutritionally sound meal to individuals. Each meal provides a minimum of one-third of the current recommended dietary allowance (RDA) for the individual as adopted by the United States Department of Agriculture. The meal is delivered to the participant’s home. Home delivered meals do not constitute a full nutritional regimen.

**Additional needs-based criteria for receiving the service, if applicable (specify):**

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

**Choose each that applies:**

- [x] Categorically needy *(specify limits):*
  - The provision of home delivered meals does not provide a full nutritional regimen (i.e., 3 meals a day).
- [ ] Medically needy *(specify limits):*
  - N/A

### Provider Qualifications

**Provider Qualifications** *(For each type of provider. Copy rows as needed):*

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<td></td>
<td></td>
<td>HCBS-AMH provider agency enrolled and contracted with HHSC to provide HCBS-AMH services, which employs or contracts with home-delivered meal providers.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>An individual home delivered meals provider must follow procedures and maintain facilities that comply with all applicable state and local laws and regulations related to fire,</td>
</tr>
</tbody>
</table>
Before entering into a provider agreement with the provider agency, HHSC verifies the providers’ compliance with these qualifications through a credentialing process. Contracted providers are obligated to verify on an ongoing basis that these qualifications are achieved, maintained, and documented in personnel files. HHSC will conduct biennial review to verify these requirements continue to be met after the provider and HHSC enter into an agreement.

**Verification of Provider Qualifications** *(For each provider type listed above. Copy rows as needed):*

<table>
<thead>
<tr>
<th>Provider Type (Specify):</th>
<th>Entity Responsible for Verification (Specify):</th>
<th>Frequency of Verification (Specify):</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCBS Provider Agency that meets the minimum eligibility and standards for HCBS-AMH provider enrollment.</td>
<td>HHSC</td>
<td>Biennial</td>
</tr>
</tbody>
</table>

**Service Delivery Method.** *(Check each that applies):*  
- [ ] Participant-directed  
- ✔ Provider managed

**Service Specifications** *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

<table>
<thead>
<tr>
<th>Service Title:</th>
<th>Minor Home Modifications</th>
</tr>
</thead>
</table>

**Service Definition (Scope):**  
Minor home modifications are those physical adaptations to an individual’s home that are necessary to ensure the individual’s health, welfare, and safety, or that enable the individual to function with greater independence in the home. In order to receive minor home modifications under this program, the individual would require institutionalization without these adaptations. Adaptations may include widening of doorways, modification of bathroom facilities, installation of ramps, or other minor modifications which are necessary to achieve a specific rehabilitative goal defined in the IRP and prior approved by HHSC. Adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. are excluded from minor home modifications. Adaptations that add to the total square footage of the home are excluded from this benefit. Minor home modifications are not made to residential settings that are leased, owned, or controlled by service providers. All minor home modifications are provided in accordance with applicable state or local building codes.

**Additional needs-based criteria for receiving the service, if applicable (specify):**  
The minor home modifications must be necessary to address specific functional limitations documented in the individual’s recovery plan and must be approved by HHSC.

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

*(Choose each that applies):*  
- ✔ Categorically needy *(specify limits):*  
  There is an individual limit of $7,500.00 per lifetime for minor home modifications. Once that maximum
is reached, $300 per service plan year per individual will be allowed for repair, replacement, or updating of existing modifications. The agency is responsible for obtaining cost-effective modifications authorized on the individual's plan. Should an individual require environmental modifications after the cost cap has been reached, the service planning team will assist the individual/family to access any other resources or alternate funding sources. Requests for exceptions will be evaluated on a case-by-case basis, including evaluation of need and exhaustion of all other means of obtaining the necessary minor home modification.

Medically needy (specify limits):
N/A

Provider Qualifications (For each type of provider. Copy rows as needed):

<table>
<thead>
<tr>
<th>Provider Type (Specify):</th>
<th>License (Specify):</th>
<th>Certification (Specify):</th>
<th>Other Standard (Specify):</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCBS provider agency that meets the minimum eligibility and standards for HCBS-AMH provider enrollment.</td>
<td></td>
<td></td>
<td>HCBS provider agency enrolled and contracted with HHSC to provide HCBS services.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>The agency must comply with the requirements for delivery of minor home modifications, which include requirements as to type of allowed modifications, time frames for completion, specifications for the modification, inspections of modifications, and follow-up on the completion of the modification.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Individual providers must meet applicable laws and regulations for the provision of the approved minor home modification and provide modifications in accordance with applicable state and local building codes.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Qualified building contractors provide minor home modifications in accordance with state and local building codes and other applicable regulations.</td>
</tr>
</tbody>
</table>

Verification of Provider Qualifications (For each provider type listed above. Copy rows as needed):

<table>
<thead>
<tr>
<th>Provider Type (Specify):</th>
<th>Entity Responsible for Verification (Specify):</th>
<th>Frequency of Verification (Specify):</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCBS provider agency that meets the minimum eligibility and standards for HCBS-AMH provider enrollment.</td>
<td>HHSC</td>
<td>Biennial</td>
</tr>
</tbody>
</table>

Service Delivery Method. (Check each that applies):

- Participant-directed
- Provider managed

Service Specifications (Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):

<table>
<thead>
<tr>
<th>Service Title:</th>
<th>Nursing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Definition (Scope):</td>
<td></td>
</tr>
</tbody>
</table>
Nursing services are those services that are within the scope of the Texas Nurse Practice Act and are provided by an RN (or licensed vocational nurse under the supervision of an RN), licensed to practice in the state. Services cover ongoing chronic conditions such as wound care, medication administration (including training, monitoring, and evaluation of side effects), and supervising delegated tasks. This broadens the scope of these services beyond state plan services. Nursing services provide treatment and monitoring of health care procedures prescribed by a physician/medical practitioner, or as required by standards of professional practice or state law to be performed by licensed nursing personnel.

This 1915(i) service is only provided to individuals age 21 and over. All medically necessary nursing services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.

Additional needs-based criteria for receiving the service, if applicable (specify):

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):

- **Categorically needy (specify limits):**
  - Nursing services are provided only after benefits available through Medicare, Medicaid, or other third party resources have been exhausted or are not applicable, including home health benefits.
- **Medically needy (specify limits):**
  - N/A

**Provider Qualifications (For each type of provider. Copy rows as needed):**

<table>
<thead>
<tr>
<th>Provider Type (Specify)</th>
<th>License (Specify)</th>
<th>Certification (Specify)</th>
<th>Other Standard (Specify)</th>
</tr>
</thead>
</table>
| HCBS provider agency that meets the minimum eligibility and standards for HCBS-AMH provider enrollment. | RN (or licensed vocational nurse under the supervision of a registered nurse), licensed to practice in the state. | | HCBS provider agency enrolled and contracted with HHSC to provide HCBS services, which employs or contracts with nursing providers.  
An individual service provider must be an RN (or licensed vocational nurse under the supervision of a registered nurse), licensed to practice in the state or otherwise authorized to practice in Texas under the Nurse Licensure Compact.  
Nurses providing this service must comply with the requirements for delivery of nursing services, which include requirements such as compliance with the Texas Nurse Practice Act and delegation of nursing tasks. |

**Verification of Provider Qualifications (For each provider type listed above. Copy rows as needed):**

<table>
<thead>
<tr>
<th>Provider Type (Specify)</th>
<th>Entity Responsible for Verification (Specify)</th>
<th>Frequency of Verification (Specify)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCBS provider agency that meets the minimum eligibility and standards for HCBS-AMH provider</td>
<td>HHSC</td>
<td>Annual</td>
</tr>
</tbody>
</table>
**Service Delivery Method.** *(Check each that applies):*

- ✔ Participant-directed
- Biennial

**Service Specifications** *(Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):*

<table>
<thead>
<tr>
<th>Service Title:</th>
<th>Substance Use Disorder (SUD) Services (abuse and dependence)</th>
</tr>
</thead>
</table>

Service Definition (Scope):

Substance Use Disorder (SUD) services are assessment and ambulatory group and individual counseling for substance use disorders. Services are specialized to meet the needs of individuals who have experienced extended institutional placement. Providers must follow evidence-based or evidence-informed treatment modalities approved by HHSC. Services may be provided in the individual’s home or other community-based setting. Individuals must exhaust other state plan SUD benefits before choosing the HCBS SUD benefit unless other state plan benefits are not appropriate to meet the individual’s needs, limitations, and recovery goals as determined by the independent evaluation (e.g. severe cognitive or social functioning limitations, or a mental disability). Services are designed to assist the individual in achieving specific recovery goals identified in the IRP and in preventing relapse. Services are also designed to respect the individual’s culture, while addressing attitudinal and behavioral challenges that may impede the individual from realizing their desired recovery goals. Therapeutic modalities may include motivational interviewing; individual, group, and family counseling; psycho-education; medication management; harm reduction; and relapse-prevention. SUD treatment plans will be developed with active participation of the individual to specifically address and accommodate the individual’s needs, goals, and preferences and will support the overall HCBS recovery goals. Services will be provided using a team approach which integrates other HCBS services, such as peer support as appropriate to the individual’s needs and preferences.

This 1915(i) service is only provided to individuals age 21 and over. All medically necessary SUD services for children under age 21 are covered in the state plan pursuant to the EPSDT benefit.

**Additional needs-based criteria for receiving the service, if applicable (specify):**

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

*(Choose each that applies)*:

- ✔ Categorically needy *(specify limits)*:
  - This service may not be provided on the same day and at the same time as state plan SUD services.

- ☐ Medically needy *(specify limits)*:
  - N/A

**Provider Qualifications** *(For each type of provider. Copy rows as needed):*

<table>
<thead>
<tr>
<th>Provider Type <em>(Specify):</em></th>
<th>License <em>(Specify):</em></th>
<th>Certification <em>(Specify):</em></th>
<th>Other Standard <em>(Specify):</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>HCBS provider agency that meets the minimum eligibility and standards for HCBS-AMH provider enrollment, which employs or contracts</td>
<td>Individual counselors providing the SUD service must be Qualified Credential Counselors</td>
<td>If the HCBS provider contracts with SUD treatment programs, these programs must be licensed by the Texas Department of State Health Services as Chemical Dependency Treatment Programs.</td>
<td>Individual providers must be licensed and/or appropriately credentialed to provide services</td>
</tr>
</tbody>
</table>
and directly supervises Licensed Chemical Dependency Treatment providers

and act within the scope of their licensure and/or credentialing.

Before entering into a provider agreement with the provider agency, HHSC verifies the providers’ compliance with these qualifications through a credentialing process. Contracted providers are obligated to verify on an ongoing basis that these qualifications are achieved, maintained, and documented in personnel files. HHSC will conduct biennial review to verify these requirements continue to be met after the provider and HHSC enter into an agreement.

<table>
<thead>
<tr>
<th>Verification of Provider Qualifications</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Type (Specify):</td>
<td>Entity Responsible for Verification (Specify):</td>
<td>Frequency of Verification (Specify):</td>
</tr>
<tr>
<td>HCBS provider agency that meets the minimum eligibility and standards for HCBS-AMH provider enrollment.</td>
<td>HHSC</td>
<td>Biennial</td>
</tr>
</tbody>
</table>

Service Delivery Method. (Check each that applies):

- Participant-directed
- Provider managed

Service Specifications (Specify a service title for the HCBS listed in Attachment 4.19-B that the state plans to cover):

- Service Title: HCBS – AMH Recovery Management

Service Definition (Scope):

Recovery Management includes services assisting beneficiaries in gaining access to needed Medicaid State Plan and HCBS services, as well as medical, social, educational, and other resources, regardless of funding source. Recovery Managers are responsible for monitoring the provision of services included in the IRP to ensure that the individual’s needs, preferences, health, and welfare are promoted. The recovery manager:

- Coordinates / leads development of the IRP using a person-centered planning approach which supports the individual in directing and making informed choices according to the individual’s needs and preferences;
- Provides supporting documentation to be considered by HHSC in the independent evaluation and reevaluations;
- Identifies services / providers, brokers to obtain and integrate services, facilitates, and advocates to resolve issues that impede access to needed services;
- Develops / pursues resources to support the individual’s recovery goals including non-HCBS Medicaid, Medicare, and/or private insurance or other community resources;
- Assists the individual in identifying and developing natural supports (family, friends, and other community members) and resources to promote the individual’s recovery;
- Informs consumers of fair hearing rights;
- Assists HCBS-AMH consumers with fair hearing requests when needed and upon request;
- Educates and informs individuals about services, the individual recovery planning process, recovery resources, rights, and responsibilities;
- Actively coordinates with other individuals and/or entities essential to physical and/or behavioral services for the individual (including the individual’s MCO) to ensure that other services are integrated and support the individual’s recovery goals, health, and welfare;
• Monitors health, welfare, and safety through regular contacts (visits with the individual, paid and unpaid supports, and natural supports) at a minimum frequency required by HHSC;
• Responds to and assesses emergency situations and incidents and assures that appropriate actions are taken to protect the health, welfare, and safety of individuals;
• Reviews provider service documentation and monitors the individual’s progress;
• Initiates recovery plan team discussions or meetings when services are not achieving desired outcomes.
Outcomes include housing status, employment status, involvement in the criminal justice system, response to treatment and other services, and satisfaction with services; and
• Through the recovery plan monitoring process, solicits input from consumer and/or family, as appropriate, related to satisfaction with services.

In the performance of the monitoring function, the recovery manager will:
• Arrange for modifications in services and service delivery, as necessary;
• Advocate for continuity of services, system flexibility and integration, proper utilization of facilities and resources, accessibility, and beneficiary rights; and
• Participate in any HHSC-identified activities related to quality oversight and provide reporting as required by HHSC.

Recovery management includes functions necessary to facilitate community transition for beneficiaries who receive Medicaid-funded institutional services (e.g., Institutions for Mental Disease). Recovery management activities for individuals leaving institutions must be coordinated with, and must not duplicate, institutional discharge planning. This service may be provided up to 180 days in advance of anticipated movement to the community.

The maximum caseload for a recovery manager providing services through HCBS-AMH is set by HHSC and includes individuals in other waiver or state plan programs and other funding sources, unless the requirement is waived by HHSC.

Services must be delivered in a manner that supports the consumer’s communication needs, including age-appropriate communication and translation services for beneficiaries that are of limited-English proficiency or who have other communication needs requiring translation assistance.

Additional needs-based criteria for receiving the service, if applicable (specify):

Specify limits (if any) on the amount, duration, or scope of this service. Per 42 CFR Section 440.240, services available to any categorically needy recipient cannot be less in amount, duration and scope than those services available to a medically needy recipient, and services must be equal for any individual within a group. States must also separately address standard state plan service questions related to sufficiency of services.

(Choose each that applies):
✔ Categorically needy (specify limits):

The following activities are excluded from recovery management as a billable HCBS-AMH service:
• Travel time incurred by the recovery manager may not be billed as a discrete unit of service;
• Services that constitute the administration of another program such as child welfare or child protective services, parole and probation functions, legal services, public guardianship, special education, and foster care; and
• Representative payee functions.

Recovery management may only be provided by agencies and individuals employed by agencies who are not:
• Related by blood or marriage to the consumer;
• Financially or legally responsible for the consumer;
• Empowered to make financial or health-related decisions on behalf of the consumer; or
• Providers of HCBS-AMH for the individual, or those who have interest in or are employed by a provider of HCBS-AMH on the IRP, except when the provider is the only willing and qualified entity in a geographic area whom the individual consumer chooses to provide the service (provider of last resort)
The Recovery Manager is responsible for coordination of services, including coordinating HCBS-AMH services, coordinating with the MCO that is providing other Medicaid services, and coordinating services provided by third parties. Recovery management providers will coordinate with the individual’s MCO to assure that other case management services are not being provided to the individual. The State will periodically review claims data in search of duplicative claims and adjust system edits accordingly, and when claims processing is automated through MMIS, system edits will prevent processing of duplicative claims.

HHSC will enroll HCBS-AMH Provider Agencies and Recovery Management entities through separate Open Enrollments and will actively recruit both types of entities. Due to enormous geographic area of Texas and mental health professional shortages in the state (especially rural and frontier areas), Texas anticipates that some service areas may not have separate Provider Agencies and Recovery Management Entities that meet requirements of the program and provider agreement. In lieu of denying an individual life in his/her community of choice due to lack of available Provider Agencies and Recovery Management Entities, the State foresees that in this circumstance an HCBS provider of last resort may also provide recovery management services with certain conflict of interest protections in place.

When an HCBS provider of last resort also provides recovery management services, HHSC will require a clear separation of provider and recovery management functions. The distinct individual staff providing recovery management must be administratively separate from other HCBS-AMH provider functions and any related utilization review units and functions. Recovery Managers who work for provider agencies that are providing other HCBS-AMH services as the provider of last resort will not be providers of any other HCBS-AMH service on the IRP. HHSC reviews the administrative structure of the HCBS-AMH agency to ensure that there is a clear administrative separation of recovery management and HCBS-AMH provider staff/functions before approving a provider to serve as a recovery manager, and periodically reviews (including unannounced site-reviews) the individuals performing recovery management to ensure that they are not providers of HCBS-AMH and not under the administrative control of units providing HCBS-AMH services. HHSC will also review resulting IRPs to ensure that there is no conflict of interest.

This service may not be provided on the same day and at the same time as services that contain elements integral to the delivery of this service.

Recovery management functions necessary to facilitate community transition may not be billed under TAS.

☐ Medically needy (specify limits):

N/A

Provider Qualifications (For each type of provider. Copy rows as needed):

<table>
<thead>
<tr>
<th>Provider Type (Specify):</th>
<th>License (Specify):</th>
<th>Certification (Specify):</th>
<th>Other Standard (Specify):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recovery management provider enrolled and contracted with HHSC to provide recovery management services, or a recovery management entity which employs or contracts with individual recovery management providers</td>
<td></td>
<td></td>
<td>Individual providers of recovery management must:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Have at least 2 years of experience working with people with severe mental illness;</td>
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<tr>
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<td></td>
<td></td>
<td>• Have a master’s degree in human services or a related field (the requirement to have a master’s degree may be waived by HHSC if HHSC determines that waiver is necessary to provide access to care to Medicaid recipients);</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Demonstrate knowledge of issues affecting people with severe mental illness and community-based interventions/resources for this population; and</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Complete HHSC-required training in the HCBS-AMH program.</td>
</tr>
</tbody>
</table>
**Verification of Provider Qualifications** *(For each provider type listed above. Copy rows as needed)*:

<table>
<thead>
<tr>
<th>Provider Type (Specify):</th>
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<th>Frequency of Verification (Specify):</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCBS provider agency that meets the minimum eligibility and standards for HCBS-AMH provider enrollment.</td>
<td>HHSC</td>
<td>Biennial</td>
</tr>
</tbody>
</table>

**Service Delivery Method.** *(Check each that applies)*:

- Participant-directed
- Provider managed
2. Policies Concerning Payment for State plan HCBS Furnished by Relatives, Legally Responsible Individuals, and Legal Guardians. (By checking this box the state assures that): There are policies pertaining to the payment the state makes to qualified persons furnishing State plan HCBS, who are relatives of the individual. There are additional policies and controls if the state makes payment to qualified legally responsible individuals or legal guardians who provide State Plan HCBS. (Specify (a) who may be paid to provide State plan HCBS; (b) the specific State plan HCBS that can be provided; (c) how the state ensures that the provision of services by such persons is in the best interest of the individual; (d) the state’s strategies for ongoing monitoring of services provided by such persons; (e) the controls to ensure that payments are made only for services rendered; and (f) if legally responsible individuals may provide personal care or similar services, the policies to determine and ensure that the services are extraordinary (over and above that which would ordinarily be provided by a legally responsible individual):

<table>
<thead>
<tr>
<th>The State permits HCBS agencies to make payment to legally responsible individuals, legal guardians, and relatives for furnishing State Plan HCBS, only for Host Home services.</th>
</tr>
</thead>
<tbody>
<tr>
<td>A) relative other than a spouse; court appointed guardian; legally authorized representative</td>
</tr>
<tr>
<td>B) Host Home/Companion Care</td>
</tr>
<tr>
<td>C) Host Home/Companion Services are provided to meet the person’s needs as determined by an individualized assessment performed in accordance with HHSC. The services are coordinated within the context of the IRP which delineates how Host Home/Companion Care Services are intended to achieve the identified goals.</td>
</tr>
<tr>
<td>D) HHSC reviews the authorized host home/companion setting on an ongoing basis to ensure that it is community-based, inclusive and meets federal and state HCBS setting requirements. HHSC staff conduct periodic reviews of residential services in all settings to include unannounced site visits to provider-owned or operated settings. If the monitoring suggests that a change in service is needed, an independent reassessment is conducted by HHSC, or its designee, to re-evaluate the participant to determine the appropriateness of the service in accordance with HHSC requirements.</td>
</tr>
<tr>
<td>E) HCBS-AMH Provider must have written documentation to support a service claim for Host Home/Companion Care as outlined in the HCBS-AMH billing guidelines. HHSC shall monitor performance of program activities and conduct regular data verification via onsite and/or desk reviews. The process includes comparing the scope, frequency, duration, and amount of authorized services reported on the IRP with services reported on the provider invoice. Billable services are subject to prior approval by HHSC and may be subject to periodic reviews to ensure fidelity with evidence-based practice.</td>
</tr>
</tbody>
</table>
Participant-Direction of Services

Definition: Participant-direction means self-direction of services per §1915(i)(1)(G)(iii).

1. Election of Participant-Direction. (Select one):
   - The state does not offer opportunity for participant-direction of State plan HCBS.
   - Every participant in State plan HCBS (or the participant’s representative) is afforded the opportunity to elect to direct services. Alternate service delivery methods are available for participants who decide not to direct their services.
   - Participants in State plan HCBS (or the participant’s representative) are afforded the opportunity to direct some or all of their services, subject to criteria specified by the state. (Specify criteria):

2. Description of Participant-Direction. (Provide an overview of the opportunities for participant-direction under the State plan HCBS, including: (a) the nature of the opportunities afforded; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the approach to participant-direction):

3. Limited Implementation of Participant-Direction. (Participant direction is a mode of service delivery, not a Medicaid service, and so is not subject to state wideness requirements. Select one):
   - Participant direction is available in all geographic areas in which State plan HCBS are available.
   - Participant-direction is available only to individuals who reside in the following geographic areas or political subdivisions of the state. Individuals who reside in these areas may elect self-directed service delivery options offered by the state, or may choose instead to receive comparable services through the benefit’s standard service delivery methods that are in effect in all geographic areas in which State plan HCBS are available. (Specify the areas of the state affected by this option):

4. Participant-Directed Services. (Indicate the State plan HCBS that may be participant-directed and the authority offered for each. Add lines as required):

<table>
<thead>
<tr>
<th>Participant-Directed Service</th>
<th>Employer Authority</th>
<th>Budget Authority</th>
</tr>
</thead>
</table>

5. Financial Management. (Select one):
   - Financial Management is not furnished. Standard Medicaid payment mechanisms are used.
   - Financial Management is furnished as a Medicaid administrative activity necessary for administration of the Medicaid State plan.
6. **Participant-Directed Person-Centered Service Plan.** *(By checking this box the state assures that):* Based on the independent assessment required under 42 CFR §441.720, the individualized person-centered service plan is developed jointly with the individual, meets federal requirements at 42 CFR §441.725, and: Specifies the State plan HCBS that the individual will be responsible for directing; Identifies the methods by which the individual will plan, direct or control services, including whether the individual will exercise authority over the employment of service providers and/or authority over expenditures from the individualized budget; Includes appropriate risk management techniques that explicitly recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assures the appropriateness of this plan based upon the resources and support needs of the individual; Describes the process for facilitating voluntary and involuntary transition from self-direction including any circumstances under which transition out of self-direction is involuntary. There must be state procedures to ensure the continuity of services during the transition from self-direction to other service delivery methods; and Specifies the financial management supports to be provided.

7. **Voluntary and Involuntary Termination of Participant-Direction.** *(Describe how the state facilitates an individual’s transition from participant-direction, and specify any circumstances when transition is involuntary):*

8. **Opportunities for Participant-Direction**

   a. **Participant–Employer Authority** *(individual can select, manage, and dismiss State plan HCBS providers).* *(Select one):*

   - [ ] The state does not offer opportunity for participant-employer authority.

   - Participants may elect participant-employer Authority *(Check each that applies):

     - [ ] **Participant/Co-Employer.** The participant (or the participant’s representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions.

     - [ ] **Participant/Common Law Employer.** The participant (or the participant’s representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant’s agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

   b. **Participant–Budget Authority** *(individual directs a budget that does not result in payment for medical assistance to the individual).* *(Select one):*

   - [ ] The state does not offer opportunity for participants to direct a budget.

   - Participants may elect Participant–Budget Authority.

     - **Participant-Directed Budget.** *(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including the method for calculating the dollar values in the budget based on reliable costs and service utilization, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the person-centered service plan):*
| **Expenditure Safeguards.** (Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards.) |
Quality Measures

(Describe the state's quality improvement strategy. For each requirement, and lettered sub-requirement, complete the table below):

1. Service plans a) address assessed needs of 1915(i) participants; b) are updated annually; and (c) document choice of services and providers.

2. Eligibility Requirements: (a) an evaluation for 1915(i) State plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future; (b) the processes and instruments described in the approved state plan for determining 1915(i) eligibility are applied appropriately; and (c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved state plan for 1915(i) HCBS.

3. Providers meet required qualifications.

4. Settings meet the home and community-based setting requirements as specified in this SPA and in accordance with 42 CFR 441.710(a)(1) and (2).

5. The SMA retains authority and responsibility for program operations and oversight.

6. The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.

7. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation, including the use of restraints.

(Table repeats for each measure for each requirement and lettered sub-requirement above.)

<table>
<thead>
<tr>
<th>Requirement</th>
<th>An evaluation for 1915(i) SPA eligibility is provided to all applicants for whom there is reasonable indication that services may be needed in the future. The processes and instruments described in the approved 1915(i) SPA are applied appropriately and according to the approved description to determine if the needs-based criteria were met and 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or, if more frequent, as specified in the approved state plan for 1915(i) HCBS.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Discovery</strong></td>
<td></td>
</tr>
</tbody>
</table>
| **Discovery Evidence**  <br>(Performance Measure) | 1. The number and percent of individuals that were determined to meet needs-based criteria requirements prior to receiving 1915(i) services.  
2. The number and percent of individuals’ initial needs-based criteria determination forms/instruments that were completed, as required in the approved SPA.  
3. The number and percent of individuals’ initial determinations, where level of need criteria was applied correctly. |
<p>| <strong>Discovery Activity</strong>  &lt;br&gt;(Source of Data &amp; sample size) | Record review, onsite; Representative sample with a confidence level of 95 percent. |
| <strong>Monitoring Responsibilities</strong>  &lt;br&gt;(Agency or entity that conducts discovery activities) | HHSC collects, generates, aggregates, and analyzes |</p>
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<tr>
<th>Requirement</th>
<th>Service plans address assessed needs of 1915(i) participants, are updated annually, and document choice of services and providers.</th>
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<tr>
<td>An evaluation for 1915(i) SPA eligibility is provided to all applicants for whom there is reasonable indication that services may needed in the future. The processes and instruments described in the approved 1915(i) SPA are applied appropriately and according to the approved description to determine if the needs-based criteria were met. 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or, if more frequent, as specified in the approved state plan for 1915(i) HCBS.</td>
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<td>Remediation</td>
<td></td>
</tr>
<tr>
<td>Remediation Responsibilities (Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)</td>
<td>HHSC</td>
</tr>
<tr>
<td>Frequency</td>
<td>Annually</td>
</tr>
<tr>
<td>(of Analysis and Aggregation)</td>
<td></td>
</tr>
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<td>5. Number and percent of participants with services delivered in accordance with the IRP, including the type, scope, amount, duration, and frequency specified in the service plan.</td>
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(of Analysis and Aggregation)

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HCBS-AMH Provider Agencies and HCBS-AMH service providers meet required qualifications.

HCBS-AMH Provider agencies must meet the minimum eligibility and standards for HCBS-AMH provider enrollment, which include:

- Must have experience with and/or demonstrated capacity to administer services for people with severe mental illness or related populations
- Must be a legal entity under state law, have the authority to do business in Texas, and be in good standing to do business in Texas and conduct the activities required by HHSC.
- Must have a Texas address; and
- Must have organizational policies and procedures acceptable to HHSC to deliver HCBS-AMH services

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1. Number and percent of HCBS providers initially meeting licensure and certification requirements prior to furnishing HCBS services.
2. Number and percent of HCBS providers meeting licensure and certification requirements while furnishing services.
3. Number and percent of HCBS-AMH provider agencies with an active agreement with HHSC/HHSC.
4. Number and percent of HCBS providers who meet training requirements for delivering HCBS services.
5. Number and percent of enrolled HCBS providers serving HCBS clients (by provider type).

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Representative sample, with a confidence level of 95 percent, of provider agencies, open enrollment applications, provider agreements, state licensure authorities, and provider personnel records.

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<td>Discovery Activity</td>
<td>Representative sample, with a confidence level of 95 percent, of provider agencies, desk or on-site reviews, and report of recovery managers</td>
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<td>Monitoring Responsibilities</td>
<td>HHSC collects, generates, aggregates, and analyzes a representative sample, with a confidence level of 95 percent, of provider agencies, onsite reviews, and report of recovery managers of the number and percent of HCBS settings meeting appropriate licensure or certification and Federal HCBS requirements</td>
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<td>Frequency</td>
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**Remediation**

**Remediation Responsibilities**

(Who corrects, analyzes, and aggregates remediation activities; required timeframes for remediation)

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<tr>
<td>Discovery</td>
<td>1. Number and percent of aggregated performance measure reports generated and reviewed by the State Medicaid Agency that contain discovery, remediation, and system improvements for ongoing compliance of the assurances. 2. Number and percent of state plan amendments, renewals, and financial reports approved by HHSC prior to implementation by HHSC. 3. Number and percent of SPA concepts and policies requiring MMIS programming approved by HHSC prior to the development of a formal implementation plan by HHSC.</td>
</tr>
<tr>
<td>Discovery Evidence</td>
<td>Reports to HHSC on delegated administrative functions; 100 percent sample size</td>
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<td>Monitoring Responsibilities</td>
<td>HHSC collects, generates, aggregates, analyzes</td>
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<td>HHSC maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.</td>
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<tr>
<td>Discovery</td>
<td>Number and percent of paid claims that reflect only the services listed in accordance with the participant’s IRP. 2. Number and/or percentage of rates which remain consistent with the approved rate methodology throughout the five-year SPA cycle.</td>
</tr>
<tr>
<td>Discovery Evidence</td>
<td>Routine claims verification audits; Representative sample, with confidence level of 95 percent of case managers. Annual review of rate setting methodology</td>
</tr>
<tr>
<td>Discovery Activity</td>
<td>(Source of Data &amp; sample size)</td>
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<td>The State identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation (ANE), including the use of restraints.</td>
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<tr>
<td>Discovery Evidence</td>
<td>1. Number and/or percent of reports related to the abuse, neglect, exploitation, and unexplained deaths of participants where an investigation was completed within time frames established by State law.</td>
</tr>
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<td></td>
<td>2. Number and percent of participants who received information on how to report the suspected abuse, neglect, or exploitation of adults.</td>
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<td>3. Number and percent of participants who received information regarding their rights to a state fair hearing via the official state form.</td>
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<td>4. Number and percent of grievances filed by participants that were resolved within 14 calendar days according to approved SPA guidelines.</td>
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<td>5. Number and percent of allegations of abuse, neglect, or exploitation investigated that were later substantiated, where recommended actions to protect health and welfare were implemented.</td>
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<td>6. Number and percent of participants’ critical incidents related to ANE that were reported, initiated, reviewed, and completed within required timeframes as specified in the approved SPA.</td>
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<td></td>
<td>7. Number and percent of unauthorized uses of restrictive interventions that were appropriately reported.</td>
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<td></td>
<td>8. Number and percent of HCBS participants reviewed who had an annual comprehensive nursing assessment.</td>
</tr>
<tr>
<td>Discovery Activity</td>
<td>100 percent sample, HHSC performance monitoring of reports related to abuse, neglect, exploitation, or unexplained deaths; critical incidents; reports of restrictive intervention application; and; reports of ANE by primary care or physical health providers.</td>
</tr>
<tr>
<td>Monitoring Responsibilities</td>
<td>HHSC collects, generates, aggregates, and analyzes.</td>
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</table>

**System Improvement**

(Describe the process for systems improvement as a result of aggregated discovery and remediation activities.)

1. **Methods for Analyzing Data and Prioritizing Need for System Improvement**

   - Program performance data
     - Track and trend system performance
     - Analyze discovery
   - Quality management meetings
     - Assess system
     - changes
     - Focus on reporting requirements and refining reports
   - Onsite and/or desk reviews
     - Documentation review
     - Interviews
   - Corrective action plans (CAP)

2. **Roles and Responsibilities**

   HHSC will collect, collate, review, and post. HHSC will review the data and have final direction over corrective action plans. HHSC will collect, analyze, and report. HHSC provides oversight and direction.

   HHSC coordinates and conducts onsite and/or desk reviews. HHSC provides oversight and direction. Biennially, HHSC [reviews] clinical operations (utilization management, quality management, care management, compliance with HCB settings requirements). Compliance issues will require the submission of a corrective action plan to HHSC for approval and ongoing monitoring.

   The provider shall be actively engaged in the development of the corrective action plan (CAP) to the satisfaction of the State. The CAP is monitored by HHSC, which has final direction over the CAP. Areas for improvement will be monitored as per CAP and presented quarterly during Quality Management meetings and includes analysis of performance data and onsite review findings of program non-compliance follow-up.

3. **Frequency**
4. Method for Evaluating Effectiveness of System Changes

- Program performance data
  - Updated monthly and reported quarterly
- Quality management meetings – Quarterly meetings
- Onsite and/or desk reviews – Biennially
- Corrective action plans (CAP) - Areas for improvement will be monitored as per CAP and presented quarterly during Quality Management meetings

- Program performance data
  - Set performance benchmarks
  - Review of service trends
  - Review program implementation
  - Track and trend system performance
  - Analyze the discovery; synthesize the data;
  - HHSC, with HHSC, will make corrective action plans regarding quality improvement (QI).
  - HHSC will review QI recommendations quarterly and build upon those improvements through continuous quality improvement.

- Quality management meetings
  - Monitoring contract and HCBS compliance for service delivery
  - Review of clinical assessment client outcome measures

- Onsite and/or desk reviews
  - Review of clinical operations (utilization management, quality management, care management, compliance with HCB settings requirements)
  - Compliance issues will require the submission of a corrective action plan to HHSC for approval and ongoing monitoring.

- Corrective action plans (CAP) - Areas for improvement will be monitored as per CAP and presented quarterly during Quality Management meetings
  - Analysis of performance data
  - Onsite and/or desk review findings of program non-compliance follow-up
6. **Voluntary and Involuntary Termination of Participant-Direction.** *(Describe how the State facilitates an individual’s transition from participant-direction, and specify any circumstances when transition is involuntary):*

7. **Opportunities for Participant-Direction**
   a. **Participant–Employer Authority** *(individual can hire and supervise staff). *(Select one):*

   | ☑ | The State does not offer opportunity for participant-employer authority. |
   | ☐ | Participants may elect participant-employer Authority *(Check each that applies):* |
   | ☐ | **Participant/Co-Employer.** The participant (or the participant’s representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions. |
   | ☐ | **Participant/Common Law Employer.** The participant (or the participant’s representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant’s agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions. |

b. **Participant–Budget Authority** *(individual directs a budget). *(Select one):*

   | ☑ | The State does not offer opportunity for participants to direct a budget. |
   | ☐ | Participants may elect Participant–Budget Authority. |
   | ☐ | **Participant-Directed Budget.** *(Describe in detail the method(s) that are used to establish the amount of the budget over which the participant has authority, including how the method makes use of reliable cost estimating information, is applied consistently to each participant, and is adjusted to reflect changes in individual assessments and service plans. Information about these method(s) must be made publicly available and included in the person-centered service plan):* |

   | ☐ | **Expenditure Safeguards.** *(Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards):* |
Quality Improvement Strategy

(Describe the State’s quality improvement strategy in the tables below):

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Discovery Activities</th>
<th>Remediation</th>
<th>Frequency</th>
<th>Remediation Responsibilities</th>
<th>Frequency</th>
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<tbody>
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<td>The processes and instruments described in the approved 1915(i) SPA are</td>
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<td>aggregates, and analyzes</td>
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<td>determine if the needs-based criteria were met.</td>
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<td>onsite; Representative</td>
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<tr>
<td>2. The number and percent of individuals’ initial needs-based criteria</td>
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<tr>
<td>Nr.</td>
<td>Description</td>
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<tbody>
<tr>
<td>1. Number and percent of aggregated performance measure reports generated by the Operating Agency (DSHS) and reviewed by the State Medicaid Agency that contain discovery, remediation, and system improvements for ongoing compliance of the assurances.</td>
<td>Reports to HHSC on delegated administrative functions; 100 percent sample size</td>
<td>Annually</td>
<td>DSHS</td>
</tr>
<tr>
<td>2. Number and percent of SPA amendments, renewals, and financial reports approved by HHSC prior to implementation by DSHS.</td>
<td></td>
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<tr>
<td>3. Number and percent of SPA concepts and policies requiring MMIS programming approved by HHSC prior to the development of a formal implementation plan by DSHS.</td>
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</tr>
</tbody>
</table>
HHSC maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.

1. Number and percent of providers that have payment recouped for HCBS services without supporting documentation.
   - Routine claims verification audits; Representative sample, with a confidence level of 95 percent of case managers.

2. Number and/or percent of claims verified through the DSHS compliance audit to have paid in accordance with the participant’s IRP.
   - Annual review of rate setting methodology

3. Number and/or percentage of rates which remain consistent with the approved rate methodology throughout the five year SPA cycle.
   - DSHS collects, generates, aggregates, and analyzes

The State identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation (ANE), including the use of restraints.

1. Number and/or percent of reports related to the abuse, neglect, exploitation, and unexplained deaths of participants where an investigation was completed within time frames established by State law.
   - 100 percent sample, DSHS performance monitoring of reports related to abuse, neglect, exploitation, or unexplained deaths; critical incidents; reports of restrictive intervention application; and reports of ANE by primary care or physical health providers.

2. Number and percent of participants who received information on how to report the suspected abuse, neglect, or exploitation of adults.

3. Number and percent of participants who received information regarding their rights to a state fair hearing via the

DSHS collects, generates, aggregates, and analyzes

Annually

DSHS

Annually
4. Number and percent of grievances filed by participants that were resolved within 14 calendar days according to approved SPA guidelines.

5. Number and percent of allegations of abuse, neglect, or exploitation investigated that were later substantiated, where recommended actions to protect health and welfare were implemented.

6. Number and percent of participants’ critical incidents related to ANE that were reported, initiated, reviewed, and completed within required timeframes as specified in the approved SPA.

7. Number and percent of unauthorized uses of restrictive interventions that were appropriately reported.

8. Number and percent of HCBS participants who received physical exams consistent with state 1915(i) policy.
### System Improvement:
(Describe process for systems improvement as a result of aggregated discovery and remediation activities)

<table>
<thead>
<tr>
<th>Methods for Analyzing Data and Prioritizing Need for System Improvement</th>
<th>Roles and Responsibilities</th>
<th>Frequency</th>
<th>Method for Evaluating Effectiveness of System Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Program performance data</strong>&lt;br&gt;• Track and trend system performance&lt;br&gt;• Analyze discovery</td>
<td>DSHS will collect, collate, review, and post. HHSC will review the data and have final direction over corrective action plans.</td>
<td>Updated monthly and reported quarterly</td>
<td>• Set performance benchmarks&lt;br&gt;• Review of service trends&lt;br&gt;• Review program implementation&lt;br&gt;• Track and trend system performance&lt;br&gt;• Analyze the discovery; synthesize the data;&lt;br&gt;• DSHS, with HHSC, will make corrective action plans regarding quality improvement (QI).&lt;br&gt;• DSHS will review QI recommendations quarterly and build upon those improvements through continuous quality improvement.</td>
</tr>
<tr>
<td><strong>Quality management meetings</strong>&lt;br&gt;• Assess system changes&lt;br&gt;• Focus on reporting requirements and refining reports</td>
<td>DSHS will collect, analyze, and report. HHSC provides oversight and direction.</td>
<td>Quarterly meetings</td>
<td>• Monitoring contract and HCBS compliance for service delivery&lt;br&gt;• Review of clinical assessment client outcome measures</td>
</tr>
<tr>
<td><strong>Onsite reviews</strong>&lt;br&gt;• Documentation review&lt;br&gt;• Onsite interviews</td>
<td>DSHS coordinates and conducts onsite reviews and reports findings to HHSC. HHSC provides oversight and direction. Annually, DSHS [reviews] clinical operations (utilization management, quality management, care management, compliance with HCB settings requirements). Compliance issues will require the submission of a corrective action plan to DSHS for approval and ongoing monitoring.</td>
<td>Annually</td>
<td>• Review of clinical operations (utilization management, quality management, care management, compliance with HCB settings requirements)&lt;br&gt;• Compliance issues will require the submission of a corrective action plan to DSHS for approval and ongoing monitoring.</td>
</tr>
<tr>
<td><strong>Corrective action plans (CAP)</strong></td>
<td>The provider shall be actively engaged in the development of the corrective action plan (CAP) to the satisfaction of the State. The CAP is monitored by DSHS-subject to the authority of the state Medicaid agency, which has final direction over the CAP. Areas for improvement will be monitored as per CAP and presented quarterly during Quality Management meetings and includes analysis of performance data and onsite review findings of program non-compliance follow-up.</td>
<td>Areas for improvement will be monitored as per CAP and presented quarterly during Quality Management meetings</td>
<td>• Analysis of performance data&lt;br&gt;• Onsite review findings of program non-compliance follow-up</td>
</tr>
</tbody>
</table>
1. **Services Provided Under Section 1915(i) of the Social Security Act.** For each optional service, describe the methods and standards used to set the associated payment rate. *(Check each that applies, and describe methods and standards to set rates):*

<table>
<thead>
<tr>
<th>Service</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCBS Case Management</td>
<td></td>
</tr>
<tr>
<td>HCBS Homemaker</td>
<td></td>
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<tr>
<td>HCBS Home Health Aide</td>
<td></td>
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<tr>
<td>HCBS Personal Care</td>
<td></td>
</tr>
<tr>
<td>HCBS Adult Day Health</td>
<td></td>
</tr>
<tr>
<td>HCBS Habilitation</td>
<td></td>
</tr>
<tr>
<td><strong>✅ HCBS Respite Care</strong></td>
<td>• The In-Home Respite rate is based on the Community Based Alternatives (CBA – terminated 9/1/2014) Medicaid Waiver program and the Community Living Assistance and Support Services (CLASS) Medicaid Waiver program rate. This rate is set using cost report data from both programs combined into a single array. Please see below for details on setting rates using cost report data and the rate setting process in general.</td>
</tr>
<tr>
<td></td>
<td>• Out-of-Home Respite in a Nursing Facility rates are the State Plan Nursing Facility rates. These rates are set using cost report data. Please see below for details on setting rates using cost report data and the rate setting process in general.</td>
</tr>
<tr>
<td></td>
<td>• The Out-of-Home Respite in a Licensed Assisted Living Facility rates are the CBA Assisted Living rates. These rates are set using cost report data. Please see below for details on setting rates using cost report data and the rate setting process in general.</td>
</tr>
<tr>
<td></td>
<td>• The Out-of-Home Respite in a 24-hour Residential Habilitation Home rate is based on a weighted average of the Home and Community-based Services (HCS) Medicaid Waiver program Supervised Living Services rates. These rates are set using cost report data. Please see below for details on setting rates using cost report data and the rate setting process in general.</td>
</tr>
<tr>
<td></td>
<td>• The Out-of-Home Respite in an Adult Foster Care home rates are the CBA Out-of-Home Respite in an Adult Foster Care home rates. These rates are determined by modeling the estimated amount of one-on-one time the adult foster care provider would provide to the individual multiplied by a reimbursement amount appropriate for the skill level of the caregiver providing the assistance. These rates are updated periodically for inflation. Please see below for information on the rate setting process in general.</td>
</tr>
</tbody>
</table>

For Individuals with Chronic Mental Illness, the following services:

<table>
<thead>
<tr>
<th>Service</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>✅ HCBS Psychosocial Rehabilitation</strong></td>
<td>The rates for psychosocial rehabilitative services are based on the established State Plan Medicaid fee schedule.</td>
</tr>
<tr>
<td>HCBS Clinic Services (whether or not furnished in a facility for CMI)</td>
<td></td>
</tr>
</tbody>
</table>
Other Services (specify below)

General Rate Setting
The rates for all services in the HCBS-AMH program are available on the agency’s website, as outlined in Attachment 4.19-B, Page 1. Unless otherwise specified, all rates are effective as of September 1, 2023.

HHSC determines payment rates every two years for each service. The rates for services are prospective and uniform statewide. HHSC determines payment rates after analysis of financial and statistical information and the effect of the payment rates on the achievement of program objectives, including economic conditions and budgetary considerations. Payment rates are developed as described below.

Cost Reports
The rates for certain services are set using cost report data from providers of similar services in the Home and Community-Based Services Waiver (HCS) and Texas Home Living (TxHmL) waiver programs. Providers of these services are required to submit cost reports to HHSC every other year. Providers are responsible for eliminating all unallowable expenses from the cost report prior to submission of the cost report. HHSC reviews all cost reports, and a sample of cost reports are reviewed on-site. HHSC removes any unallowable costs and corrects any errors detected on the cost report during the review or on-site audit. Audited cost reports are used in the determination of statewide prospective rates. Cost principles follow 2 CFR § 200.

The recommended unit of service rates for each service are determined as follows: (1) total allowable costs for each provider are determined from the audited cost report; (2) each provider’s total allowable costs are projected from the historical cost reporting period to the prospective reimbursement period using the appropriate inflationary factors outlined below; (3) payroll taxes and benefits are allocated to each salary item; (4) total projected allowable costs are divided by the number of units of service to determine the projected cost per unit of service; (5) the allowable costs per unit of service for each contracted provider are arrayed and weighted by the number of units of service and the median cost per unit of service is calculated; and (6) the median cost per unit of service for each service is multiplied by 1.044.

For general inflation adjustments, HHSC uses the Personal Consumption Expenditures (PCE) chain-type price index published by the Bureau of Economic Analysis of the U.S. Department of Commerce. HHSC uses a PCE forecast published by IHS Markit or its successor. HHSC uses specific indices in place of the general inflation index when appropriate item- or program-specific inflation indices are available from cost reports or other surveys, other Texas state agencies, nationally recognized public agencies, or independent private firms or sources, and HHSC has determined that these specific inflation indices are derived from information that adequately represents the program(s) or cost(s) to which the specific index is to be applied.

For inflation adjustments of costs pertaining to wages and salaries of licensed vocational nurses and nurse aides, HHSC uses an employment cost index of wages and salaries for private industry workers in nursing and residential care facilities published by the U.S. Bureau of Labor Statistics. HHSC uses a forecast of this inflation index published by IHS Markit or its successor. Periodic reviews of the chosen inflation index will be performed based on cumulative cost report data on nursing wages and salaries.

HHSC includes Federal Insurance Contributions Act (FICA) payroll tax rates, such as for Social Security taxes and Medicare taxes, and federal and state unemployment tax rates in its projected costs of non-contracted staff salaries and wages. When a FICA tax rate or unemployment tax rate is amended per federal or state statute, HHSC adjusts its cost projections in accordance with the amended tax rate.
The Supported Employment and Employment Assistance rates are based on the CLASS, Deaf Blind with Multiple Disabilities (DBMD) Medicaid Waiver program, HCS, and Texas Home Living (TxHmL) Medicaid Waiver program rates. These rates are set using cost report data from these programs combined into a single array. Please see below for details on setting rates using cost report data and the rate setting process in general.

The Nursing Services rates are based on the CBA, CLASS, DBMD, HCS, Medically Dependent Children Program (MDCP), and TxHmL rates. These rates are set using cost report data from these programs combined into a single array. Please see below for details on setting rates using cost report data and the rate setting process in general.

The Community Psychiatric Supports and Treatment rate is based on the Behavioral Support Services rate in the CLASS, DBMD, HCS, and TxHmL programs. This rate is set using cost report data from these programs combined into a single array. Please see below for details on setting rates using cost report data and the rate setting process in general.

Modeled Rates
If payment rates are not available from other programs that provide similar services, or when historical costs are unavailable, such as in the case of a new program, payment rates are determined using a pro-forma analysis in accordance with Title 1 of the Texas Administrative Code (TAC) § 355.105(h) (relating to General Reporting and Documentation Requirements, Methods, and Procedures).

A pro-forma analysis is defined as an item-by-item, or classes-of-items, calculation of the reasonable and necessary expenses for a provider to operate. The analysis may involve assumptions about the salary of an administrator or program director, staff salaries, employee benefits and payroll taxes, building depreciation, mortgage interest, contracted client care expenses, and other building or administration expenses. To determine the cost per unit of service, HHSC adds all the pro-forma expenses and divides the total by the estimated number of units of service that a fully operational provider is likely to provide. The pro-forma analysis is based on available information that is determined to be sufficient, accurate, and reliable by HHSC, including valid cost report data and survey data. Pro-forma rate setting involves using historical costs of delivering similar services, where appropriate data are available, and estimating the basic types and costs of products and services necessary to deliver services meeting federal and state requirements. The pro-forma analysis is conducted in a way that ensures that the resultant reimbursements are sufficient to support the requirements of the contracted program. When HHSC staff determine that sufficient and reliable cost report data have become available, the pro-forma reimbursement determination may be replaced with a process based on cost reports.

The following rates are modeled using a pro-forma analysis:

The rate for Transition Assistance Services is a one-time payment for the procurement of items and services the participant needs to move from an institution, a provider-operated setting, or family home to their own private community residence. The rate is determined by modeling the estimated salary for a person with the necessary skills and training, the estimated time spent with the participant, and the procurement of the necessary goods and services. The salary and time estimates were based upon the experience of providers delivering similar services under a different program. This rate is updated periodically for inflation.

Non-Medical Transportation is paid at the rate set by the Texas Comptroller of Public Accounts. The Texas Comptroller adopts the maximum mileage rate established by the IRS for personal income tax purposes.

The home delivered meals rate is a cost limit, established at the 80th percentile of provider costs using cost report data submitted by providers of service.

Peer support rates are modeled based on the estimated salary for a person with the necessary skills and training to provide peer support.

Adaptive Aids, Vehicular Modification, and Minor Home Modifications rates are at cost.

The rates for Substance Abuse Disorder services and HCBS – Adult Mental Health Recovery Management are based on the established State Plan Medicaid fee schedule.
their own private community residence. The rate is determined by modeling the estimated salary for a person with the necessary skills and training, the estimated time spent with the participant, and the procurement of the necessary goods and services. The salary and time estimates were based upon the experience of providers delivering similar services under a different program. This rate is updated periodically for inflation.

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The rates for Substance Abuse Disorder services and HCBS – Adult Mental Health Recovery Management are based on the established State Plan Medicaid fee schedule.
Community First Choice State Plan Option

1. Eligibility

(a) The State determines eligibility for Community First Choice (CFC) services in the manner prescribed under 42 CFR §441.510. To receive CFC services and supports in Texas, an individual must meet the following requirements:

(1) Be eligible for medical assistance under the state plan;

(2) As determined annually, be in an eligibility group under the state plan that includes nursing facility services; and

(3) Receive a determination, at least annually, that in the absence of the home and community-based personal assistance services and supports, the individual would otherwise require the level of care furnished in a hospital, a nursing facility, an intermediate care facility for individuals with an intellectual disability or a related condition, an institution providing psychiatric services for individuals under age 21, or an institution for mental diseases for individuals age 65 or over, if the cost could be reimbursed under the state plan.

(b) Individuals who qualify for medical assistance under the special home and community-based waiver eligibility group defined at section 1902(a)(10)(A)(ii)(VI) of the Social Security Act must meet all section 1915(c) requirements and receive at least one home and community-based service per month.

(c) Individuals receiving services through CFC are not precluded from receiving other home and community-based long-term services and supports (LTSS) through other Medicaid state plan, waiver, grant, or demonstration authorities.

2. Statewideness

CFC is available to all eligible individuals in Texas, regardless of their location within the State, in a manner that provides the services and supports in the most integrated setting appropriate to the individual's needs, and without regard to the individual's age, type or nature of disability, severity of disability, or the form of CFC services and supports the individual requires to lead an independent life.
3. Included Services

(a) **CFC personal assistance services**: assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs), as defined in 42 CFR §441.505, through hands-on assistance, supervision, and/or cueing. Such assistance is provided to an individual in performing ADLs and IADLs based on a person-centered service plan. CFC personal assistance services include:

(1) Non-skilled assistance with the performance of ADLs and IADLs;
(2) Household chores necessary to maintain the home in a clean, sanitary, and safe environment;
(3) Escort services, which consist of accompanying, but not transporting, and assisting an individual to access services or activities in the community; and
(4) Assistance with health-related tasks as defined in 42 CFR §441.505. Health-related tasks, in accordance with state law, include tasks delegated by a registered nurse, health maintenance activities, and extension of therapy. An extension of therapy is an activity that a speech therapist, physical therapist or occupational therapist, instructs the individual to do as follow-up to therapy sessions. If appropriate, the individual's attendant can assist the individual in accomplishing such activities with supervision, cueing and hands-on assistance.

In the consumer-directed services model, the individual or legally-authorized representative determines health-related tasks without a nurse assessment, in accordance with state law.

(b) **CFC habilitation**: acquisition, maintenance, and enhancement of skills necessary for the individual to accomplish ADLs, IADLs, and health-related tasks as defined in 42 CFR §441.505. This service is provided to allow an individual to reside successfully in a community setting by assisting the individual to acquire, retain, and improve self-help, socialization, and daily living skills or assisting with and training the individual on ADLs and IADLs. Personal assistance may be a component of CFC habilitation for some individuals. CFC habilitation services include training, which is interacting face-to-face with an individual to train the individual in activities such as:

(1) self-care;
(2) personal hygiene;
(3) household tasks;
Community First Choice State Plan Option (continued)

(4) mobility;
(5) money management;
(6) community integration, including how to get around in the community;
(7) use of adaptive equipment;

(8) personal decision-making;
(9) reduction of challenging behaviors to allow individuals to accomplish ADLs, IADLs, and health-related tasks; and
(10) self-administration of medication.

(c) **CFC emergency response services**: backup systems and supports, as defined in 42 CFR §441.505, to ensure continuity of services and supports. Reimbursement for backup systems and supports is limited to electronic devices to ensure continuity of services and supports and are available for individuals who live alone, who are alone for significant parts of the day, or have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

(d) **CFC support management**: voluntary training on how to select, manage, and dismiss attendants.
4. Home and Community-Based Setting

All CFC services are provided in a home or community-based setting, which does not include a nursing facility, hospital providing long-term care services, institution for mental disease, intermediate care facility for individuals with an intellectual disability or related condition, or setting with the characteristics of an institution. All CFC settings comply with 42 CFR §441.530. The state has process and procedures to ensure ongoing compliance with the setting requirements outlined in 42 CFR §441.530. Settings include individual homes, apartment buildings, and non-residential settings that meet the settings criteria outlined in 42 CFR §441.530. Settings do not include provider-owned or controlled residential settings. The State will amend the state plan if it determines that other settings meet the settings criteria outlined in 42 CFR §441.530.

5. Assessment of Institutional Level of Care and Functional Need

Individuals receive an assessment of institutional level of care (LOC) and functional need by a qualified provider initially and on an annual basis.

(a) LOC Assessment:

(1) To determine nursing facility and hospital LOC, Texas uses the Medical Necessity/Level of Care (MN/LOC) assessment. MN is the determination that an individual requires the services (supervision, assessment, planning, and intervention) of licensed nurses in an institutional setting to carry out a physician’s planned regimen for total care.

(1) To determine ICF/IID LOC, Texas uses the Intellectual Disability/Related Condition assessment (ID/RC). The ID/RC assessment includes all factors needed to determine an LOC: diagnostic information that includes age of onset of the qualifying conditions, names of qualifying conditions, the appropriate International Classification of Diseases codes, results of standardized intelligence testing, and the adaptive behavior level as determined by an approved adaptive behavior assessment tool.

(2) To determine psychiatric inpatient LOC for individuals under age 21, and institution for mental disease LOC for individuals age 65 and over, the Child and Adolescent Needs and Strengths assessment (CANS) or Adult Needs and Strengths assessment (ANSA) is completed and entered into a State
Community First Choice State Plan Option (continued)

system which has an automated clinical and diagnostic tool that helps
determine an individual’s LOC. The system uses CANS or ANSA data to
determine whether an individual meets Medicaid inpatient psychiatric
admission criteria.

(b) Functional Needs Assessment: Assessments for CFC services are conducted by
assessors who are determined to be qualified by the State. Such assessments
are performed as an administrative function. The functional needs assessment
and service plan development process comply with the requirements set forth in
42 CFR §§441.535-441.540.

(1) CFC functional need assessments are conducted initially and at least
annually, unless a change in condition, health status, or support needs
requires reassessment at an earlier date, or the individual requests a
reassessment. The assessments are conducted face-to-face and include an
assessment of an individual’s functional needs, strengths, preferences, and
goals for the services and supports provided under CFC.

(2) Individuals are assessed for functional need at a time and location convenient
for the individual. The assessment is conducted as part of a person-centered
planning process with the individual and anyone else chosen by the
individual. Initially and at least annually, in partnership, the assessor,
individual, and a service planning team comprised of members chosen by the
individual develop a recommended service plan for review and consideration
by the State or its designee.

(3) Qualified assessors of functional need include local intellectual and
developmental disability and mental health authorities, MCO service
coordinators or service managers, Department of State Health Services
(DSHS) case workers, direct service agencies, and case managers.

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Date Received: 10 October, 2014
Date Approved: 2 April, 2015
Date Effective: 1 June, 2015
Transmittal Number: 14-0026
6. **Person-Centered Service Plan**

The person centered service planning process will be provided in accordance with 42 CFR 441.540.

**Responsible parties and qualifications:**

A. The person-centered service plan is created simultaneously and in conjunction with the functional needs assessment by qualified assessors which include local intellectual and developmental disability and mental health authorities, MCO service coordinators or service managers, DSHS case workers, direct service agencies, and case managers.

B. Texas partners with the Institute for Person-Centered Practices (the Institute) for development of a person-centered thinking and person-centered plan facilitation training, which is tailored to teach facilitators to meet the person-centered planning requirements contained in the CFC and the HCBS settings federal requirements.

C. Every person-centered plan facilitator will complete the Institute for Person-Centered Practices training or an HHSC-approved training developed and delivered within two years of the implementation of CFC. The parties required to complete the training include those that conduct the functional assessment for CFC in the Deaf Blind with Multiple Disabilities (DBMD) and Community Living Assistance and Support Services (CLASS) programs; local intellectual and developmental disability authorities in the Home and Community-based Services (HCS), Texas Home Living (TxHmL), and STAR+PLUS programs; managed care organizations in STAR+PLUS and STAR Health programs; and DSHS case workers.

**Development of the person-centered service plan:**

A. The person-centered plan facilitator contacts the individual to schedule a time to complete the person-centered service plan, which is conducted face-to-face and occurs at a time and location convenient to the individual.

B. As the individual’s functional need is assessed simultaneously, the person-centered plan facilitator works with the individual to identify the individual’s goals, needs, and preferences through use of a series of discovery skills: rituals and routines, good day/bad day communication chart, relationship map, and other tools. The individual or legally authorized representative may choose who is included in the person-centered plan development process. The individual and people who know and care about the individual are considered the content experts that provide the information to the person-centered plan facilitator.
Community First Choice State Plan Option (continued)

C. The person-centered plan facilitators have previous experience with the creation of service plans for individuals with disabilities and incorporate cultural considerations of the individual.

D. Person-centered plan facilitators use a variety of skills to resolve conflict or disagreement while developing the plan. The “Four Plus One” skill and the “What’s Working/What’s Not Working” skill are used in these instances. The “Four Plus One” is a skill used to collect, evaluate, and learn from everyday situations. “What’s Working/What’s Not Working” is a problem-solving negotiation skill that analyzes issues across multiple perspectives.

E. The person-centered service plan is reviewed and revised at least annually, upon reassessment of functional need, when the individual's circumstances or needs change significantly, and at the request of the individual or legally authorized representative through contact with the individual's person-centered plan facilitator. The person-centered service plan is reviewed by the service planning team, which consists of the individual, the individual's LAR, the person-centered plan facilitator, and any other individuals designated by the individual or the individual’s legally authorized representative. The provider may be a participant on the service planning team.

F. Throughout development of the person-centered plan, the facilitator ensures consideration of information from the individual or legally authorized representative to determine any risks that might exist to health and welfare of the individual as a result of living in the community. The discovery process utilized by the person-centered facilitator is designed to address all areas of an individual’s life: social inclusion/relationships, health and safety, work/school, self-determination, financial security, living environment, physical/emotional/behavioral, rights/legal status, and daily living skills. Following the discovery process, the facilitator identifies and documents in the person-centered plan those services that are critical to the health and welfare of the individual for which a backup plan must be developed.

G. The person-centered plan includes documentation on whether the individual has chosen the agency model or the self-directed model of service delivery.

H. The person-centered plan is finalized and agreed to in writing by the individual and signed by all individuals and providers responsible for its implementation.

I. The person-centered service plan will reflect that the setting meets the criteria outlined in 42 CFR 441.530 and is chosen by the individual.
Community First Choice State Plan Option (continued)

7. **Service Delivery Model**

- **X** Agency-Provider Model – The agency-provider model is based on the person-centered assessment of need. The agency-provider model is a delivery method in which the services and supports are provided by entities under a contract with the Health and Human Services Commission (HHSC) or its designee.

  Individuals may also elect to use the Service Responsibility Option (SRO) model. In the SRO model, a provider agency is the attendant's employer of record and handles the business details. The member is responsible for the day-to-day management of the attendant's activities, beginning with interviewing and selecting the person who will be the attendant.

- Self-Directed Model with service budget – This model is one in which the individual has both a person-centered service plan and service budget based on the assessment of need. The service plan conveys authority to perform the functions pursuant to 42 CFR §441.550. The service budget meets the requirements set forth in 42 CFR §441.560.

- Direct Cash

- Vouchers

- **X** Other Service Delivery Model as described below:

  **Consumer-Directed Services Model**

  - **X** – In this model, the individual or the legally authorized representative is the common-law employer of service providers and has decision-making authority and budget authority over the services he or she is directing. The employer assumes and retains responsibility to recruit, determine the competence of, hire, train, manage, and fire their employees.

  The financial management services include, but are not limited to, the following activities: collect and process timesheets of the individual’s attendant care providers; process payroll, withholding, filing, and payment of applicable federal, state, and local employment related taxes and insurance; separately track budget funds and expenditures for each individual; track and report disbursements and

  **State: Texas**
  Date Received: 10 October, 2014
  Date Approved: 2 April, 2015
  Date Effective: 1 June, 2015
  Transmittal Number: 14-0026

  **TN 14–026**
  Approval Date 4/2/15
  Effective Date 6/1/15

  Supersedes TN New Page
balances of each individual's funds; process and pay invoices for services in the person-centered service plan; and provide individual periodic reports of expenditures and the status of the approved service budget to the individual and to the State.

The consumer directed budget, developed by the CDS employer (the individual or Legally Authorized Representative), with assistance from the FMSA is based on the cost of the self-directed services in the approved service plan. The cost of self-directed services is defined as the number of hours authorized for the service multiplied by adopted consumer directed services reimbursement rate for the service. The CDS employer allocates the wages and benefits, if any, to be paid to the employee and any employer supports. Employer supports are permissible services and supports that are linked to an assessed need or goal in the individual's person-centered service plan that increase an individual's independence or substitute for human assistance. Employer supports are defined as services and items the employer needs to perform employer and employment responsibilities. Employer supports include recruiting expenses, required employee specific training (if not available through the State), fax machine, mailing costs, envelopes, file folders, and support consultation provided by certified support advisors. The FMSA must approve the budget by ensuring that projected expenditures are within the authorized budget for each service, are allowable and reasonable, and are projected over the effective period of the plan to ensure that sufficient funds will be available to the end date of the service plan. A revision to the budget for a particular service or a request to shift funds from one service to another requires a service plan change and must be justified by the service planning team and authorized by the State. Information described above concerning budget methodology for the consumer directed services budget is available to the public in Title 40 of the Texas Administrative Code, Part 1, Chapter 41, Subchapter E.

Support consultation provides a level of training, assistance, and support that does not duplicate or replace the services delivered through FMS, case management services, or other available program or non-program service or resource; practical skills training and assistance to successfully manage service providers for authorized program services delivered through the CDS option; and skills training and assistance for employer responsibilities including recruitment and hiring, maintaining employment documentation, communication and problem solving, decision making, coaching and one-on-one assistance, and conflict resolution related to being an employer.
Community First Choice State Plan Option (continued)

8. **Support System**

(a) Texas provides, or arranges for the provision of, a support system that meets all of the required conditions as described in 42 CFR §441.555. Components of the support system include the local intellectual and developmental disability authorities; MCOs, including the MCO service coordinators and service managers; case management agencies; financial management services agencies; support advisors; Personal Care Services case managers; comprehensive mental health providers including local mental health authorities; and provider agencies. The support system ensures:

1. Appropriate assessment and counseling for an individual before receiving services;
2. Provision of appropriate information, counseling, training, and assistance to ensure an individual is able to manage the services;
3. Establishment of conflict of interest standards for the assessments of functional need and the person-centered service plan development process that apply to all individuals and entities, public or private; and
4. Identification of the responsibilities for assessment of functional need and person-centered service plan development.
Community First Choice State Plan Option (continued)

9. Provider Qualifications

CFC services are provided by LTSS and state plan service providers determined to be qualified by the State in a program already approved by CMS. Texas ensures all current qualification standards are maintained. Providers delivering CFC services include licensed home and community support services agencies (HCSSAs), certified HCS and TxHmL providers, licensed personal emergency response services agencies, qualified financial management services agencies, and providers hired by individuals using the CDS option who meet qualifications. In accordance with Section 1902(a)(23) of the Act, the state assures that individuals will have free choice of provider, unless a limitation is authorized through a Section 1915(b)(4) waiver authority.

<table>
<thead>
<tr>
<th>Service</th>
<th>Personal Assistance Services and Habilitation (PAS/HAB)</th>
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| Service Provider Qualifications | • is at least 18 years of age; and  
| | • has a high school diploma or a certificate recognized by a state as the equivalent of a high school diploma; or  
| | • documentation of a proficiency evaluation of experience and competence to perform the job tasks that includes:  
| | o a written competency-based assessment; and  
| | o at least three written personal references from persons not related by blood that indicate the ability to provide a safe, healthy environment for the individuals being served.  
| | • is not the parent of an individual who is under 18 years of age or the individual's spouse; and  
| | • meets any other qualifications requested by the individual or legally authorized representative (LAR) based on the individual's needs and preferences.  
| | • if requested by an individual the provider must allow the individual to train a CFC PAS/HAB service provider in the specific assistance needed by the individual and to have the service provider perform CFC PAS/HAB in a manner that comports with the individual's personal, cultural, or religious preferences; and  
| | • ensure that an individual has the right to access other training provided by or through the State so that the service provider can meet any additional qualifications required or desired by the individual. |
### Consumer Directed Services

- is at least 18 years of age; and
- has a high school diploma; or
  - a certificate recognized by a state as the equivalent of a high school diploma; or
  - documentation of a proficiency evaluation of experience and competence to perform the job tasks that includes:
    - (1) a written competency-based assessment; and
    - (2) at least three written personal references from persons not related by blood that indicate the ability to provide a safe, healthy environment for the individuals being served.
- is not the individual’s legally authorized representative (LAR), LAR’s spouse, designated representative, or designated representative’s spouse; and
- meets any other qualifications requested by the individual or LAR based on the individual’s needs and preferences.

### Provider Entity Qualifications

- Licensed home and community support services agencies (HCSSAs). The agency must be licensed as a home and community support service agency under Title 40 of the Texas Administrative Code, Part 1, Chapter 97.
- Certified HCS and TxHmL providers.

### Service

#### Emergency Response Services

- See provider entity qualifications

### Service Provider Qualifications

- be licensed as a personal emergency response system provider in accordance with 25 TAC Chapter 140, Subchapter B (relating to Personal Emergency Response System Providers); or
- contract with a personal emergency response system provider licensed in accordance with 25 TAC Chapter 140, Subchapter B
Community First Choice State Plan Option (continued)

<table>
<thead>
<tr>
<th>Service</th>
<th>Support Management</th>
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<td>Service Provider Qualifications</td>
<td>• is at least 18 years of age; and</td>
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<td>Provider Entity Qualifications</td>
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<td>support service agency under Title 40 of the Texas Administrative Code, Part 1, Chapter 97</td>
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<td></td>
<td>• Certified HCS and TxHmL providers</td>
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<td>• Financial Management Services Agencies (FMSAs)</td>
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<td>See provider entity qualifications</td>
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<tr>
<td>Provider Entity Qualifications</td>
<td>Financial Management Services Agencies (FMSAs)</td>
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<td>Prior to contracting with DADS or an MCO, FMSAs must</td>
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<td>• attend a mandatory three-day training conducted by DADS; and</td>
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<td>• demonstrate knowledge of training material including the definition and responsibilities of a vendor fiscal employer agent in accordance with IRS Revenue Procedure and an explanation of fiscal employer agent based on Section 3504 of the IRS code and state tax (unemployment) requirements as a Vendor Fiscal/Employer Agent.</td>
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<td>Individual service provider must not be the individual's legal guardian; the spouse of the individual's legal guardian; the individual's designated representative; or the spouse of the individual's designated representative</td>
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State: Texas  
Date Received: 10 October, 2014  
Date Approved: 2 April, 2015  
Date Effective: 1 June, 2015  
Transmittal Number: 14-0026
10. **State Assurances**

Necessary safeguards are in place to protect the health and welfare of individuals provided services under this state plan option, and to prevent payment for items or services furnished by service providers or entities excluded from participating in the Medicaid program, in accordance with §1903(i) of the Act.

With respect to expenditures during the first full 12 month period in which the state plan amendment is implemented, the State will maintain or exceed the level of state expenditures for home and community-based attendant services and supports provided under section 1905(a), section 1915, section 1115, or otherwise to individuals with disabilities or elderly individuals attributable to the preceding 12 month period.

CFC services and supports are provided in accordance with the requirements of the Fair Labor Standards Act of 1938 and all applicable provisions of Federal and State laws regarding withholding and payment of Federal and State income and payroll taxes, the provision of unemployment and workers compensation insurance, maintenance of general liability insurance, occupational health and safety, and any other employment or tax related requirements.

The State intends to include the Community First Choice (Section 1915(k)) payments in the MCO capitation rate.

- The State provides an assurance that at least annually, it will submit to the regional office as part of its capitated rate actuarial certification a separate Community First Choice section which outlines the following:
  - Any program changes based on the inclusion of Community First Choice services in the array of benefits delivered by the MCOs
  - Estimates of, or actual (base) costs to provide Community First Choice services (including detailed description of the data used for the cost estimates)
  - Assumptions on the expected utilization of Community First Choice services and number of eligible beneficiaries (including detailed description of the data used for utilization estimates)
  - Any risk adjustments made by plan that may be different than overall risk adjustments
  - How the final capitation amount is determined in either a percent of the total capitation or an actual PMPM
11. Development and Implementation Council

HHSC identifies the Promoting Independence Advisory Committee (PIAC) to serve in the role of the Development and Implementation Council. The PIAC was established in 2001 in response to several key laws, decisions, and State actions related to supporting the choice of individuals with disabilities to receive LTSS in the most integrated setting. The PIAC helps to ensure Texas Medicaid home and community-based programs and benefits effectively foster independence and productivity and provide opportunities for people with disabilities to live in the most appropriate care setting. Members of the PIAC include individuals with disabilities, advocates of individuals with disabilities, representatives of long-term care service providers who serve individuals with disabilities (including individuals who are older) and representatives of Texas health and human services agencies.
Community First Choice State Plan Option (continued)

12. Quality Assurance System

Texas proposes to provide CFC services through the state plan, leveraging existing program infrastructure. Cited below are the various activities engaged in by the State to meet the standards outlined in 42 CFR §441.585 (Quality assurance system). The State uses these policies and processes to the greatest extent possible, and is actively identifying areas where new policies will need to be developed.

**a) Quality Improvement Strategy (§441.585(a)(1))**

_The state must ensure the quality assurance system will employ methods that maximizes individual independence and control, and provides information about the provisions of quality improvement and assurance to each individual receiving such services and supports. §441.585(b))_

1) CFC services provided through managed care

The Texas Healthcare Transformation and Quality Improvement Program Quality Improvement Strategy is posted at http://www.hhsc.state.tx.us/medicaid/about/transformation-waiver.shtml. The State posts any revisions to the Strategy on the website and requests public comment when changes are necessary. The State is in the process of developing a comprehensive Texas Medicaid managed care quality improvement strategy. All Texas Medicaid managed care programs will be included in this Strategy. A summary of the existing strategy follows.

The Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver, known as the 1115 Transformation Waiver, is a five-year demonstration waiver running through September 2016 that allows the state to expand Medicaid managed care while preserving federal hospital funding historically received as Upper Payment Limit payments. The 1115 Transformation Waiver includes multiple Texas Medicaid managed care programs, including STAR+PLUS, a program through which CFC services will be provided.

HHSC’s mission is to create a customer-centered, innovative, and adaptable managed care system that provides the highest quality of care to individuals served by the agency while ensuring access to services. To this end, the 1115 Transformation Waiver goals and objectives include improving outcomes and transitioning to quality-based payment systems across managed care and hospitals. The 1115 Quality Improvement Strategy outlines the internal and
Community First Choice State Plan Option (continued)

external resources, mechanisms, and initiatives that together will achieve these goals. The Code of Federal Regulations includes requirements outlining the components of a state quality strategy. CMS has approved the 1115 Managed Care Strategy, demonstrating that it meets all federal requirements.

The 1115 Quality Improvement Strategy encompasses multiple programs and divisions within HHSC as well as advisory committees, and the external quality review organization. Each of these areas is responsible for complex, unique activities and serves a specific purpose in the overall Texas Medicaid quality system. Their distinct roles interact with each other to fluctuating degrees, largely dictated by specific projects and needs of the agency and stakeholders.

EVIDENCE-BASED CARE AND QUALITY MEASUREMENT

Measurement
Texas relies on a combination of established and state-developed measures that are validated by the external quality review organization, including:

- National Committee for Quality Assurance Healthcare Effectiveness Data and Information Set (HEDIS®)
- Agency for Healthcare Research and Quality Pediatric Quality Indicators/Prevention Quality Indicators
- 3M Software for Potentially Preventable Events
- Consumer Assessment of Healthcare Providers & Systems (CAHPS®) Surveys

Encounter Data Requirements
Managed care organizations (MCOs) are required to submit complete and accurate encounter data for all covered services, including value-added services, to a data warehouse for reporting purposes at least monthly. HHSC contracts with the external quality review organization to certify the accuracy and completeness of this organization encounter data. Encounter data that does not meet quality standards must be corrected and returned within a time period specified by HHSC.

Data certification reports support rate-setting activities and provide information relating to the quality, completeness, and accuracy of the MCO encounter data.

MCO-generated data and reports
Quality Assessment and Performance Improvement
Each MCO must develop, maintain, and operate a Quality Assessment and Performance Improvement Program that meets state and federal requirements.

Performance Improvement Projects
Each MCO must develop and implement performance improvement projects as required by CMS and the State. When conducting performance improvement projects, MCOs are required to follow the ten-step CMS protocol published in the CMS External Quality Review Organization Protocols.

External quality review organization processes and reports
The EQRO conducts multiple activities and develops reports to assist the State in ensuring high quality delivery of Medicaid managed care services and to meet federal requirements. These activities and reports include:

- MCO Administrative Interviews
- Data Certification Reports
- Encounter Data Validation Report
- Quarterly Topic Reports
- Summary of Activities Report
- Member Surveys and Reports
- Quality of Care Reports
- FREW-related activities and reports

TEXAS QUALITY INITIATIVES

Pay-for-Quality Program
To comply with legislative direction and to best identify quality of care measures that reflect the needs of the population served and areas needing improvement, HHSC implemented the Pay-for-Quality Program, which uses an incremental improvement approach that provides financial incentives and disincentives to MCOs based on year-to-year incremental improvement on pre-specified quality goals. The State also operates a similar dental pay-for-quality program.

Performance Indicator Dashboards
The Performance Indicator Dashboard includes a series of measures that identify key aspects of performance and support MCO accountability. The Performance
Community First Choice State Plan Option (continued)

Indicator Dashboard is not an all-inclusive set of performance measures, but it does include those measures that assess many of the most important dimensions of MCO performance and that incentivize excellence.

**MCO Report Cards**
HHSC develops annual MCO report cards for each program service area to allow members to easily compare the MCOs on specific quality measures. MCO report cards are posted on the HHSC website and included in Medicaid enrollment packets sent by the enrollment broker to potential members.

**Innovation**
Texas is engaging in multiple activities to develop new strategies to measure and encourage quality service delivery in Medicaid managed care. Examples of these activities include 1115 Waiver Regional Healthcare Partnership Projects, legislatively mandated activities such as reduction of potentially preventable events, and participation in the Texas Dual Eligible Integrated Care Project.

Data on utilization of managed care long-term services and supports is shared at regularly-scheduled STAR+PLUS stakeholder meetings. Additionally, reports developed by the State’s external quality review organization are posted for public viewing on the Health and Human Services Commission website.

2) CFC services provided through fee-for-service

For most individuals receiving fee-for-service CFC services, the quality improvement strategy is referred to as the Quality Oversight Plan (the Plan). Central to the Plan is the Quality Review Team (the Team), which consists of representatives from several agencies within the Texas health and human services enterprise. In addition to establishing quality-related priorities and directing improvement activities, the Team oversees implementation of the Plan and related processes. The Plan uses numerous quality indicators that are tracked and reported on a quarterly basis using data compiled from multiple automated systems. The areas covered by the reports include: demographics; service utilization; enrollment; level of care; service planning; consumer direction; critical incidents; provider compliance and oversight; transfers; and discharges. Activities are underway to include the remaining fee-for-service population not covered in this plan.
Community First Choice State Plan Option (continued)

The State has multiple mechanisms through which to communicate with external stakeholders, including:

- Advisory committees made up of interested professionals, such as the Medical Care Advisory Committee, the Department of Aging and Disability Services Advisory Council, and the Health and Human Services Commission Advisory Council.
- Advisory committees made up of other interested community members, such as the Intellectual and Developmental Disability System Redesign Advisory Committee, the STAR+PLUS Quality Council, and the Promoting Independence Advisory Committee.

b) Methods to continuously monitor the health and welfare of each individual who receives home and community-based attendant services and supports, including a process for the mandatory reporting, investigation, and resolution of allegations of neglect, abuse, or exploitation in connection with the provision of such services and supports. (42 CFR §441.585(a)(2))

(1) CFC services provided through managed care

The State Medicaid Agency or its designee monitors licensed or certified provider compliance with state requirements.

Licensed or certified CFC providers are required to report instances of abuse, neglect, or exploitation of an individual to the State Medicaid Agency or its designee immediately upon suspicion of such activities. This includes suspicion of abuse, neglect, or exploitation of a child by an employee of the HCSSA.

Abuse, neglect, and exploitation requirements for licensed CFC providers require the provider to adopt and enforce a written policy relating to the agency’s procedures for reporting alleged acts of abuse, neglect, and exploitation of a client by an employee of the agency. At the time an individual begins receiving services from a licensed CFC provider, the provider must give the individual a written statement informing him that complaints against the agency may be directed to the State Medicaid Agency or its designee.

Certified CFC providers must ensure that employees, subcontractors, and volunteers are knowledgeable of the acts that constitute abuse, neglect, and exploitation; the requirement to report suspicion of such acts to the State
Community First Choice State Plan Option (continued)

Medicaid Agency or its designee; how to report allegations; and methods to prevent the occurrence of abuse, neglect, or exploitation. Individuals must be informed of how to report abuse, neglect or exploitation before the individual begins receiving services from the provider.

MCOs monitor contract performance on a biannual basis. Critical events or incidents are defined in the applicable managed care contract and include:

- abuse, neglect, or exploitation;
- the unauthorized use of restraint, seclusion, or restrictive interventions;
- serious injuries that require medical intervention or result in hospitalization;
- criminal victimization;
- unexplained death;
- medication errors; and
- other incidents or events that involve harm or risk of harm to a member.

MCOs, their subcontractors, and providers must report any suspicion or allegation of abuse or neglect of a child in accordance with Texas Family Code § 261.101. The MCO, its subcontractors, and providers must report any suspicion or allegation of abuse, neglect or exploitation of an individual who is aged or who has a disability in accordance with Texas Human Resources Code § 48.051. The MCO must establish ongoing provider training regarding the providers' obligation to identify and report to the State a critical event or incident such as abuse, neglect, or exploitation related to LTSS delivered in the STAR+PLUS program. MCO member service hotline representatives must be knowledgeable about how to identify and report to the State a critical event or incident such as abuse, neglect, or exploitation related to LTSS delivered in the STAR+PLUS program. At a minimum, the STAR Health MCO’s member service representatives must be knowledgeable and trained in issues related to child abuse and how to assist members and medical consenters seeking care and services. The MCO must include information in its provider manuals and training materials regarding recognition of abuse and neglect, and the mandatory reporting requirements under the Texas Family Code. MCO service coordinators must complete service coordination training every two years. MCOs must administer the training, which must include how to identify and report critical events or incidents such as abuse, neglect, or exploitation and educating Members regarding protections. At the time a STAR+PLUS or STAR Health member is approved for long-term services and supports, the MCO must ensure that the member is informed orally and through the member handbook of the processes for reporting allegations of
abuse, neglect, or exploitation. The MCO must ensure that members are provided the toll-free numbers for the State Medicaid Agency or its designee.

Qualified providers

Before contracting with a long-term services and supports provider not licensed or certified by a Texas health and human services agency, the MCOs must ensure that the provider:

1. has not been convicted of a crime listed in Texas Health and Safety Code §250.006;
2. is not listed as "unemployable" in the Employee Misconduct Registry or the Nurse Aide Registry maintained by the State Medicaid Agency or its designee by searching or ensuring a search of such registries is conducted, before contracting with the provider and annually thereafter;
3. is knowledgeable of acts that constitute abuse, neglect, or exploitation of a member;
4. is instructed on and understands how to report suspected abuse, neglect, or exploitation;
5. adheres to applicable state laws governing transportation if providing transportation; and
6. is not the spouse of, legally responsible person for, or employment supervisor of the member who receives the service.

The MCO must also ensure the non-licensed, non-certified provider is not listed on either the State or federal Office of Inspector General lists as excluded from participation in any federal or state health care program by searching or ensuring a search of those websites is conducted before contracting and at least monthly thereafter.

As part of their licensure requirements, licensed CFC providers are required to check the Employee Misconduct Registry prior to offering employment to anyone that will have duties that include face-to-face contact with a member.

Through their credentialing process, the MCOs ensure the licensed agencies they contract with have met all licensure requirements.

Complaints
MCOs must develop, implement, and maintain a member complaint and appeal system that complies with the requirements in applicable federal and state laws and regulations, including 42 Code of Federal Regulations §431.200, 42 Code of Federal Regulations Part 438, Subpart F, “Grievance System,” and the provisions of 1 Texas Administrative Code Chapter 357 relating to Medicaid MCOs. The complaint and appeal system must include a complaint process, an appeal process, and access to the Health and Human Services Commission’s fair hearing system. The procedures must be the same for all members and must be reviewed and approved in writing by the Health and Human Services Commission or its designee. Modifications and amendments to the member complaint and appeal system must be submitted for the Health and Human Services Commission’s approval at least 30 days prior to the implementation.

The STAR Health appeal process includes a process for pre-appeals, standard appeals, and expedited appeals. The MCO is required by contract to inform all members that they have the right to request a fair hearing at any point during the appeal process, and the MCO must continue the member’s benefits if certain criteria are met.

(2) CFC services provided through fee-for-service

The State Medicaid Agency or its designee monitors licensed or certified provider compliance with state requirements.

Licensed and certified CFC providers are required to report instances of abuse, neglect, or exploitation of an individual to the State Medicaid Agency or its designee immediately upon suspicion of such activities. This includes suspicion of abuse, neglect, or exploitation of a child by an employee of the HCSSA.

Abuse, neglect, and exploitation requirements for licensed CFC providers require the provider to adopt and enforce a written policy relating to the agency’s procedures for reporting alleged acts of abuse, neglect, and exploitation of a client by an employee of the agency. At the time an individual begins receiving services from licensed CFC provider, the provider must give the individual a written statement informing him that complaints against the agency may be directed to the State Medicaid Agency or its designee.

Certified CFC providers must ensure that employees, subcontractors, and volunteers are knowledgeable of the acts that constitute abuse, neglect, and
exploitation; the requirement to report suspicion of such acts to the State Medicaid Agency or its designee; how to report allegations; and methods to prevent the occurrence of abuse, neglect, or exploitation. Individuals must be informed of how to report abuse, neglect or exploitation before the individual begins receiving services from the provider.

Qualified providers

Licensed and certified CFC providers, financial management services agencies, and individuals/employers employing providers of CFC services through the consumer-directed services option must comply with Texas Health and Safety Code, Chapter 250 and 253, including taking the following actions regarding applicants, contractors, and employees:

1) Prior to employment, obtain Texas criminal history record information from the Texas Department of Public Safety that relates to an unlicensed applicant, volunteer, contractor, or employee whose duties would or do involve direct contact with an individual; and

2) Refrain from employing or contracting with, or immediately discharge, a person who has been convicted of an offense that bars employment under Texas Health and Safety Code, Chapter 250, or an offense that the provider or participant employer determines is a contraindication to the person's employment or contract to provide services to the individual.

3) Prior to employment, search the Nurse Aide Registry maintained by the State Medicaid Agency or its designee and refrain from employing or contracting with, or immediately discharge, a person who is designated in the registry as having abused, neglected, or mistreated an individual of a facility or has misappropriated an individual's property; and

4) Prior to employment, search the Employee Misconduct Registry maintained by the State Medicaid Agency or its designee and refrain from employing or contracting with or immediately discharge, a person whose duties would or do involve direct contact with an individual, and who is designated in the registry as having abused, neglected, or exploited an individual or has misappropriated an individual's property.

All licensed and certified CFC providers and consumer directed services individual/employers are required to maintain documentation of the criminal history checks performed. All licensed and certified CFC providers, financial management services agencies, and individual/employers must screen all
employees and contractors for exclusion prior to hiring or contracting, and on an ongoing monthly basis, by searching both the State and federal Office of Inspector General lists of excluded individuals and entities. As part of on-site provider reviews, the State Medicaid Agency or its designee monitors if criminal history checks are conducted as required.

Complaints

Complaints that pertain to licensed or certified CFC providers are reported directly to the State Medicaid Agency or its designee. This includes complaints from individuals, members of the public, case managers, licensed home and community support services agency staff, and certified Home and Community-based Services and Texas Home Living providers delivering CFC services. As necessary, complaints are referred to the appropriate state agency unit (e.g. Community Services Contracts, Regulatory Services, etc.) or to another agency, if appropriate (e.g., HHS Ombudsman, Office of Inspector General) for follow-up and resolution.

c) Measures of individual outcomes associated with the receipt of home and community-based attendant services and supports as set forth in the person centered service plan, particularly for the health and welfare of individuals receiving such services and supports. (§441.585(a)(3))

(1) CFC services provided through managed care

Texas is participating in a national initiative to obtain feedback from individuals receiving long-term services and supports on their experience receiving those services through the NCI-AD survey. Data for the project is gathered through yearly in-person member surveys of a sample that includes managed care members receiving CFC services.

(2) CFC services provided through fee-for-service

Performance measures that assess for level of care, service planning, and health and safety are used to measure CFC outcomes for most individuals receiving fee-for-service CFC services. These measures address the following assurances:
• An evaluation for level of care is provided to all individuals for whom there is a reasonable indication that services may be needed in the future.
• The process and instruments described in the state plan are applied appropriately and according to the approved description to determine level of care.
• Service plans address individual's assessed needs and personal goals.
• Services are delivered in accordance with the service plan.
• The State demonstrates on an ongoing basis that it identifies, addresses, and seeks to prevent instances of abuse, neglect, and exploitation.

Activities are underway to include the remaining fee-for-service population not covered in this plan.

d) Standards for all service delivery models for training, appeals for denials, and reconsideration procedures for an individual’s person-centered service plan. (42 CFR §441.585(a)(4))

(1) CFC services provided through managed care- provider requirements

Provider requirements are described in Attachment 3.1-K, Section 9: Provider Qualifications.

(2) CFC services provided through managed care- appeals

Individuals receiving CFC are entitled to appeal the following actions:

1. an action to reduce, suspend, terminate, or deny benefits or eligibility;
2. a failure to act with reasonable promptness on a client's claim for benefits or services;
3. the denial of a prior authorization request; and
4. the failure to reach a service authorization decision within the time period specified by federal law.

In accordance with 42 C.F.R. §438.410, the MCO must establish and maintain an expedited review process for appeals.

In accordance with 42 C.F.R.§ 438.406, the MCO’s policies and procedures must require that individuals who make decisions on appeals are not involved in any previous level of review or decision-making, and are health care
professionals who have the appropriate clinical expertise in treating the member’s condition or disease. In accordance with 42 C.F.R. §438.420, the MCO must continue the member’s benefits currently being received by the member, including the benefit that is the subject of the appeal, if all criteria are met.

During the appeal process, the MCO must provide the member a reasonable opportunity to present evidence and any allegations of fact or law in person as well as in writing. The MCO must provide the member and his or her representative opportunity, before and during the appeal process, to examine the member’s case file, including medical records and any other documents considered during the appeal process.

In accordance with 42 C.F.R. §438.420(d), if the final resolution of the appeal upholds the MCO’s action, then to the extent that the services were furnished to comply with the managed care contract, the MCO may recover such costs from the member. STAR Health MCOs agree to waive this right. If the MCO or state fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the MCO must authorize or provide the disputed services promptly and as expeditiously as the member’s health condition requires. If the MCO or state fair hearing officer reverses a decision to deny authorization of services and the member received the disputed services while the appeal was pending, the MCO is responsible for the payment of services. In accordance with 42 C.F.R.§ 438.408, the MCO must provide written notice of resolution of appeals, including expedited appeals, as expeditiously as the member’s health condition requires, but the notice must not exceed the timeframes for standard appeals or expedited appeals. The written resolution notice must include the results and date of the appeal resolution.

Access to Fair Hearings
The MCO must inform members that they have the right to access the fair hearing process at any time during the appeal system provided by the MCO, with the following exception. If a member requests a fair hearing, the MCO will submit the request to the fair hearings office. The MCO will prepare an evidence packet for submission to the HHSC fair hearings staff and send a copy of the packet to the member.

Appeals for IDD Eligibility Purposes
Community First Choice State Plan Option (continued)

For STAR+PLUS or STAR Health members with an intellectual disability or related condition, the local authority completes the level of care assessment instrument and submits the information to the State Medicaid Agency or its designee. The State Medicaid Agency or its designee determines whether the member meets the criteria for an institutional level of care for an intermediate care facility for individuals with an intellectual disability or related conditions. If the level of care is approved, the local authority and MCO are notified to continue the eligibility process. If a member does not demonstrate a need for services but has an approved level of care, the MCO sends a denial notice and the member has the opportunity to appeal through the MCO’s established procedures. If the State Medicaid Agency or its designee denies the level of care, a denial notice is sent to the member, who can then appeal that decision through state agency appeal processes.

State: Texas
Date Received: 10 October, 2014
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Community First Choice State Plan Option (continued)

(3) CFC services provided through fee-for-service- provider requirements

Provider requirements are described in Attachment 3.1-K, Section 9: Provider Qualifications.

(4) CFC services provided through fee-for-service- appeals

All Medicaid programs are subject to the Uniform Fair Hearing Rules adopted by HHSC. Medicaid recipients may appeal the following actions:

- an action to reduce, suspend, terminate, or deny benefits or eligibility;
- a failure to act with reasonable promptness on a client's claim for benefits or services;
- the denial of a prior authorization request; and
- the failure to reach a service authorization decision within the time period specified by federal law.

HHSC is required to follow the notice requirements set forth in the appropriate state or federal law or regulation for the affected program. In addition, HHSC must give clients timely and adequate notice of the right to a fair hearing; explain the right of appeal; explain the procedures for requesting an appeal; explain the right to be represented by others, including legal counsel; provide information about legal services available in the community; and continue benefits if required to do so by state or federal law or regulations of the affected program; and

Except as specifically provided in federal regulations, written notice to an individual of the individual's right to a hearing must contain an explanation of the circumstances under which Medicaid is continued if a hearing is requested; and must be mailed before the date the individual's Medicaid eligibility or service is scheduled to be terminated, suspended, or reduced, except as provided by federal rules.

The individual is permitted to examine the content of his or her case file as well as all documents and records to be used by the agency at the hearing. The individual may review the appeal procedures outlined in agency policy and may request a copy of the official recording at no charge after the decision is issued.
Community First Choice State Plan Option (continued)

An individual or his or her authorized representative or legal counsel may send written questions or request a pre-hearing conference to obtain additional information. The individual may also:

- present the case personally or with the aid of others, including but not limited to the individual's representative or legal counsel;
- bring witnesses;
- present information about all pertinent facts and circumstances;
- present arguments or address anything about the case without undue interference;
- confront and cross-examine adverse witnesses; and
- submit documentary evidence to the hearings officer before, during, or after the hearing as allowed by the hearings officer. Evidence submitted after the hearing, if accepted, must be entered into the record and shared with all parties.

The HHSC hearings officer issues a decision based exclusively on testimony and evidence introduced at the hearing. The HHSC hearings officer must provide the individual with a copy of the decision.

The appeals processes for individuals receiving CFC services while enrolled in a 1915(c) waiver are summarized below. These processes are summarized below.

If services are reduced, denied, suspended, or terminated, the case manager or the State Medicaid Agency or its designee informs the individual of the change and that the individual is entitled to a fair hearing. In cases where services are being reduced or terminated, the notice includes the date by which the individual or legally authorized representative must request the hearing in order to maintain the individual's current level of services, pending the hearing decision.

If an individual requests a fair hearing, the State Medicaid Agency or its designee notifies the hearing officer of the request. The State Medicaid Agency or its designee sends copies of all relevant documentation to the individual and, depending on the program, to all known parties and required witnesses.

The State Medicaid Agency or its designee must implement the decision of the hearing officer and must send to the Health and Human Services Commission hearing office documentation that the decision has been implemented.
Community First Choice State Plan Option (continued)

(f) The State must elicit and incorporate feedback from individuals and their representatives, disability organizations, providers, families of disabled or elderly individuals, members of the community, and others to improve the quality of the community-based attendant services and supports benefit. (42 CFR §441.585(c))

The primary mechanism for obtaining stakeholder feedback on the CFC implementation is the Promoting Independence Advisory Committee, which holds quarterly public meetings. In addition, CFC-specific information has been solicited through a dedicated website and email inbox. Multiple public meetings and trainings held at least in part for the purposes of sharing CFC information and obtaining stakeholder feedback have been held and are continuing.
Community First Choice State Plan Option (continued)

13. Data Collection
As required under 42 CFR §441.580, the State will annually provide CMS with the following data on the provision of CFC services:

(a) Number of individuals estimated to receive state plan Community First Choice services and supports;

(b) Number of individuals who received the state plan CFC services and supports during the preceding federal fiscal year;

(c) Number of individuals who received state plan CFC services during the preceding federal fiscal year, reported by:

(1) disability;
(2) age;
(3) gender;
(4) education level; and
(5) employment status;

(d) Number of individuals who have been previously served under sections 1115, 1915(c) and (i) of the Social Security Act, or the personal care State plan option;

(e) Number of individuals receiving services through non-CFC LTSS services;

(f) Total dollars spent on CFC and other LTSS;

(g) Number of individuals offered the choice between community and institutional care during the service planning process and number of individuals receiving CFC who continue to remain in a community setting; and

(h) Data regarding the impact of CFC services and supports on the physical and emotional health of individuals.
The following method is used to provide benefits under Part A and Part B of title XVIII to the groups of Medicare-eligible individuals indicated:

A. Part B buy-in agreements with the Secretary of HHS. This agreement covers:

1. [ ] Individuals receiving SSI under title XVI or State supplementation, who are categorically needy under the State's approved title XIX plan.

Persons receiving benefits under title II of the Act or under the Railroad Retirement System are included:

Yes [ ] No [ ]

2. [ ] Individuals receiving SSI under title XVI, State supplementation, or a money payment under the State's approved title IV-a plan, who are categorically needy under the State's approved title XIX plan.

Persons receiving benefits under title II of the Act or under the Railroad Retirement System are included:

Yes [ ] No [ ]

3. [X] All individuals eligible under the State's approved title XIX plan.

4. [X] Qualified Medicare beneficiaries provided by section 301 of P.L. 100-360 as amended by section 8434 of P.L. 100-647.

B. Part A group premium payment billing arrangement with the Health Care Financing Administration (HCFA). This arrangement covers the following groups:

Qualified Medicare beneficiaries provided by section 301 of P.L. 100-360 as amended by section 8434 of P.L. 100-647.

C. Payment of Part A and Part B deductible and coinsurance costs. Such payments are made in behalf of the following groups:

1. Qualified Medicare beneficiaries provided by section 301 of P.L. 100-360 as amended by section 8434 of P.L. 100-647.

2. See page 1a.

3. [ ]
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State________________ Texas

COORDINATION OF TITLE XIX WITH PART A AND PART B OF TITLE XVIII

(Note for Item C.2., Attachment 3.2-A, page 1)

* All eligible recipients enrolled in Medicare who are not qualified Medicare beneficiaries. Payments are made, within reimbursement limits of this Plan, for Part B Medicare deductibles irrespective of whether the service is or is not covered under this Plan; however, payment for Part B Medicare coinsurance and Part A Medicare deductible and coinsurance is made only if the coinsurance or deductible is for services specified and covered within the amount, duration, and scope of services in this Plan, and only if a payment would be made under this Plan, if Medicare did not exist.

TN No. 89-05
Supersedes TN No. 57-10

Approval Date 9/1/89

STATE TX
DATE REC'D 4/13/89
DATE APT 11/1/89
DATE EFF 9/1/89
HCFA 89-05
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State of Texas

STANDARDS FOR INSTITUTIONS

The following are the types or kinds of institutions that provide medical care and services under the plan and are licensed and/or approved by the designated state licensing or standard-setting authority.

1. Hospitals, both public and private, are licensed by the Texas Department of State Health Services (DSHS) under the authority of Chapter 241 of the Texas Health and Safety Code and 25 Texas Administrative Code Chapter 133, except as noted below.

   University owned and operated hospitals are subject to the authority of their Board of Regents, which acts as the standard-setting authority.

   State owned and operated hospitals are subject to the standard-setting authority of DSHS.

2. Nursing facilities are licensed by the Department of Aging and Disability Services (DADS) under the authority of Chapter 242 of the Texas Health and Safety Code and 40 Texas Administrative Code Chapter 19.

3. Intermediate care facilities are licensed by DADS under the authority of Chapter 252 of the Texas Health and Safety Code and 40 Texas Administrative Code Chapter 90.

4. Facilities owned and operated by the Christian Science faith are not subject to licensing or approved by a state standard-setting authority.

Supersedes TN: 94-30

TN: 12-01 Approval Date: 4-26-12 Effective Date: 3-1-12

Supersedes TN: 94-30
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: TEXAS

Utilization Review - Intermediate Care Facilities

1. Title XIX Intermediate Care Facility utilization review activities for Title XIX (Medicaid) recipients may, at the option of the Single State Agency, be conducted by an approved facility-based Utilization Review Committee or the field-based Medical Assistance Unit.

2. The Single State Agency Medical Assistance Unit, through its Utilization Control Section, will determine the method of utilization review for a given facility. Such determination will be based on the circumstances involved in a given situation. In every case the method selected will be that which is most likely to achieve the desired result.

3. If a Utilization Review Committee is to perform utilization review activities for an Intermediate Care Facility, the committee composition and utilization review plan must have prior approval as a condition to its functioning and reimbursement for these services. Approval must be obtained from the Utilization Control Section of the Medical Assistance Unit of the Single State Agency.

4. If utilization review activities for a given facility are not performed by an approved Utilization Review Committee, the appropriate field-based Medical Assistance Unit will be responsible for this function.

5. Title XIX Intermediate Care Facility Utilization Review activities will be accomplished in accordance with utilization review plans approved by the Single State Agency.
I. General Information

Commission

The Texas Rehabilitation Commission/for the Blind, and Crippled Children's Division of the State Health Department have traditionally served their clients in the medical area and have accumulated vast knowledge and unique skills in the field of serving people. Therefore, the Department of Public Welfare has joined in cooperative agreements with these agencies to insure comprehensive service to the client through the combined efforts and skills of these agencies.

A. Agreement between the Department of Public Welfare and Vocational Rehabilitation

The needs of a large group of residents of the State of Texas are such that services rendered jointly by the Texas State Department of Public Welfare, through its programs of Public Assistance and Title XIX Medical Assistance, and the Texas Rehabilitation Commission can provide the most effective means of achieving maximum self-help. The skills and resources of these two agencies complement each other. The Texas Rehabilitation Commission has demonstrated competence in the fields of vocational counseling, physical restoration, employment training and retraining, and job placement.

The Public Assistance Division has demonstrated competence in the fields of family counseling, assessment of readiness for change by individuals, knowledge of community resources for the correction of problems of social functioning, and in providing the day-to-day funds for the maintenance of families and individuals. Each of these agencies has staff assigned to give services in each county of the State. Traditionally, both have given service in many instances to the same individual. Because of this mutuality of interest, to avoid any possible duplication of service,
and in order to make the sum total of the benefits to the client greater than the parts played by the two agencies separately, the following agreement is made between the Texas Rehabilitation Commission and the Texas State Department of Public Welfare. Nothing in the agreement is intended to state or imply that either agency will carry out duties which are properly the responsibility of the other, or that one agency will assume supervision over the staff of the other.

1. **Case Planning**

(a) **Referral.** Cases in need of either welfare or rehabilitative services may be identified by either the Public Assistance Worker or the Rehabilitation Counselor. The Public Assistance Worker will refer in writing to the appropriate Rehabilitation Counselor all those cases in which it appears that physically, mentally, and/or emotionally handicapped persons may be able to qualify for Rehabilitation services. The Rehabilitation Counselor will likewise refer in writing to the appropriate Public Assistance Worker all applicants who appear to be in need of welfare services. This will be for the dual purpose of assisting the individual in determining his eligibility for financial and casework services available from the Department of Public Welfare staff.

(b) **Rehabilitative Plan.** The establishment of a rehabilitative plan is one that will be arrived at jointly by the worker and the counselor with the handicapped individual participating within the limitations of his capabilities and understanding. It will be the responsibility of the counselor and/or the worker, as appropriate, to carefully interpret to the individual his own responsibility to adhere to the plan's objective. Control of plans for medical evaluations and physical restoration services will be vested in and be the responsibility of the Texas Rehabilitation Commission, once

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a consensus is reached between the worker and the counselor, that the handicapped individual may benefit from joint agency planning.

2. **Client's Right of Free Choice in Accepting Medical Plan**

   It is understood, however, that this in no way abridges the right of the individual recipient of Public Assistance to receive medical care from any physician or hospital of his choosing that is participating in the Title XIX Program. The recipient for whom joint planning is undertaken remains free to reject or to abandon the plan at any point and by reason thereof, he shall not be denied any rights to receive medical assistance or other services to which he would otherwise be entitled from either agency.

3. **Financial Agreement with Respect to Title XIX**

   (a) The Department of Public Welfare now has available substantial financial resources for meeting certain basic medical needs which heretofore have been borne out of limited Rehabilitation funds. Since the basic objectives are to achieve maximum benefits for the handicapped individual and to make such benefits available to all persons in need of services, and eligible for services of both programs, it is agreed that Title XIX funds, insofar as possible, will be utilized in all cases until maximum limitations have been exhausted. Available Rehabilitation funds will then be used to supplement this basic coverage in order to provide the highest quality of medical care possible.

**Exception:**

The Texas Rehabilitation Commission has traditionally served its clients in the medical area and has accumulated vast knowledge and unique skills in the field of
serving people requiring prosthetic devices, braces and special medical equipment and has developed special techniques in giving home health services. With this background and this skill it is desirable that the Texas Rehabilitation Commission retain complete control of all cases requiring medical services in these areas. Therefore, the Texas Rehabilitation Commission will continue to perform these services and will assume all financial responsibility for such services to individuals who are otherwise eligible for the services under their regulations.

(b) In order to achieve maximum efficiency in the handling of cases, it is agreed that both agencies will strive to obtain uniformity (as between the two agencies) relative to fees for medical evaluations, physical restoration services, and hospital payments.

4. **Liaison Between Department of Public Welfare and Texas Rehabilitation Commission**

(a) **State Office Level.** The two agencies will maintain close liaison at the State level. This will be accomplished through the establishment of a Coordinating Committee.

The purpose of the committee will be to review mutual operations, evaluate pertinent policies of both agencies, arrive at agreements as to activities, periodically evaluate the functioning of each agency, occasionally review individual cases which present unusual problems affecting agency relationships, and handle any other matters which seem appropriate. The Director of Public Assistance of the State Department of Public Welfare, and the Director of the Texas Rehabilitation Commission, will serve as co-chairman of the committee.

(b) **Liaison on Intermediate Level.** Caseloads of each agency will be maintained at a size which will permit maximum effective treatment to each individual.
case. These maximum caseloads will be reviewed from time to time by the Coordinating Committee.

Mutual caseloads will be established. In the larger centers of population, this will mean that one or more workers for each agency will be assigned to carry mutual caseloads. The number of cases to be carried by each staff member will be established by the Coordinating Committee. In those localities having a caseload too scattered to be moved into a single caseload either for the Public Assistance Worker or the Rehabilitation Counselor, a suitable plan for cooperative effort will be worked out by the Coordinating Committee.

In both concentrated caseload areas and scattered caseload areas appropriate plans will be established for formalized and regularly scheduled consultations on individual cases by the worker and/or supervisor. These plans will include defined periods in the progress of each case at which a specific evaluation will be made, and treatment plans of each agency will be either restored or amended.

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5. Continuous Exchange of Information

At both the State level and the local level, good communication is essential. As staff members of each agency become aware of information which would be helpful to the other agency, such information should be shared. In addition to information about individual cases this would include such matters as changes in policy, pending or enacted legislation, changes in the types of cases being received, expansion or restrictions of financial resources, and any other matters which affect the operation of either agency.

It will be the responsibility of all interagency agreement participants on all levels to explain to their respective counterparts, any portion of this agreement which is inherent to and limited by their respective agency policies, as the necessity for such clarification appears appropriate in the opinion of either.

6. Statistical Information

The two agencies will develop means whereby statistical information will be shared. Preferably systems of joint collection and analysis of statistical data will be established.

7. Coordinated Staff Development

At the State Office level, plans will be formulated for initial orientation and for regular and on-going staff development which will involve both State Department of Public Welfare staff and Vocational Rehabilitation staff assigned to mutual caseloads. Timing and content will be worked out by the training staff of each agency, in consultation with the Coordinating Committee, or other appropriate persons.

B. Agreement Between Department of Public Welfare and Department of Health - Crippled Children's Division

The State Department of Public Welfare and the State Department of Health jointly recognize that both agencies carry a responsibility to provide recipients of their services with a high quality of medical care achieved through both social and medical services and resources. This agreement has been made to insure such services to the clients.

To further this objective, the Crippled Children's Division agrees to prepare a statement of conditions under which children are eligible for their services. The State Department of Public Welfare will disseminate this statement to its offices throughout the State in order to assist its worker in identifying those cases that can benefit from the program.
The Department of Public Welfare agrees to submit to the Crippled Children's Division a similar statement of conditions under which children are eligible for participation in its financial assistance and medical assistance programs. The Crippled Children's Division will disseminate this statement to interested parties throughout the State in order that referrals can be made on those cases not receiving but believed to be eligible for Department of Public Welfare programs.

1. Case Planning

(a) Referral. To achieve this objective, the State Department of Public Welfare will make a concerted effort to identify within its caseloads all those children who could be benefited by the high quality of services now being provided by the Crippled Children's Program and make a written referral of such families to the Crippled Children's Division of the State Department of Health, Austin, Texas. The Department of Public Welfare Worker and the Division of Crippled Children's Counselor will have a joint conference on each eligible case whenever feasible and will agree upon a plan of working with the family.

(b) Rehabilitative Plan. The Crippled Children's Division will carry primary responsibility for evolving a plan that will achieve the highest degree of medical care possible and thus achieve for the child maximum benefits under their program. The Department of Public Welfare Worker will lend support and encouragement to the family in its pursuit of this plan. If the family undertakes the plan, the Crippled Children's Division will make the necessary arrangements with the providers of medical services and will issue authorizations for services.

2. Client's Right to Free Choice in Accepting Medical Plan

The family of the recipient for whom joint planning is undertaken remains free to reject or abandon the plan at any point and the family cannot be denied the right to receive medical assistance or other services to which it would otherwise be entitled to receive from either agency.

It is understood that none of the foregoing in any way abridges the right of the individual recipient of public assistance to receive medical care from any provider of services of his choosing if such provider of service is participating in the Title XIX Program.

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3. Financial Agreement with Respect to Title XIX

In recognition of the fact that the Crippled Children's Division has insufficient funds to meet its total responsibilities, the Crippled Children's Division will instruct its providers of services to bill first the fiscal intermediary for Department of Public Welfare's Title XIX Program for the basic services and out-patient services. Any unpaid cost for such services, due to maximum limitations in the Title XIX Program (e.g., 30 day limitation on hospitalization in the case involving a more extended stay), will remain the financial responsibility of the Crippled Children's Division as eligible for treatment pursuant to Article 4419c, Vernon's Texas Civil Statutes.

Exception:

Since the Crippled Children's Division has traditionally served its clients in the medical area and has accumulated vast knowledge and unique skills in the field of serving people requiring prosthetic devices, braces and special medical equipment and has developed special techniques in giving home health services, it is desirable that the Crippled Children's Division retain complete control of all cases requiring medical services in these particular areas. Therefore, the Crippled Children's Division will continue to perform these services to individuals who are eligible for the services under their regulations.

It is understood that Department of Public Welfare cannot guarantee it will assume financial obligation to the providers of Title XIX basic services until such time that eligibility has been established. Although it is possible for medical assistance to be made retroactive to the date of application on cases eventually found to be eligible, it is understood that no financial obligation on the part of Department of Public Welfare accrues for services rendered prior to such time.

In order to achieve maximum efficiency in the handling of cases in which both agencies may become a party to payment, it is agreed that both agencies will strive to obtain uniformity insofar as practical with respect to fees, physical restoration services and hospital payments.

4. Liaison Between Department of Public Welfare and Crippled Children's Division

(a) Liaison at the State Level. The two agencies will maintain close liaison at the State Office level. This will be achieved by establishing a Coordinating Committee which would consist of the Assistant Commissioner for Medical Administration and the Director of Public Assistance, representing the State Department of Public Welfare, and the Section Chief of Special Health Services and Director of Crippled Children's Services, representing the State Department of Health, and such other personnel as the Commissioners may from time to time designate. This committee will meet from time to time for the purpose of evaluating the effectiveness of this agreement and recommending such modifications in procedures and policies as may be indicated.
(b) Liaison at the Local Level. Joint conferences will be held on the local level whenever feasible and appropriate to further the well being of the client and the achievement of the case plan.

5. Continuous Exchange of Information

Both agencies agree to a free exchange of confidential information to the extent necessary to achieve effective case planning. Both agencies agree to respect the confidential nature of case records and other case information and not to share such information with unauthorized persons or agencies.

C. Agreement Between Department of Public Welfare and State Commission for the Blind

The purpose of the agreement is to provide for the orderly, effective and efficient administration of services to those disabled Texans whose services represent a mutual responsibility of Department of Public Welfare and the State Commission for the Blind, and to insure, pursuant to applicable state and federal law, that all state and federal resources available for the assistance and improvement of the visually handicapped are utilized to the maximum extent possible. The objective of this agreement, therefore, is to provide a basis for sound working relationships between the state office personnel and the field staff of both agencies. Recognizing the maximal benefits to individual clients are best achieved through cooperative activity, these working relationships intend that the respective efforts of each agency shall complement the efforts of the other agency and that there shall be no duplication of services.

1. Case Planning

(a) Referral. The State Department of Public Welfare agrees to refer all visually impaired persons (regardless of age or degree of visual loss) to the State Commission for the Blind for rehabilitative services. Referrals may be made directly to the local office of the State Commission for the Blind or to the Commission's state office. The State Commission for the Blind agrees to refer to the appropriate Public Assistance Worker, all applicants who appear to be in need of welfare services.

(b) Rehabilitative Plan. Control of plans for medical evaluations and physical restoration services will be vested in and be the responsibility of the State Commission for the Blind, once a consensus is reached between appropriate representatives of the field staff of both agencies that the handicapped individual may benefit from joint agency planning.

2. Client's Right of Free Choice in Accepting Medical Plan

It is understood, however, that this in no way abridges the right of the individual recipient of Public Assistance to receive medical care from any hospital or hospital of his choosing that is participating in the Title XIX Medical Assistance Program. The recipient for whom joint planning is undertaken remains free to reject or to abandon the plan at any point and by whom thereof he shall not be denied any rights to receive medical assistance from agencies to which he would otherwise be entitled from either...
3. **Financial Agreement with Respect to Title XIX**

(a) **Basic Title XIX Services Supplemented by State Commission for the Blind.** Clients who are eligible for aid through the Title XIX Medical Assistance Program operated by the Department of Public Welfare or for maintenance available from other public assistance funds will first receive assistance through the Department of Public Welfare. If the basic coverage through the Department's Title XIX Medical Assistance is not adequate and if the individual is otherwise eligible for the services of the State Commission for the Blind, the funds of the State Commission for the Blind will then be used to supplement the basic Title XIX Medical Assistance coverage for hospitalization, physicians' services, X-ray and laboratory services, out-patient services, and skilled nursing home services.

(b) **Additional Services Responsibility of State Commission for the Blind.** The parties agree that because of the experience of the Commission for the Blind with regard to providing medical services to people requiring prosthetic devices, braces, and special medical equipment, it is desirable that the Commission for the Blind retain complete control of all cases requiring medical services of these types. The Commission for the Blind, therefore, will continue to perform these services and will assume all financial responsibility for such services to individuals who are otherwise eligible for the services under the statutes and regulations applicable to the Commission for the Blind.

The amounts respectively paid for medical services by the parties to this agreement shall be determined by the respective fee schedules of the parties, and the parties agree to strive for such uniformity in fees as each agency finds to be feasible.

(c) **Subsistence Payments.** It is not a function of the Commission for the Blind to provide subsistence payments to assist individuals in meeting the financial costs of their basic living needs. The provision of such assistance is a basic responsibility of the Department of Public Welfare. Both parties recognize, however, that additional personal costs are inherent in most rehabilitation plans formulated by the Commission for the Blind for individual clients. It is further recognized that the responsibility for assisting individuals in meeting such additional costs necessarily is that of the Commission for the Blind. Any cash payment, therefore, made by the Commission for the Blind to or for a client represents an allowance for a training-related expense imposed as a consequence of rehabilitation services extended by the Commission. Department of Public Welfare staff accordingly, will disregard such payments in budgeting for individual clients.

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**APPROVED BY DHHS/HCFA/DPO**

**DATE:** 11-6-74

**TRANSMITTAL NO:** 14-50
4. Liaison Between Department of Public Welfare and State Commission for the Blind

(a) State Office Level. The two agencies will maintain close liaison at the state level. This will be accomplished through routine and periodic communication on the part of those individuals on the state office staff of the two agencies who are primarily concerned with each agency's provision of medical services. Other appropriate state office representatives of both agencies will meet from time to time, as special problems might require and for the purpose of evaluating periodically the effectiveness of this agreement.

(b) Liaison on the Intermediate and Local Level. Both agencies will encourage intermediate level staff and field staff to cooperate with one another, to develop close working relationships and to communicate directly when it is apparent that cooperative effort is desirable on particular cases.

5. Continuous Exchange of Information

It is recognized that good communication is essential at both the state level and the local level if this agreement is to be efficiently implemented. Therefore, when staff members of either agency become aware of information which would be helpful to the other agency, such information will be shared. The information to be shared includes, but is not limited to, such matters as changes in policy, actual or proposed legislative changes, changes in the types of cases being received, expansion or restriction of financial resources, and other similar matters which affect the operation of either agency.

6. Statistical Information

The two agencies will develop adequate means whereby statistical information will be shared.

7. Coordinated Staff Development

At the state office level within both agencies, plans will be formulated for initial orientation and for regular and on-going staff development which will involve personnel from both the State Department of Public Welfare and the State Commission for the Blind. Timing and consent will be worked out by the training staff of each agency in consultation with appropriate representatives of the other agency.

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DATE: 11-6-74

TRANSMITTAL NO: 74-50
II. Implementation of the Agreements

A. Identify Clients

The DPW worker will review his caseload to identify individuals who could profit by referral to one of the three cooperating agencies. Although the final eligibility will be determined by the other agency involved, the DPW worker will use the general eligibility outlines to determine the advisability of referral.

B. Discussion of Referral with Clients

The DPW worker will discuss with the client, (or, if he is a child, with his parents or other responsible relative or legal guardian) his willingness to be referred for treatment, training, etc., explaining the reasons for, and benefits to be derived from, the services of the other agency. Since illnesses and handicaps have various meanings to people, it is a prerequisite that the worker understand how the client feels about his condition, and what he would like to do about it before he can effectively discuss the proposed referral. Resistance and problems will have to be handled on an individual basis, allowing the client to move toward this step at his own rate of speed.

Case work services are especially important in those instances where a family prefers to use a doctor other than the specialist selected by the other agency.

C. Referral to Other Agency

If the client is willing to be referred, the DPW worker will send a written referral to the other agency, giving identifying information, the reason for the referral (including the client's feeling about going to the other agency), and requesting a conference to discuss the situation.

D. Joint Conference With Department of Public Welfare and Other Agency

The DPW worker and his supervisor should confer with the worker and supervisor from the other agency concerning the decision to accept or reject the referral.

1. Acceptance of the Case

The representatives of the two agencies will discuss reasons for the referral, the possibilities for treatment or rehabilitation, mutual responsibilities, and social problems involved in treatment before arriving at a decision as to acceptance of the case.
2. Case Planning

If the case is accepted, plans will be formulated for follow up on the situation; an agreement will be made regarding mutual responsibilities; and an understanding will be reached as to the frequency of exchange of information while the patient is receiving mutual services.

(a) Medical Planning

Medical treatment will be supervised by the other agency. They will plan the treatment or the training courses and work out plans to deal with problem areas, such as transportation, living arrangements away from home, etc.

(b) Social Planning

The DPW worker will help implement the plan by giving the family and the patient interpretive and supportive case-work help. The worker will help to smooth out any social problems involved, such as substitute child care, assistance with financial problems, etc.

(c) Financial Agreements

According to the agreements made by the Department of Public Welfare with Vocational Rehabilitation, Crippled Children's Division, and the State Commission for the Blind, the financing of medical treatment will be as follows:

Title XIX will be billed for the basic medical services, i.e., in-patient hospitalization, physicians' services, X-ray and laboratory services, skilled nursing home services, and out-patient services.

Any balance unpaid by Title XIX will be the responsibility of the respective agency.

Other items and services will be paid for out of the funds of the other agency, according to their own billing system. These items would ordinarily include such items as prosthetic devices, braces, and special medical equipment, as well as home health services.

Note:

Any physical or mental examinations performed by the other agency which are necessary to establish the eligibility of the client for their program, are the financial responsibility of the other agency. This is especially true in relation to Crippled Children's Division since the Department of Public Welfare is not to pay for any separate and complete diagnostic workup.
In the referral conference a plan will be decided upon for any future conferences and exchange of information which will be needed to implement the plan.

3. Follow-up

The responsibilities of the two agencies will continue as long as the case is mutually handled. The DPW worker will give casework services to help the client follow through with his treatment or training so that he may make the optimum use of the services offered him. The cooperative agency will continue to give the required medical and rehabilitative services, carrying primary responsibility for these services.

4. Exchange of Information

Both agencies will exchange information on the progress of the case, indicating any areas of difficulty encountered which would have a bearing on the functions of the other agency.

5. Termination of Services

When either agency prepares to terminate the case, a summary will be sent to the other agency stating the progress of the case, the goals achieved, any accomplishments made or not made, and any recommendations for the future.

Interrelations Between Title XIX and Title V Grantees

The State Agency will when feasible make cooperative arrangements with grantees under Title V of the Social Security Act to provide for utilizing such grantees in furnishing to recipients eligible for Medical Assistance under Title XIX the care and services which are available under Title V plans or projects provided such care or services are included in the Texas State Plan for Medical Assistance under Title XIX of the Social Security Act. Where requested by the Title V grantee and agreed to by the State Agency and in accordance with the arrangements specified in 45 CFR 251.10 (a) (3) provisions may be made for reimbursement of the cost of such care and services furnished by or through the Title V grantee to an individual eligible therefor under the Texas State Plan for Medical Assistance under Title XIX. The cooperative arrangements, where such reimbursement is provided for, shall be in writing, and the State Agency may pay the providers directly or through its Health Insuring Agent or may reimburse the Title V grantee as determined by the State Agency.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: TEXAS

LIENS AND ADJUSTMENTS OR RECOVERIES

1. The State uses the following process for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home:

Not applicable since Texas is not pursuing liens.

2. The following criteria are used for establishing that a permanently institutionalized individual's son or daughter provided care as specified under regulations at 42 CFFR §433.36(f):

Not applicable since Texas is not pursuing liens.

3. The State defines the terms below as follows:

Estate – The real and personal property of a decedent, both as such property originally existed and as from time to time changed in form by sale, reinvestment, or otherwise, and as augmented by any accretions and additions and substitutions that is included in the definition of the probate estate in Section 3(l) of the Texas Probate Code.
4. The State defines undue hardship as follows:

373.209 Undue Hardship Waivers
MERP will not recover from estates if recovery would cause undue hardship. An undue hardship waiver request form will be provided with the Notice of Intent to File Claim.

(a) An undue hardship does not exist solely because:

1. Recovery would prevent heirs or legatees from receiving an anticipated inheritance; or,
2. The circumstances giving rise to the hardship were created by, or are the result of estate planning methods under which assets were sheltered or divested in order to avoid estate recovery.

(b) Undue hardship waivers include:

1. The estate property subject to recovery has been the site of the operation of a family business, farm, or ranch at that location for at least 12 months prior to the death of the decedent; is the primary income producing asset of heirs and legatees and produces 50 percent or more of their livelihood, and recovery by the State would affect the property and result in the heirs or legatees losing their primary source of income;
2. One or more siblings or direct descendents of the deceased person (lineal heir(s), such as children and grandchildren) will inherit the homestead of the deceased Medicaid recipient, provided that each sibling or lineal heir inheriting the homestead has family income below 300 percent of the federal poverty level.

"Family" means that the department will consider each heir separately. Heirs will not be aggregated into one family unless the heirs are minor children who are siblings. In the case of an adult heir, his or her family will be limited to the heir, the heir’s spouse, the heir’s minor children, and the spouse’s minor...
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: TEXAS

children residing in the household. In the case of the heir who is a minor, the heir’s family will be the heir, his or her parent(s) or stepparent residing in the household, and the heir’s minor siblings residing in the household, including half-, step-, and adoptive siblings.

“300 percent of the federal poverty level” is a gross income test; no exclusions or deductions are allowed.

When there are multiple heirs and not all heirs qualify for the hardship waiver, only that percentage of the homestead that corresponds to the qualifying heir or heirs’ share of the homestead will be exempt from Medicaid recovery.

(3) Heirs and legatees would become eligible for public and/or medical assistance if a recovery claim were made;

(4) Allowing one or more survivors to receive the estate will enable him or her or them to discontinue eligibility for public and/or medical assistance; or,

(5) Other compelling reasons, for example:

(a) a sibling or parent of the recipient who has an equity interest in the recipient’s home and who was residing in such home for a period of at least (1) year immediately before the date of the recipient’s admission to the institution and who has been residing in the home on a continuous basis; or

(b) a married adult child or grandchild of the recipient who was residing in the recipient’s home for a period of at least (2) years immediately before the date of the recipient’s admission to the institution and who establishes by a preponderance of evidence that he/she provided necessary care to the recipient, and the care she/he provided allowed the recipient to remain at home rather than in the institution.

SUPERSEDES: NONE - NEW PAGE
5. The following standards and procedures are used by the State for waiving estate recoveries when recovery would cause an undue hardship, and when recovery is not cost-effective:

HHSC has exclusive authority to waive its claim and grant undue hardship waivers as determined by the HHSC MERP program on an individual case-by-case basis. An undue hardship waiver determination will be made by MERP within 30 days of the receipt of an undue hardship waiver request form and all required necessary supporting documents by MERP.

Undue hardship waiver request forms shall be submitted to the following address:
MERP, P.O. Box 13247, Austin, Texas, 78711.

6. The state defines cost-effective as follows (include methodology/thresholds used to determine cost-effectiveness):

Recovery will not be cost-effective when the value of the estate is $10,000 or less, or the cost involved in the sale of the property would be equal to or greater than the value of the property.

On average, a funeral in Texas costs approximately $10,000. This is just one of six classes of claims under Texas Probate Code that precede estate recovery. Others include estate preservation, safekeeping and management; tax liens and second mortgages; and state taxes, penalties and interests thereon. Given the precedence of these claims and their potential costs, the state would incur administrative costs for estates valued at $10,000 or less, but have little chance of regaining those costs.

7. The State uses the following collection procedures (include specific elements contained in the advance notice requirement, the method for applying for a waiver, hearing and appeals procedures, and time frames involved):

The Medicaid Estate Recovery Program (MERP) will provide written notice of the estate recovery program provisions from the time of initial application through certification to Medicaid recipients. Medicaid long-term services provided before the effective dates of this amendment are not covered services for the purpose of the MERP.

Written notice will be provided to the following, if known by MERP at the time of notice:
(1) The recipient:
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: TEXAS

(2) The recipient's guardian of the person, if any, guardian of the estate, if any, or guardian of the person and estate, if any, provided that the name and address of the guardian or guardians are known by MERP; or

(3) The recipient's attorney in fact under a durable power of attorney if the name and address of the attorney in fact are known by the MERP; or

(4) The recipient's agent under a medical power of attorney if the name and address of the attorney in fact are known by the MERP; or

If none of the above are known, then family members acting on behalf of the recipient provided that the name and address of those family members acting on behalf of the recipient are known by MERP.

The written notice provided by the MERP to those listed above will contain the following information:

1. Description of Medicaid Estate Recovery Program (MERP) provisions;
2. Information as to covered Medicaid long-term care services subject to estate recovery;
3. Claim procedures as required in state statutes (Section 322 of the Texas Probate Code);
4. Information as to applicable "look-back" penalties for transfers of property for less than market value during the 36 months prior to applying for Medicaid benefits;
5. Description of hardship exemptions and related procedures in regard to any recovery claim;
6. Information concerning the MERP Notice of Intent to File a Claim and Medicaid Estate Recovery Claim upon the death of a Medicaid recipient.

MERP will, within 30 days of the notification of the death of a Medicaid recipient, provide a Notice of Intent to File a Claim, to the following:

1. Estate representative;
2. Recipient's guardian of the person, if any, guardian of the estate, if any, or guardian of the person and estate, if any, provided that the name and address of the guardian or guardians are known by MERP;
3. Recipient's attorney in fact under a durable power of attorney if the name and address of the attorney in fact are known by MERP; or
4. Recipient's agent under a medical power of attorney if the name and address of the attorney in fact are known by MERP; or,
5. If none of the above are known, then family members who have acted on behalf of the recipient provided that the name and address of those family members who have acted on behalf of the recipient are known by MERP.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: TEXAS

Written notice will be provided to those listed above of MERP’s intent to file an estate recovery claim against the estate of a deceased Medicaid recipient for covered services. The notice will include the following:

(1) A program overview;
(2) A questionnaire that seeks to determine whether the deceased recipient had:
   a. A surviving spouse; or
   b. A surviving child under age 21; or
   c. A surviving child who is blind or disabled as defined by 42 United States Code §1382c; or
   d. An unmarried adult child residing continuously in the decedent’s homestead for at least one year prior to the time of the Medicaid recipients’ death.

An undue hardship waiver request form is due to MERP within 30 days of the date of the Notice of Intent to File a Claim. The Notice of Intent to File a Claim will state the date that MERP received notification of the death of a Medicaid recipient and the source of the death notification of the Medicaid recipient.

MERP will not recover from estates if recovery would cause undue hardship. An undue hardship waiver request form will be provided with the Notice of Intent to File Claim.

HHSC has exclusive authority to waive its claim and grant undue hardship waivers as determined by the HHSC MERP program on an individual case-by-case basis. An undue hardship waiver determination will be made by MERP within 30 days of the receipt of an undue hardship waiver request form and all required necessary supporting documents by MERP.

An applicant may request a review of the denial of an undue hardship waiver within 30 days of receiving notice of the denial from MERP. The review is an informal process and is not a hearing. All requests for a review of the denial of an undue hardship waiver request must be made in writing.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Texas

A. The following charges are imposed on the categorically needy:

<table>
<thead>
<tr>
<th>Service</th>
<th>Nature of Charge</th>
<th>Amount and Basis for Determination</th>
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DATE EFF 6-4-03
HCFA 179 TX 03-08

STATE Texas
DATE REC'D 6-4-03
DATE APPV'D 8-1-03
DATE EFF 4-1-03

TN No. 03-08
Supersedes TN No. 02-15
Approval Date 8-1-03
Effective Date 4-1-03

SUPERSEDES: TN 02-15
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Texas

B. The method used to collect cost sharing charges for categorically needy individuals:

☐ Providers are responsible for collecting the cost sharing charges from individuals.

☐ The agency reimburses providers the full Medicaid rate for services and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

SUPERSEDES: TN. 02-15

TN. No. 03-08

Supersedes TN No. 02-15 Approval Date 8-1-03 Effective Date 4-1-03

HCFA ID: 0053C/0061E
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Texas

D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b) are described below:

E. Cumulative maximums on charges:

☐ State policy does not provide for cumulative maximums.

☐ Cumulative maximums have been established as described below:

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TN. No. 03-08
Supersedes TN No. 02-15 Approval Date 8-1-03 Effective Date 4-1-03

HCFA ID: 0053C/0061E
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Texas

A. The following charges are imposed on the medically needy for services:

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TN No. 03-08

Supersedes TN No. 02-15

Approval Date 8-1-03

Effective Date 7-1-03

SUPERSEDES: TN 02-15
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State:  Texas

B. The method used to collect cost sharing charges for categorically needy individuals:

☐ Providers are responsible for collecting the cost sharing charges from individuals.

☐ The agency reimburses providers the full Medicaid rate for services and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

SUPERSEDES: TN- 02-15

STATE: Texas
DATE REC'D 6-4-03
DATE APPV'D 8-1-03
DATE EFF 4-1-03
HCFA 179 TX 03-08

TN. No. 03-08
Supersedes TN No. 02-15 Approval Date 8-1-03 Effective Date 4-1-03

HCFA ID: 0053C/0061E
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Texas

D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b) are described below:

E. Cumulative maximums on charges:

☐ State policy does not provide for cumulative maximums.

☐ Cumulative maximums have been established as described below:

SUPERSEDES: TN-02-15

STATE TEXAS
DATE REC'D 6-4-03
DATE APPV'D 8-1-03
DATE EFF 4-1-03
HCFA 179 TX 03-08

HCFA ID: 0053C/0061E
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Texas

Premiums Imposed on Low Income Pregnant Women and Infants

A. The following method is used to determine the monthly premium imposed on optional categorically needy pregnant women and infants covered under section 1902(a)(10)(A)(ii)(IX)(A) and (B) of the Act:

B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):

*Description provided on attachment.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Texas

C. State or local funds under other programs are used to pay for premiums:
   ☐ Yes  ☐ No

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:

*Description provided on attachment.

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HCFA ID: 7986E
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Texas

Optional Sliding Scale Premiums Imposed on Qualified Disabled and Working Individuals

A. The following method is used to determine the monthly premium imposed on qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act:

B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):

*Description provided on attachment.

TN No. 91-34 Supersedes Approval Date JAN 14 1992 Effective Date OCT 01 1991

HCFA ID: 7986E
C. State or local funds under other programs are used to pay for premiums:

[ ] Yes  [ ] No

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:

*Description provided on attachment.*
The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES- INPATIENT HOSPITAL SERVICES

(a) Introduction. The Texas Health and Human Services Commission (HHSC) uses the methodology described in this section to calculate reimbursement for a covered inpatient hospital service.

(b) Definitions.

(1) Add-on--An amount that is added to the base Standard Dollar Amount (SDA) to reflect high-cost functions and services or regional cost differences.

(2) Adjudicated--The approval or denial of an inpatient hospital claim by HHSC.

(3) Base standard dollar amount (base SDA)--A standardized payment amount calculated by HHSC, as described in subsections (c) and (d) of this section, for the costs incurred by prospectively-paid hospitals in Texas for furnishing covered inpatient hospital services.

(4) Base year--For the purpose of this section, the base year is a state fiscal year (September through August) to be determined by HHSC.

(5) Base year claims--For the purposes of rate setting, including diagnosis related group (DRG) relative weights, mean length of stay (MLOS) and day thresholds, and rebasing or realignment of base rates effective September 1, 2021 and after, HHSC includes Medicaid inpatient fee-for-service (FFS) and MCO encounters that meet the criteria in subparagraphs (A) - (F) of this paragraph in the Base Year claims data. For base rates set prior to September 1, 2021, individual sets of base year claims are compiled for children’s hospitals and urban hospitals for the purposes of rate setting and realignment. All Medicaid traditional fee-for-service (FFS) and Primary Care Case Management (PCCM) inpatient hospital claims for reimbursement filed by an urban or children’s hospital that:

(A) had a date of admission occurring within the base year;

(B) were adjudicated and approved for payment during the base year and the six-month grace period that immediately followed the base year, except for such claims that had zero inpatient days;

(C) were not claims for patients who are covered by Medicare;

(D) were not Medicaid spend-down claims;

(E) were not claims associated with military hospitals, out-of-state hospitals, state owned teaching hospitals, and freestanding psychiatric hospitals; and

(F) Individual sets of base year claims are compiled for children’s hospitals, and urban hospitals for the purposes of rate setting and rebasing.

TN: 21-0032 Approval Date: April 12, 2022

Supersedes TN: 19-0026 Effective Date: 09-01-21
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES- INPATIENT HOSPITAL SERVICES

(6) Children's hospital--A Medicaid hospital designated by Medicare as a children's hospital and exempted by the Centers for Medicare and Medicaid Services (CMS) from the Medicare prospective payment system.

(7) Cost outlier payment adjustment--A payment adjustment for a claim with extraordinarily high costs.

(8) Cost outlier threshold--One factor used in determining the cost outlier payment adjustment.

(9) Day outlier payment adjustment--A payment adjustment for a claim with an extended length of stay.

(10) Day outlier threshold--One factor used in determining the day outlier payment adjustment.

(11) Diagnosis-related group (DRG)--The classification of medical diagnoses as defined in the 3M™ All Patient Refined Diagnosis Related Group (APR-DRG) system or as otherwise specified by HHSC.

(12) Final settlement--Reconciliation of cost in the Medicare/Medicaid hospital fiscal year end cost report performed by HHSC within six months after HHSC receives the cost report audited by a Medicare intermediary or HHSC.

(13) Final standard dollar amount (final SDA)--The rate assigned to a hospital after HHSC applies the add-ons and other adjustments described in this section.

(14) Geographic wage add-on--An adjustment to a hospital's base SDA to reflect geographical differences in hospital wage levels. Hospital geographical areas correspond to the Core-Based Statistical Areas (CBSAs) established by the federal Office of Management and Budget in 2003.

(15) HHSC--The Texas Health and Human Services Commission or its designee.

(16) Impact file--The Inpatient Prospective Payment System (IPPS) Final Rule Impact File that contains data elements by provider used by the Centers for Medicare and Medicaid Services (CMS) in calculating Medicare rates and impacts. The impact file is publicly available on the CMS website.

(17) Inflation update factor--Cost of living index based on the annual CMS Prospective Payment System Hospital Market Basket Index.

(18) Inpatient Ratio of cost-to-changes (RCC)--A ratio that covers all applicable Medicaid hospital costs and charges relating to inpatient care.

(19) In-state children's hospital--A hospital located within Texas that is recognized by Medicare as a children's hospital and is exempted by Medicare from the Medicare prospective payment system.

(20) Interim payment--An initial payment made to a hospital that is later settled to Medicaid-allowable costs for hospitals reimbursed under methods and procedures in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA).
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES- INPATIENT

HOSPITAL SERVICES (continued)

(21) Interim rate-The ratio of Medicaid allowed inpatient costs to Medicaid allowed inpatient charges filed on a hospital's Medicare/Medicaid cost report, expressed as a percentage. The interim rate established during a cost report settlement for an urban hospital or a rural hospital reimbursed under this section excludes the application of TEFRA target caps and the resulting incentive and penalty payments.

(22) Managed Care Organization (MCO) Adjustment Factor—Factor used to estimate Managed Care premium tax, risk margin, and administrative costs related to contracting with HHSC. The estimated amounts are subtracted from appropriations.

(23) Mean length of stay (MLOS)-One factor used in determining the payment amount calculated for each DRG; the average number of inpatient days.

(24) Medical education add-on-An adjustment to the base SDA for an urban teaching hospital to reflect higher patient care costs relative to non-teaching urban hospitals.

(25) Military hospital-A hospital operated by the armed forces of the United States.

(26) New Hospital-A hospital that was enrolled as a Medicaid provider after the end of the base year and has no base year claims data.

(27) Out-of-state children's hospital-A hospital located outside of Texas that is recognized by Medicare as a children's hospital and is exempted by Medicare from the Medicare prospective payment system.

(28) Realignment—Recalculation of the base SDA and add-ons using current RCCs, inflation factors, and base year claims as specified by HHSC, or its designee, for one or more hospital types. Realignment will occur based on legislative direction.

(29) Rebasing—Calculation of SDAs and add-ons, DRG relative weights, MLOS, and day outlier thresholds for all hospitals using a base period as specified by HHSC, or its designee. Rebasing will occur based on legislative direction.

(30) Relative weight-The weighting factor HHSC assigns to a DRG representing the time and resources associated with providing services for that DRG.

(31) Rural base year stays—An individual set of base year stays is compiled for rural hospitals for the purposes of rate setting and realignment. All inpatient FFS claims and inpatient Managed Care encounters for reimbursement filed by a rural hospital that:

(A) had a date of admission occurring within a base year;

(B) were adjudicated and approved for payment during the base year and the six-month grace period that immediately followed the base year, except for such stays that had zero inpatient days;

(C) were not stays for patients who are covered by Medicare; and

(D) were not Medicaid spend-down stays; and were not stays associated with military hospitals out-of-state hospitals, state-owned teaching hospitals, and freestanding psychiatric hospitals.
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT

HOSPITAL SERVICES (continued)

(32) Rural hospital-A hospital that:
   (A) is located in a county with 60,000 or fewer persons based on the 2010 decennial census; or
   (B) is designated by Medicare as a Critical Access Hospital (CAH), a Sole Community Hospital (SCH), or a Rural Referral Center (RRC) that is not located in a Metropolitan Statistical Area (MSA), as defined by the U.S. Office of Management and Budget; or
   (C) meets all of the following criteria:
      (i) has 100 or fewer beds;
      (ii) is designated by Medicare as a CAH, SCH, or RRC; and
      (iii) is located in an MSA

(33) Safety-Net add-on-An adjustment to the base SDA for a safety-net hospital to reflect the higher costs of providing Medicaid inpatient services in a hospital that provides a significant percentage of its services to Medicaid and/or uninsured patients.

(34) Safety-Net hospital-An urban or children’s hospital that meets the eligibility and qualification requirements described in Appendix 1 to Attachment 4.19-A (relating to Disproportionate Share Hospital Reimbursement Methodology) in the Texas State Medicaid Plan for the most recent federal fiscal year for which such eligibility and qualification determinations have been made.

(35) Standard Dollar Amount (SDA)—A standardized payment amount calculated by HHSC, as described for the costs incurred by prospectively paid hospitals in Texas for furnishing covered inpatient hospital services.

(36) State-owned teaching hospital- Acute Care Hospital owned and operated by the state of Texas.

(37) Teaching hospital-A hospital for which CMS has calculated and assigned a percentage Medicare education adjustment factor under 42 CFR §412.105.

(38) Teaching medical education add-on-An adjustment to the base SDA for a children’s teaching hospital with a program approved by the Accreditation Council for Graduate Medical Education (ACGME) to reflect higher patient care costs relative to non-teaching children’s hospitals.

(39) TEFRA target cap-A limit set under the Social Security Act §1886(b) (42 U.S.C.§1395ww(b)) and applied to a hospital’s cost settlement under methods and procedures in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). TEFRA target cap is not applied to services provided to patients under age 21, and incentive and penalty payments associated with this limit are not applicable to those services.
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT

HOSPITAL SERVICES (continued)

(40) Tentative settlement- Reconciliation of cost in the Medicare/Medicaid hospital fiscal year-end cost report performed by HHSC within six months after HHSC receives an acceptable cost report filed by a hospital.

(41) Texas provider identifier (TPI)- A unique number assigned to a provider of Medicaid services in Texas.

(42) Trauma add-on- An adjustment to the base SDA for a trauma hospital to reflect the higher costs of obtaining and maintaining a trauma facility designation, as well as the direct costs of providing trauma services, relative to non-trauma hospitals or to hospitals with lower trauma facility designations. To be eligible for the trauma add-on, a hospital must be eligible to receive an allocation from the trauma facilities and emergency medical services account under Texas Health and Safety Code Chapter 780.

(43) Trauma hospital- An inpatient hospital that meets the Texas Department of State Health Services criteria for a Level I, II, III, or IV trauma facility designation.

(44) Universal mean- Average base year cost per claim for all urban hospitals.

(45) Urban hospital- Hospital located in a metropolitan statistical area and not fitting the definition of rural hospitals, children’s hospitals, state-owned teaching hospitals, or freestanding psychiatric hospitals.
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT

HOSPITAL SERVICES (continued)

(c) Base children’s (SDA) calculations. HHSC will use the methodologies described in this subsection to determine average statewide base SDA and final SDA for each children’s hospital.

(1) HHSC calculates the average base year cost per claim as follows.

(A) To calculate the total inpatient base year cost per children’s hospital:

(i) sum the allowable inpatient charges by hospital for the base year claims; and

(ii) multiply clause (i) of this subparagraph by the inpatient RCC and the inflation update factors to inflate the base year cost to the current year.

(B) Sum the amount of all hospitals’ base year costs from subparagraph (A) of this paragraph.

(C) Subtract an amount equal to the estimated outlier payment amount for the base year claims for all children’s hospitals from subparagraph (B) of this paragraph.

(D) To derive the average base year cost per claim, divide the result from subparagraph (C) of this paragraph by the total number of base year claims.

(2) HHSC calculates the base children’s SDA as follows.

(A). From the amount determined in paragraph (1)(C) of this subsection, HHSC sets aside an amount for add-ons as described in paragraph (3) of this subsection. In determining the amount to set aside, HHSC considers factors including other funding available to reimburse high-cost hospital functions and services, available data sources, historical costs, Medicare practices, and feedback from hospital industry experts.

(B) The amount remaining from paragraph (1)(C) of this subsection after HHSC sets aside the amount for add-ons in subparagraph (A) of this paragraph is then divided by the sum of the relative weights for all children’s base year claims to derive the base SDA.

(3) A children’s hospital may receive increases to the base SDA for any of the following.

(A) Add-on amounts, which will be determined or adjusted based on the following.

(i) Impact files.

(I) HHSC will use the most recent finalized impact file available at the time of realignment to calculate add-ons; and

(II) HHSC will use the impact file in effect at the last realignment to calculate add-ons for new hospitals, except as otherwise specified in this section.
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT

HOSPITAL SERVICES (continued)

(ii) Geographic wage reclassification. If a hospital becomes eligible for the geographic wage reclassification under Medicare, the hospital will become eligible for the adjustment upon the next realignment.

(iii) Teaching medical education add-on during the fiscal year. If a hospital becomes eligible for the teaching medical education add-on the hospital will receive an increased final SDA to include these newly eligible add-ons, effective for claims that have a date of discharge occurring on or after the first day of the next state fiscal year.

(iv) Safety-net add-on during the fiscal year. The hospital will receive an increased final SDA to include these newly eligible add-ons, effective for claims that have a date of discharge occurring on or after the first day of the next state fiscal year.

(v) New children’s hospital teaching medical education add-on. If an eligible children’s hospital is new to the Medicaid program and a cost report is not available, the teaching medical education add-on will be calculated at the beginning of the state fiscal year after a cost report is received.

(B) Geographic wage add-on.

(i) CBSA assignment. For claims with dates of admission beginning September 1, 2013, and continuing until the next realignment, the geographic wage add-on for children’s hospitals will be calculated based on the corresponding CBSA in the impact file in effect on September 1, 2011.

(ii) Designated impact file. Subsequent add-ons will be based on the impact file available at the time of realignment.

(iii) Wage index. To determine a children’s hospital geographic wage add-on, HHSC first calculates a wage index for Texas as follows.

(I) HHSC identifies the Medicare wage index factor for each CBSA in Texas.

(II) HHSC identifies the lowest Medicare wage index factor in Texas.

(III) HHSC divides the Medicare wage index factor in subclause (I) of this clause for each CBSA by the lowest Medicare wage index factor identified in subclause (II) of this clause and subtracts one from each resulting quotient.

(iv) County assignment. HHSC will initially assign a hospital to a CBSA based on the county in which the hospital is located. A hospital that has been approved for geographic reclassification under Medicare may request that HHSC recognize its Medicare CBSA reclassification under the process described in subparagraph (E) of this paragraph.

(v) Medicare labor-related percentage. HHSC uses the Medicare labor-related percentage available at the time of realignment.

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HOSPITAL SERVICES (continued)

(vi) Geographic wage add-on calculation. The final geographic wage add-on is equal to the product of the base SDA calculated in subsection (c)(2)(B) of this section, the wage index calculated in clause (iii)(III) of this subparagraph, and the Medicare labor-related percentage in clause (v) of this subparagraph.

(C) Teaching medical education add-on.

(i) Eligibility. A teaching hospital that is a children’s hospital is eligible for the teaching medical education add-on. Each children’s hospital is required to confirm, under the process described in subparagraph (E) of this paragraph, that HHSC’s determination of the hospital’s eligibility for the add-on is correct.

(ii) Teaching medical education add-on calculation.

(I) For each children’s hospital, identify the total hospital medical education cost from each hospital cost report or reports that cross over the base year.

(II) For each children’s hospital, sum the amounts identified in subclause (I) of this clause to calculate the total medical education cost.

(III) For each children’s hospital, calculate the average medical education cost by dividing the amount from subclause (II) of this clause by the number of cost reports that cross over the base year.

(IV) Sum the average medical education cost per hospital to determine a total average medical education cost for all hospitals.

(V) For each children’s hospital, divide the average medical education cost for the hospital from subclause (III) of this clause by the total average medical education cost for all hospitals from subclause (IV) of this clause to calculate a percentage for the hospital.

(VI) Divide the total average medical education cost for all hospitals from subclause (IV) of this clause by the total base year cost for all children’s hospitals from subsection (c)(1)(B) of this section to determine the overall teaching percentage of Medicaid cost.

(VII) For each children’s hospital, multiply the percentage from subclause (V) of this clause by the percentage from subclause (VI) of this clause to determine the teaching percentage for the hospital.

(VIII) For each children’s hospital, multiply the hospital’s teaching percentage by the base SDA amount to determine the teaching medical education add-on amount.

(D) Safety-Net add-on.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT
HOSPITAL SERVICES (continued)

(i) Eligibility. If a children’s hospital meets the definition of a “safety-net hospital” as defined in subsection (b) of this section, it is eligible for a safety-net add-on.

(ii) Add-on amount. HHSC calculates the safety-net add-on amounts annually or at the time of realignment as follows.

(I) For each eligible hospital, determine the following amounts for a period of 12 contiguous months specified by HHSC:

(-a-) total allowable Medicaid inpatient days for fee-for-service claims;

(-b-) total allowable Medicaid inpatient days for managed care encounters;

(-c-) total relative weights for fee-for-service claims; and

(-d-) total relative weights for managed care encounters.

(II) Determine the total allowable days for eligible safety-net hospitals by summing the amounts in items (-a-) and (-b-) of subclause (I) of this clause.

(III) Determine the hospital’s percentage of total allowable days to the total in subclause (II) of this clause.

(IV) Determine the hospital’s portion of appropriated safety-net funds before the MCO adjustment factor is applied by multiplying the amount in subclause (III) of this clause for each hospital by the total safety-net funds deflated to the data year.

(V) For each hospital, multiply item (-d-) of subclause (I) of this clause by the relevant MCO adjustment factor.

(VI) Sum the amounts in item (-c-) of subclause (I) of this clause and subclause (V) of this clause for each hospital.

(VII) To calculate the safety-net add-on, divide the amount in subclause (IV) of this clause by the amount in subclause (VI) of this clause for each hospital. The result is the safety-net add-on.

(iii) Reconciliation. Effective for costs and revenues accrued on or after September 1, 2015, HHSC may perform a reconciliation for each hospital that received the safety-net add-on to identify any such hospitals with total Medicaid reimbursements for inpatient and outpatient services in excess of their total Medicaid and uncompensated care inpatient and outpatient costs. For hospitals with total Medicaid reimbursements in excess of total Medicaid and uncompensated care costs, HHSC may recoup the difference.

(E) Add-on status verification.
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT

HOSPITAL SERVICES (continued)

(i) Notification. HHSC will determine a hospital's initial add-on status by reference to the impact file at the time of realignment, Medicaid days, and relative weight information from HHSC's fiscal intermediary. HHSC will notify the hospital of the CBSA to which the hospital is assigned, the Medicare teaching hospital designation for children's hospitals as applicable, and any other related information determined relevant by HHSC. For state fiscal years 2017 and after, HHSC will also notify eligible hospitals of the data used to calculate the safety-net add-on. HHSC may post the information on its website, send the information through the established Medicaid notification procedures used by HHSC's fiscal intermediary, send through other direct mailing, or provide the information to the hospital associations to disseminate to their member hospitals.

(ii) Rate realignment. HHSC will calculate a hospital's final SDA using the add-on status initially determined by HHSC unless, within 14 calendar days after the date of the notification, HHSC receives notification in writing from the hospital, in a format determined by HHSC, that any add-on status determined by HHSC is incorrect and:

(I) the hospital provides documentation of its eligibility for a different teaching medical education add-on or teaching hospital designation.

(II) the hospital provides documentation that it is approved by Medicare for reclassification to a different CBSA; or

(III) for state fiscal years 2017 and after, the hospital provides documentation of different data and demonstrates to HHSC's satisfaction that the different data should be used to calculate the safety-net add-on.

(iii) Annual SDA calculation. HHSC will calculate a hospital's final SDA annually using the add-on status initially determined during realignment by HHSC unless, within 14 calendar days after the date of the notification, HHSC receives notification in writing from the hospital, in a format determined by HHSC, that any add-on status determined by HHSC is incorrect and:

(I) the hospital provides documentation of new teaching program or new teaching hospital designation; or

(II) for state fiscal years 2017 and after, the hospital provides documentation of different data and demonstrates to HHSC's satisfaction that the different data should be used to calculate the safety-net add-on.

(iv) Failure to notify. If a hospital fails to notify HHSC within 14 calendar days after the date of the notification that the add-on status as initially determined by HHSC includes one or more add-ons for which the hospital is not eligible, resulting in an overpayment, HHSC will recoup such overpayment and will prospectively reduce the SDA accordingly.

(4) Final children’s hospital SDA calculations. HHSC calculates a children’s hospital’s final SDA as follows.
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT

HOSPITAL SERVICES (continued)

(A) Add all add-on amounts for which the hospital is eligible to the base SDA.

(B) For labor and delivery services provided to adults age 18 or greater in a children’s hospital, the final SDA is equal to the base SDA for urban hospitals without add-ons, calculated as described in subsection (d)(4)(E)(i) of this section plus the urban hospital geographic wage add-on for an urban hospital located in the same CBSA as the children’s hospital providing the service.

(C) For new children’s hospitals that are not teaching hospitals, for which HHSC has no base year claim data, the final SDA is the base SDA plus the hospital’s geographic wage add-on. The SDA will be inflated from the base year to the current period at the time of enrollment or to state fiscal year 2015, whichever is earlier.

(D) For new children’s hospitals that qualify for the teaching medical education add-on, as defined in subsection (b) of this section, for which HHSC has no base year claim data, the final SDA is calculated based on one of the following options until realignment is performed with base year claim data for the hospital. A new children’s hospital must notify the HHSC Provider Finance Department of its selected option within 60 days from the date the hospital is notified of its provider activation by HHSC's fiscal intermediary. If notice of the option is not received, HHSC will assign the hospital the SDA calculated as described in clause (i) of this subparagraph. The SDA calculated based on the selected option will be effective retroactive to the first day of the provider’s enrollment.

(i) Children's hospital base SDA plus the applicable geographic wage add-on and the minimum teaching add-on for existing children’s hospitals. No settlement of costs is required for services reimbursed under this option. The SDA will be in effect for the hospital for three years or until the next realignment when a new SDA will be determined. The SDA will be inflated from the base year to the current period at the time of enrollment or to state fiscal year 2015, whichever is earlier.

(ii) Children's base SDA plus the applicable geographic wage add-on and the maximum teaching add-on for existing children’s hospitals. A cost settlement is required for services reimbursed under this option. The SDA will be in effect for the hospital for three years or until the next realignment when a new SDA will be determined. The SDA will be inflated from the base year to the current period at the time of enrollment or to state fiscal year 2015, whichever is earlier.

(d) Base urban hospital SDA calculations. HHSC will use the methodologies described in this subsection to determine the average statewide base SDA and the final SDA for each urban hospital.

(1) HHSC calculates the average base year cost per claim (the universal mean) as follows.

(A) To calculate the total inpatient base year cost per urban hospital:

(i) sum the allowable inpatient charges by hospital for the base year claims; and
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT

HOSPITAL SERVICES (continued)

(ii) multiply clause (i) of this subparagraph by the inpatient RCC and the inflation update factors to inflate the base year cost to the current year.

(B) Sum the amount for all hospitals’ base year costs from subparagraph (A) of this paragraph.

(C) To derive the average base year cost per claim, divide the result from subparagraph (B) of this paragraph by the total number of base year claims.

(2) HHSC calculates the base urban SDA as follows.

(A) From the amount determined in paragraph (1)(B)(A)(ii) of this subsection for urban hospitals, HHSC sets aside an amount for add-ons as described in paragraph (3) of this subsection. In determining the amount to set aside, HHSC considers factors including other funding available to reimburse high-cost hospital functions and services, available data sources, historical costs, Medicare practices, and feedback from hospital industry experts.

(B) The amount remaining from paragraph (1)(B)(A)(ii) of this subsection after HHSC sets aside the amount for add-ons in subparagraph (A) of this paragraph is then divided by the total number of base year claims to derive the base SDA.

(3) An urban hospital may receive increases to the base SDA for any of the following.

(A) Add-on amounts, which will be determined or adjusted based on the following.

   (i) Impact files:

   (I) HHSC will use the most recent finalized impact file available at the time of realignment to calculate add-ons; and

   (II) HHSC will use the impact file in effect at the last realignment to calculate add-ons for new hospitals, except as otherwise specified in this section.

   (ii) Geographic wage reclassification. If a hospital becomes eligible for the geographic wage reclassification under Medicare, the hospital will become eligible for the adjustment upon the next realignment.

   (iii) Medical education add-on during fiscal year. If an existing hospital has a change in its medical education operating adjustment factor under Medicare, the hospital will become eligible for the adjustment to its medical education add-on upon the next realignment.

   (iv) New medical education add-on. If a hospital becomes eligible for the medical education add-on after the most recent realignment:

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(I) the hospital will receive a medical education add-on, effective for claims that have a date of discharge occurring on or after the first day of the next state fiscal year; and

(II) HHSC will calculate the add-on using the impact file in effect at the time the hospital initially claims eligibility for the medical education add-on; and

(III) this amount will remain fixed until the next realignment.

(B) Geographic wage add-on;

(i) Designated impact file. Subsequent add-ons will be based on the impact file available at the time of realignment.

(ii) Wage index. To determine an urban geographic wage add-on, HHSC first calculates a wage index for Texas as follows.

(I) HHSC identifies the Medicare wage index factor for each CBSA in Texas;

(II) HHSC identifies the lowest Medicare wage index factor in Texas;

(III) HHSC divides the Medicare wage index factor identified in subclause (I) of this clause for each CBSA by the lowest Medicare wage index factor identified in subclause (II) of this clause and subtracts one from each resulting quotient.

(iii) County assignment. HHSC will initially assign a hospital to a CBSA based on the county in which the hospital is located. A hospital that has been approved for geographic recategorization under Medicare may request that HHSC recognize its Medicare CBSA reclassification under the process described in subparagraph (F) of this paragraph.

(iv) Medicare labor-related percentage. HHSC uses the Medicare labor-related percentage available at the time of realignment.

(v) Geographic wage add-on calculation. The final geographic wage add-on is equal to the product of the base SDA calculated in subsection (d)(2)(B) of this section, the wage index calculated in clause (ii)(III) of this subparagraph, and the Medicare labor-related percentage in clause (iv) of this subparagraph.

(C) Medical education add-on.

(i) Eligibility. If an urban hospital meets the definition of a teaching hospital, as defined in subsection (b) of this section, it is eligible for the medical education add-on. Each hospital is required to confirm, under the process described in subparagraph (F) of this paragraph, that HHSC’s determination of the hospital’s eligibility and medical education operating adjustment factor under Medicare for the add-on is correct.
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT

HOSPITAL SERVICES (continued)

(ii) Add-on amount. HHSC multiplies the base SDA calculated in subsection (d)(2)(B) of this section by the hospital’s Medicare education adjustment factor to determine the hospital’s medical education add-on amount.

(D) Trauma add-on.

(i) Eligibility.

(I) If an urban hospital meets the definition of a trauma hospital, as defined in subsection (b) of this section, it is eligible for a trauma add-on.

(II) HHSC initially uses the trauma level designation associated with the physical address of a hospital’s TPI. A hospital may request that HHSC, under the process described in subparagraph (F) of this paragraph, use a higher trauma level designation associated with a physical address other than the hospital’s TPI address.

(ii) Add-on amount. To determine the trauma add-on amount, HHSC multiplies the base SDA:

(I) by 28.3 percent for hospitals with Level 1 trauma designation;

(II) by 18.1 percent for hospitals with Level 2 trauma designation;

(III) by 3.1 percent for hospitals with Level 3 trauma designation; or

(IV) by 2.0 percent for hospitals with Level 4 trauma designation.

(iii) Reconciliation with other reimbursement for uncompensated trauma care. Subject to General Appropriations Act and other applicable law:

(I) if a hospital’s allocation from the trauma facilities and emergency medical services account administered under Texas Health and Safety Code Chapter 780 is greater than the total trauma add-on amount estimated to be paid to the hospital under this section during the state fiscal year, the Department of State Health Services will pay the hospital the difference between the two amounts at the time funds are disbursed from that account to eligible trauma hospitals; and

(II) if a hospital’s allocation from the trauma facilities and emergency medical services account is less than the total trauma add-on amount estimated to be paid to the hospital under this section during the state fiscal year, the hospital will not receive a payment from the trauma facilities and emergency medical services account.

(E) Safety-Net add-on
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT

HOSPITAL SERVICES (continued)

(i) Eligibility. If an urban hospital meets the definition of a safety-net hospital as defined in subsection (b) of this section, they are eligible for a safety-net add-on.

(ii) Add-on amount. HHSC calculates the safety-net add-on amounts annually or at the time of realignment as follows.

(I) For each eligible hospital, determine the following amounts for a period of 12 contiguous months specified by HHSC:

(-a-) total allowable Medicaid inpatient days for fee-for-service claims;

(-b-) total allowable Medicaid inpatient days for managed care encounters;

(-c-) total relative weights for fee-for-service claims; and

(II) Determine the total allowable days for eligible safety-net hospitals by summing the amounts in items (-a-) and (-b-) of subclause (I) of this clause.

(III) Determine the hospital’s percentage of total allowable days to the total in subclause (II) of this clause.

(IV) Determine the hospital’s portion of appropriated safety-net funds before the MCO adjustment factor is applied by multiplying the amount in subclause (III) of this clause for each hospital by the total safety-net funds deflated to the data year.

(V) For each hospital, multiply item (-d-) of this subclause by the relevant MCO adjustment factor.

(VI) Sum the amounts in item (-c-) of subclause (I) of this clause and subclause (V) of this clause for each hospital.

(VII) To calculate the safety-net add-on, divide the amount in subclause (IV) of this clause by the amount in subclause (VI) of this clause for each hospital. The result is the safety-net add-on.

(iii) Reconciliation. Effective for costs and revenues accrued on or after September 1, 2015, HHSC may perform a reconciliation for each hospital that received the safety-net add-on to identify any such hospitals with total Medicaid reimbursements for inpatient and outpatient services in excess of their total Medicaid and uncompensated care inpatient and outpatient costs. For hospitals with total Medicaid reimbursements in excess of total Medicaid and uncompensated care costs, HHSC may recoup the difference.

(F) Add-on status verification.
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT

HOSPITAL SERVICES (continued)

(i) Notification. HHSC will determine a hospital's initial add-on status by reference to the impact file available at the time of realignment or at the time of eligibility for a new medical education add-on as described in subparagraph (A)(iv) of this paragraph; the Texas Department of State Health Services' list of trauma-designated hospitals; and Medicaid days and relative weight information from HHSC's fiscal intermediary. HHSC will notify the hospital of the CBSA to which the hospital is assigned, the Medicare education adjustment factor assigned to the hospital for urban hospitals, the trauma level designation assigned to the hospital, and any other related information determined relevant by HHSC. For state fiscal years 2017 and after, HHSC will also notify eligible hospitals of the data used to calculate the safety-net add-on. HHSC may post the information on its website, send the information through the established Medicaid notification procedures used by HHSC's fiscal intermediary, send through other direct mailing, or provide the information to the hospital associations to disseminate to their member hospitals.

(ii) During realignment, HHSC will calculate a hospital's final SDA using the add-on status initially determined by HHSC unless, within 14 calendar days after the date of the notification, HHSC receives notification in writing from the hospital, in a format determined by HHSC, that any add-on status determined by HHSC is incorrect and:

(I) the hospital provides documentation of its eligibility for a different medical education add-on or teaching hospital designation;

(II) the hospital provides documentation that it is approved by Medicare for reclassification to a different CBSA;

(III) the hospital provides documentation of its eligibility for a different trauma designation; or

(IV) for state fiscal years 2017 and after, the hospital provides documentation of different data and demonstrates to HHSC's satisfaction that the different data should be used to calculate the safety-net add-on.

(iii) Annually, HHSC will calculate a hospital's final SDA using the add-on status initially determined during realignment by HHSC unless, within 14 calendar days after the date of the notification, HHSC receives notification in writing from the hospital (in a format determined by HHSC) that any add-on status determined by HHSC is incorrect and:

(I) the hospital provides documentation of new teaching program or new teaching hospital designation; or

(II) the hospital provides documentation of its eligibility for a different trauma designation; or

(III) for state fiscal years 2017 and after, the hospital provides documentation of different data and demonstrates to HHSC's satisfaction that the different data should be used to calculate the safety-net add-on.
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT

HOSPITAL SERVICES (continued)

(iv) If a hospital fails to notify HHSC within 14 calendar days after the date of the notification that the add-on status as initially determined by HHSC includes one or more add-ons for which the hospital is not eligible, resulting in an overpayment, HHSC will recoup such overpayment and will prospectively reduce the SDA accordingly.

(4) Urban hospital final SDA calculations. HHSC calculates an urban hospital's final SDA as follows.

(A) Add all add-on amounts for which the hospital is eligible to the base SDA. These are the fully funded final SDAs.

(B) Multiply the final SDA determined in subparagraph (A) of this paragraph by each urban hospital's total relative weight of the base year claims.

(C) Sum the amount calculated in subparagraph (B) of this paragraph for all urban hospitals.

(D) Divide the total funds appropriated for reimbursing inpatient urban hospital services under this section by the amount determined in subparagraph (C) of this paragraph.

(E) To determine the budget-neutral final SDA:

   (i) multiply the base SDA in paragraph (2) of this subsection by the percentage determined in subparagraph (D) of this paragraph;

   (ii) multiply each of the add-ons described in paragraph (3)(B)-(E) by the percentage determined in subparagraph (D) of this paragraph; and

   (iii) sum the results of clause (i) and (ii) of this subparagraph.

(F) For new urban hospitals for which HHSC has no base year claim data, the final SDA is a base SDA plus any add-ons for which the hospital is eligible, multiplied by the percentage determined in subparagraph (D) of this paragraph.

(e) Rural hospital SDA calculations. HHSC will use the methodologies described in this subsection to determine the final SDA for each rural hospital.

(1) HHSC calculates the rural final SDA as follows.

(A) Base year cost. Calculate the total inpatient base year cost per rural hospital.

   (i) Total the inpatient charges by hospital for the rural base year stays.

   (ii) Multiply clause (i) by the inpatient RCC and the inflation update factors to inflate the base year claims to the current year of the realignment.
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT

HOSPITAL SERVICES (continued)

(B) Full-cost SDA. Calculate a hospital-specific full-cost SDA by dividing each hospital’s base year cost, calculated as described in subparagraph (A) of this paragraph, by the sum of the relative weights for the rural base year stays.

(C) Calculating the SDA floor and ceiling.

(i) Calculate the average adjusted hospital-specific SDA from subparagraph (B) of this paragraph for all rural hospitals with more than 50 claims.

(ii) Calculate the standard deviation of the hospital-specific SDAs identified in subparagraph (B) of this paragraph for all rural hospitals with more than 50 claims.

(iii) Calculate an SDA floor as clause (i) minus clause (ii) multiplied by a factor determined by HHSC to maintain budget neutrality.

(iv) Calculate an SDA ceiling as clause (i) plus clause (ii) multiplied by a factor determined by HHSC to maintain budget neutrality.

(D) Assigning a final hospital-specific SDA.

(i) If the adjusted hospital-specific SDA from subparagraph (B) is less than the SDA floor in subparagraph (C)(iii) of this paragraph, the hospital is assigned the SDA floor amount as the final SDA.

(ii) If the adjusted hospital-specific SDA from subparagraph (B) is more than the SDA ceiling in subparagraph (C)(iv), the hospital is assigned the SDA ceiling amount as the final SDA.

(iii) Assign the adjusted hospital-specific SDA as the final SDA to each hospital not described in clauses (i) and (ii) of this subparagraph.

(2) Alternate SDA for labor and delivery. For labor and delivery services provided by rural hospitals on or after September 1, 2019, the final SDA is the alternate SDA for labor and delivery stays, which is equal to the final SDA determined in paragraph (1)(D) of this subsection plus an SDA add-on sufficient to increase paid claims by no less than $500.

(3) HHSC calculates a new rural hospital’s final SDA as follows.

(A) For new rural hospitals for which HHSC has no base year claim data, the final SDA is the mean rural SDA in paragraph (1)(C)(i) of this subsection.

(B) The mean rural SDA assigned in subparagraph (A) of this paragraph remains in effect until the next realignment.

(4) Biennial review of rural rates. Every two years, HHSC will calculate new rural SDAs using the methodology in this subsection to the extent allowed by federal law and subject to limitations on appropriations.
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT

HOSPITAL SERVICES (continued)

(f) Final SDA for military and out-of-state. The final SDA for military and out-of-state hospitals is the urban hospital base SDA multiplied by the percentage determined in subsection (d)(4)(D) of this section.

(g) DRG statistical calculations. HHSC rebases the relative weights, MLOS and day outlier threshold whenever the base SDAs for urban hospitals are recalculated. The relative weights, MLOS, and day outlier thresholds are calculated using data from urban hospitals and apply to all hospitals. The relative weights that were implemented for urban hospitals on September 1, 2012, apply to all hospitals until the next realignment.

(1) Recalibration of relative weights. HHSC calculates a relative weight for each DRG as follows.

   (A) Base year claims are grouped by DRG.
   (B) For each DRG, HHSC:
      (i) sums the base year costs per DRG as determined in subsection (d) of this section;
      (ii) divides the result in clause (i) of this subparagraph by the number of claims in the DRG; and
      (iii) divides the result in clause (ii) of this subparagraph by the universal mean, resulting in the relative weight for the DRG.

(2) Recalibration of the MLOS. HHSC calculates the MLOS for each DRG as follows.

   (A) Base year claims are grouped by DRG.
   (B) For each DRG, HHSC:
      (i) sums the number of days billed for all base year claims; and
      (ii) divides the result in clause (i) of this subparagraph by the number of claims in the DRG, resulting in the MLOS for the DRG.

(3) Recalibration of day outlier thresholds. HHSC calculates a day outlier threshold for each DRG as follows.

   (A) Calculate for all claims the standard deviations from the MLOS in paragraph (2) of this subsection.
   (B) Remove each claim with a length of stay (number of days billed by a hospital) greater than or equal to three standard deviations above or below the MLOS. The remaining claims are those with a length of stay less than three standard deviations above or below the MLOS.
   (C) Sum the number of days billed by all hospitals for a DRG for the remaining claims in subparagraph (B) of this paragraph.
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT

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(D) Divide the result in subparagraph (C) of this paragraph by the number of remaining claims in subparagraph (B) of this paragraph.

(E) Calculate one standard deviation for the result in subparagraph (D) of this paragraph.

(F) Multiply the result in subparagraph (E) of this paragraph by two and add that to the result in subparagraph (D) of this paragraph, resulting in the day outlier threshold for the DRG.

(4) If a DRG has fewer than five base year claims, HHSC will use National Claim Statistics and a scaling factor to assign a relative weight, MLOS, and day outlier threshold.

(5) Adjust the MLOS, day outlier, and elbaite weights to increase or decrease with SOI to coincide with the National Claim Statistics.

(h) DRG grouper logic changes. Beginning September 1, 2021, HHSC may adjust DRG statistical calculations to align with annual grouper logic changes. The changes will remain budget neutral unless rates are rebased, and additional funding is appropriated by the legislature. The adjusted relative weights, MLOS, and day outlier threshold apply to all hospitals until the next adjustment or rebasing described in subsection (g) of this section.

(1) Base year claim data and rural base year stays are regrouped using the latest grouping software version to determine DRG assignment changes by comparing the newly assigned DRG to the DRG assignment from the previous grouper version.

(2) For DRGs impacted by the grouper logic changes, relative weights must be adjusted. HHSC calculates a relative weight for each impacted DRG as follows.

(A) Divide the total cost for all claims in the base year by the number of claims in the base year.

(B) Base year claims and rural base year stays are grouped by DRG, and for each DRG HHSC:

(i) sums the base year costs for all claims in each DRG;

(ii) divides the result in clause (i) of this subparagraph by the number of claims in each DRG; and

(iii) divides the result in clause (ii) of this subparagraph by the amount determined in subparagraph (A) of this paragraph, resulting in the relative weight for the DRG.

(3) Recalibration of the MLOS. HHSC calculates the MLOS for each DRG as follows.

(A) Base year claims and rural base year stays are grouped by DRG.

(B) For each DRG, HHSC:

(i) sums the number of days billed for all base year claims; and

(ii) divides the result in clause (i) of this subparagraph by the number of claims in the DRG, resulting in the MLOS for the DRG.
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – INPATIENT HOSPITAL SERVICES

(i) Cost reports. Each hospital must submit an initial cost report at periodic intervals as prescribed by Medicare or as otherwise prescribed by HHSC.

(1) Each hospital must send a copy of all cost reports audited and amended by a Medicare intermediary to HHSC within 30 days after the hospital's receipt of the cost report. Failure to submit copies or respond to inquiries on the status of the Medicare cost report will result in provider vendor hold.

(2) HHSC uses data from these reports in rebasing rate years to recalculate base SDAs, to calculate interim rates and to complete cost settlements.

(j) Cost Settlement.

(1) The cost settlement process is limited by the TEFRA target cap set pursuant to the Social Security Act §1866(b) (42 U.S.C. §1395ww(b)) for children's and state owned teaching hospitals.

(2) Notwithstanding the process described in paragraph (1) of this subsection, HHSC uses each hospital's final audited cost report, which covers a fiscal year ending during a base year period, for calculating the TEFRA target cap for a hospital.

(3) HHSC may select a new base year period for calculating the TEFRA target cap at least every three years.

(4) HHSC increases a hospital's TEFRA target cap in years in which the target cap is not reset under this paragraph, by multiplying the hospital's target cap by the CMS Prospective Payment System Hospital Market Basket Index adjusted to the hospital's fiscal year.

(5) For a new children's hospital, the base year for calculating the TEFRA target cap is the hospital's first full 12-month cost reporting period occurring after the date the hospital is designated by Medicare as a children's hospital. For each cost reporting period after the hospital's base year, an increase in the TEFRA target cap will be applied as described in paragraph (4) of this subsection, until the TEFRA target cap is recalculated as described in paragraph (3) of this subsection.

(6) After a Medicaid participating hospital is designated by Medicare as a children's hospital, the hospital must submit written notification to HHSC's provider enrollment contact, including documents verifying its status as a Medicare children's hospital. Upon receipt of the written notification from the hospital, HHSC will convert the hospital to the reimbursement methodology described in this subsection retroactive to the effective date of designation by Medicare.

(k) Out-of-state children's hospitals. HHSC calculates the prospective payment rate for an out-of-state children's hospital as follows:
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT

HOSPITAL SERVICES (continued)

(4) Recalibration of day outlier thresholds. HHSC calculates a day outlier threshold for each DRG as follows.

(A) Calculate for all claims the standard deviations from the MLOS in paragraph (3) of this subsection.

(B) Remove each claim with a length of stay (number of days billed by a hospital) greater than or equal to three standard deviations above or below the MLOS. The remaining claims are those with a length of stay less than three standard deviations above or below the MLOS.

(C) Sum the number of days billed by all hospitals for a DRG for the remaining claims in subparagraph (B) of this paragraph.

(D) Divide the result in subparagraph (C) of this paragraph by the number of remaining claims in subparagraph (B) of this paragraph.

(E) Calculate one standard deviation from the result in subparagraph (D) of this paragraph and multiply by two.

(F) Add the result of subparagraph (E) of this paragraph to the result in subparagraph (D) of this paragraph resulting in the day outlier threshold for the DRG.

(5) If a DRG has fewer than five base year claims. HHSC will use National Claim Statistics and a scaling factor to assign a relative weight, MLOS, and day outlier threshold.

(6) Adjust the MLOS, day outliers, and relative weights to increase or decrease with SOI to coincide with the National Claim Statistics.

(i) Reimbursements

(1) Calculating the payment amount. HHSC reimburses a hospital a prospective payment for covered inpatient hospital services by multiplying the hospital's final SDA as calculated in subsection (c)-(f) of this section as applicable by the relative weight for the DRG assigned to the adjudicated claim. The resulting amount is the payment amount to the hospital.

(2) The prospective payment as described in paragraph (1) of this subsection is considered full payment for covered inpatient hospital services. A hospital's request for payment in an amount higher than the prospective payment will be denied.

(3) Day and cost outlier adjustments. HHSC pays a day outlier or a cost outlier for medically necessary inpatient services provided to clients under age 21 in all Medicaid participating hospitals that are reimbursed under the prospective payment system. If a patient age 20 is admitted to and remains in a hospital past his or her 21st birthday, inpatient days and hospital charges after the patient reaches age 21 are included in calculating the amount of any day outlier or cost outlier payment adjustment.

(A) Day outlier payment adjustment. HHSC calculates a day outlier payment adjustment for each claim as follows:

(i) Determine whether the number of medically necessary days allowed for a claim exceeds:
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT

HOSPITAL SERVICES (continued)

(I) the MLOS by more than two days; and

(II) the DRG day outlier threshold as calculated in subsection (g)(3) of this section.

(ii) If clause (i) of this subparagraph is true, subtract the DRG day outlier threshold from the number of medically necessary days allowed for the claim.

(iii) Multiply the DRG relative weight by the final SDA.

(iv) Divide the result in clause (iii) of this subparagraph by the DRG MLOS described in subsection (g)(2) or (h)(3) of this section, to arrive at the DRG per diem amount.

(v) Multiply the number of days in clause (ii) of this subparagraph by the result in clause (iv) of this subparagraph.

(vi) Multiply the result in clause (v) of this subparagraph by 60 percent.

(vii) Multiply the allowed charges by the current interim rate to determine the cost.

(viii) Subtract the DRG payment amount calculated in clause (iii) of this subparagraph from the cost calculated in clause (vii) of this subparagraph.

(ix) The day outlier amount is the lesser of the amount in clause (vi) of this subparagraph or the amount in clause (viii) of this subparagraph.

(x) For urban and rural hospitals, multiply the amount in clause (ix) of this subparagraph by 90 percent to determine the final day outlier amount. For children's hospitals the amount in clause (ix) of this subparagraph is the final day outlier amount.

(B) Cost outlier payment adjustment. HHSC makes a cost outlier payment adjustment for an extraordinarily high-cost claim as follows:

(i) To establish a cost outlier, the cost outlier threshold must be determined by first selecting the lesser of the universal mean of base year claims and rural base year stays multiplied by 11.14 or the hospital's final SDA multiplied by 11.14.

(ii) Multiply the full DRG prospective payment by 1.5.

(iii) The cost outlier threshold is the greater of clause (i) or (ii) of this subparagraph.

(iv) Subtract the cost outlier threshold from the amount of reimbursement for the claim established under cost reimbursement principles described in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA).

(v) Multiply the result in clause (iv) of this subparagraph by 60 percent to determine the amount of the cost outlier payment.

(vi) For urban and rural hospitals, multiply the amount in clause (v) of this subparagraph by 90 percent to determine the final cost outlier amount.
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT

HOSPITAL SERVICES (continued)

children's hospitals the amount in clause (v) of this subparagraph is the final cost outlier amount.

(C) Final outlier determination:

(i) If the amount calculated in subparagraph (A)(ix) of this paragraph is greater than zero and the amount calculated in subparagraph (B)(vi) of this paragraph is greater than zero, HHSC pays the higher of the two amounts.

(ii) If the amount calculated in subparagraph (A)(ix) of this paragraph is greater than zero and the amount calculated in subparagraph (B)(vi) of this paragraph is less than or equal to zero, HHSC pays the day outlier amount.

(iii) If the amount calculated in subparagraph (B)(vi) of this paragraph is greater than zero and the amount calculated in subparagraph (A)(ix) of this paragraph is less than or equal to zero, HHSC pays the cost outlier amount.

(iv) If the amount calculated in subparagraph (A)(ix) of this paragraph and the amount calculated in subparagraph (B)(vi) of this paragraph are both less than or equal to zero HHSC will not pay an outlier for the admission.

(D) If the hospital claim resulted in a downgrade of the DRG related to reimbursement denials or reductions for preventable adverse events, the outlier payment will be determined by the lesser of the calculated outlier payment for the non-downgraded DRG or the downgraded DRG.

(4) A hospital may submit a claim to HHSC before a patient is discharged, but only the first claim for that patient will be reimbursed the prospective payment described in paragraph (1) of this subsection. Subsequent claims for that stay are paid zero dollars. When the patient is discharged, and the hospital submits a final claim to ensure accurate calculation for potential outlier payments for clients younger than age 21, HHSC recoups the first prospective payment and issues a final payment in accordance with paragraphs (1) and (3) of this subsection.

(5) Patient transfers and split billing. If a patient is transferred, HHSC establishes payment amounts as specified in subparagraphs (A) - (D) of this paragraph. HHSC manually reviews transfers for medical necessity and payment.

(A) If the patient is transferred from a hospital to a nursing facility, HHSC pays the transferring hospital the total payment amount of the patient's DRG.

(B) If the patient is transferred from one hospital (transferring hospital) to another hospital (discharging hospital), HHSC pays the discharging hospital the total payment amount of the patient's DRG. HHSC calculates a DRG per diem and a payment amount for the transferring hospital as follows.

(i) Multiply the DRG relative weight by the final SDA

(ii) Divide the result in clause (i) of this subparagraph by the DRG MLOS described in subsection (g)(2) or (h)(3) of this section, to arrive at the DRG per diem amount.

(iii) To arrive at the transferring hospital's payment amount:
ATTACHMENT 4.19-A

Pages 10-10a-10b-10b1-10c-10c1-10d

Were superseded by SPA TN 11-060 (UPL Removal)

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT

HOSPITAL SERVICES (continued)

(I) for a patient age 21 or older, multiply the result in clause (ii) of this subparagraph by the lesser of the DRG MLOS, the transferring hospital's number of medically necessary days allowed for the claim, or 30 days; or

(II) for a patient under age 21, multiply the result in clause (ii) of this subparagraph by the lesser of the DRG MLOS or the transferring hospital's number of medically necessary days allowed for the claim.

(C) HHSC makes payments to multiple hospitals transferring the same patient by applying the per diem formula in subparagraph (B) of this paragraph to all the transferring hospitals and the total DRG payment amount to the discharging hospital.

(D) HHSC performs a post-payment review to determine if the hospital that provided the most significant amount of care received the total DRG payment. If the review reveals that the hospital that provided the most significant amount of care did not receive the total DRG payment, an adjustment is initiated to reverse the payment amounts. The transferring hospital is paid the total DRG payment amount and the discharging hospital is paid the DRG per diem.

(j) Cost reports. Each hospital must submit an initial cost report at periodic intervals as prescribed by Medicare or as otherwise prescribed by HHSC.

(1) Each hospital must send a copy of all cost reports audited and amended by a Medicare intermediary to HHSC within 30 days after the hospital's receipt of the cost report. Failure to submit copies or respond to inquiries on the status of the Medicare cost report will result in provider vendor hold.

(2) HHSC uses data from these reports when realigning or rebasing to calculate base SDAs, DRG statistics, and interim rates and to complete cost settlements.

(k) Cost Settlement.

(1) The cost settlement process is limited by the TEFRA target cap set pursuant to the Social Security Act §1886(b) (42 U.S.C. §1395ww(b)) for children's and state-owned teaching hospitals.

(2) Notwithstanding the process described in paragraph (1) of this subsection, HHSC uses each hospital's final audited cost report, which covers a fiscal year ending during a base year period, for calculating the TEFRA target cap for a hospital.

(3) HHSC may select a new base year period for calculating the TEFRA target cap at least every three years.

(4) HHSC increases a hospital's TEFRA target cap in years in which the target cap is not reset under this paragraph, by multiplying the hospital's target cap by the CMS Prospective Payment System Hospital Market Basket Index adjusted to the hospital's fiscal year.

(5) For a new children's hospital, the base year for calculating the TEFRA target cap is the hospital's first full 12-month cost reporting period occurring after the date the hospital is designated by Medicare as a children's hospital. For each cost reporting period after
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT

HOSPITAL SERVICES (continued)

the hospital's base year, an increase in the TEFRA target cap will be applied as described in paragraph (4) of this subsection, until the TEFRA target cap is recalculated as described in paragraph (3) of this subsection.

(6) After a Medicaid participating hospital is designated by Medicare as a children's hospital, the hospital must submit written notification to HHSC's provider enrollment contact, including documents verifying its status as a Medicare children's hospital. Upon receipt of the written notification from the hospital, HHSC will convert the hospital to the reimbursement methodology described in this subsection retroactive to the effective date of designation by Medicare.

(l) Out-of-state children's hospitals. HHSC calculates the prospective payment rate for an out-of-state children's hospital as follows.

(1) HHSC determines the overall average cost per discharge for all in-state children's hospitals by:

(A) summing the Medicaid allowed cost from tentative or final cost report settlements for the base year; and

(B) dividing the result in subparagraph (A) of this paragraph by the number of in-state children's hospitals' base year claims.

(2) HHSC determines the average relative weight for all in-state children's hospitals' base year claims by:

(A) assigning a relative weight to each claim pursuant to subsection (g)(1)(B)(iii) or (h)(2)(B)(ii) of this section;

(B) summing the relative weights for all claims; and

(C) dividing by the number of claims.

(m) Merged hospitals.

(1) When two or more Medicaid participating hospitals merge to become one participating provider and the participating provider is recognized by Medicare, the participating provider must submit written notification to HHSC's provider enrollment contact, including documents verifying the merger status with Medicare.

(2) The merged entity receives the final SDA of the hospital associated with the surviving TPI. HHSC will reprocess all claims for the merged entity back to the effective date of the merger or the first day of the fiscal year, whichever is later.

(3) HHSC will not recalculate the final SDA of a hospital acquired in an acquisition or buyout unless the acquisition or buyout resulted in the purchased or acquired hospital becoming part of another Medicaid participating provider. HHSC will continue to reimburse the acquired hospital based on the final SDA assigned before the acquisition or buyout.
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-INPATIENT

HOSPITAL SERVICES (continued)

(4) When Medicare requires a merged hospital to maintain two Medicare numbers because they are in different CBSAs, HHSC assigns one base TPI with a separate suffix for each facility. Both suffixes receive the SDA of the primary hospital ID which remains active.

(n) - (x) Intentionally left blank.
INPATIENT DIRECT GRADUATE MEDICAL EDUCATION (GME) REIMBURSEMENT

(a) Inpatient Direct Graduate Medical Education (GME) Cost Reimbursement for state-owned and operated teaching hospitals.

(1) Effective September 1, 2008, HHSC or its designee reimburses state-owned and operated teaching hospitals Inpatient Direct Graduate Medical Education (GME) Cost for hospital cost reports ending in state fiscal year 2009.

(2) Reimbursement of inpatient direct graduate medical education (DGME) cost:

(A) Inpatient direct graduate medical education (DGME) cost as specified under methods and procedures set out in the Social Security Act, Title XVIII, as amended, effective October 1, 1982, by Public Law 97-248, is calculated under similar methods for each hospital having inpatient direct graduate medical education costs on its tentative or final audited cost report.

(B) HHSC calculates the total DGME payments for each hospital as follows:

(i) multiplies the base-year average per resident amount by the applicable CMS Prospective Payment System Hospital Market Basket index ;

(ii) multiplies the results in (i) by the number of current FTE residents;

(iii) Multiplies the results in (ii) by the DGME Medicaid inpatient utilization percentage which results in the total DGME payments.

(C) DGME definitions.

(i) Base-year average per resident amount – the Medicaid allowable inpatient direct graduate medical education cost as reported on CMS form 2552, Hospital Cost Report; worksheet B; Part I; Column 26; line 95 divided by the un-weighted FTE residents from worksheet S-3; Part I; line 25, of the hospital cost report ending in state fiscal year 2007.

(ii) current FTE residents – means the number of full-time-equivalent interns, residents, or fellows who participate in an approved medical residency program, including programs in osteopathy, dentistry, and podiatry, as required in order to become certified by the appropriate specialty board reported on CMS form 2552, Hospital Cost Report; worksheet S-3; Part I; line 25.

(iii) DGME Medicaid inpatient utilization percentage - the proportion of paid Medicaid inpatient days, including managed care days, as reported on CMS form 2552, Hospital Cost Report adjusted to Medicaid Claim summary report; worksheet S-3; Part 1; line 12; col. 5 divided by the hospital’s total inpatient days, as reported on worksheet S-3; Part 1; col. 6 lines 12, 14, 26 plus subprovider and observation days. Medicaid inpatient days and total inpatient days will include inpatient nursery days.
Inpatient Direct Graduate Medical Education (GME) Reimbursement, Continued

(D) Inpatient direct medical education costs are removed from the reimbursement methodology and not used in the calculation of the provider’s inpatient cost settlement.

(E) The DGME interim payments will be reimbursed on a Quarterly basis only after hospital services have been rendered. The interim payments will be payable within 90 days of the receipt of the hospital’s quarterly FTE data. Each hospital’s quarterly FTE data will be divided by 4 to determine the average FTE’s for each quarter. The interim payments will be reconciled and settled based on audited final cost report.

(a) Inpatient Direct Graduate Medical Education (GME) Cost Reimbursement for non-state government-owned and operated teaching hospitals.

(1) Effective October 1, 2018, HHSC or its designee reimburses non-state government-owned and operated teaching hospitals Inpatient Direct Graduate Medical Education (GME) Cost for hospital cost reports ending in state fiscal year 2019.

(2) Definitions

(A) Non-state government-owned and operated teaching hospital - a hospital with a properly approved medical residency program that is owned and operated by a local government entity, including but not limited to, a city, county, or hospital district.

(B) FTE residents - the hospital’s number of full time equivalent (FTE) interns, residents, or fellows who participate in a program that is determined by HHSC to be a properly approved medical residency program including a program in osteopathy, dentistry, or podiatry, as required in order to become certified by the appropriate specialty board.

(C) Medicare per resident amount (PRA) - average direct cost per medical resident, as reported on the Hospital Cost Report; CMS Form 2552-10; Worksheet E-4; Line 18.

(D) GME Medicaid inpatient utilization percentage - the hospital’s proportion of paid Medicaid inpatient days, including managed care days, divided by the hospital’s total inpatient days, as reported on Hospital Cost Report; CMS Form 2552-10; Worksheet S-3; Part 1; columns 7 and 8.

(3) HHSC calculates the total annual DGME payment for each hospital as follows:

(A) Multiplies the FTE residents by the Medicare per resident amount;

(B) Multiplies the result in (A) by the GME Medicaid inpatient utilization percentage.

(4) No payment under this section is dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.
Inpatient Direct Graduate Medical Education (GME) Reimbursement, Continued

(b) Inpatient Direct GME Cost Reimbursement for non-government owned or operated hospitals.

(1) Effective April 1, 2019, HHSC or its designee reimburses non-government owned or operated teaching hospitals Inpatient Direct GME cost for hospital cost reports ending in state fiscal year 2019 or later.

(2) Definitions

(A) Non-government owned or operated teaching hospital - a hospital with a properly approved medical residency program that is not both owned and operated by a government entity, including, but not limited to, a city, county, or hospital district.

(B) FTE residents - the hospital’s number of full time equivalent (FTE) interns, residents, or fellows who participate in a program that is determined by HHSC to be a properly approved medical residency program including a program in osteopathy, dentistry, or podiatry, as required in order to become certified by the appropriate specialty board.

(C) Interim Medicare per resident amount (PRA) - If a hospital does not have a Medicare PRA reported on the Hospital Cost Report; CMS Form 2552-10; Worksheet E-4; Line 18, then HHSC shall establish an interim Medicare PRA as follows:

(i) The annual estimated cost of interns and residents will be the amount on Hospital Cost Report; CMS Form 2552-10; Worksheet B, Part I, Column 25, Line 118.

(ii) Divide the result in (i) by the FTE residents to determine the interim Medicare PRA.

(D) Medicare PRA - average direct cost per medical resident, as reported on the Hospital Cost Report; CMS Form 2552-10; Worksheet E-4; Line 18.

(E) GME Medicaid inpatient utilization percentage - the hospital’s proportion of paid Medicaid inpatient days, including managed care days, divided by the hospital’s total inpatient days, as reported on Hospital Cost Report; CMS Form 2552-10; Worksheet S-3; Part 1; columns 7 and 8.

(3) HHSC calculates the total annual GME payment for each hospital as follows:

(A) Multiplies the FTE residents by the Medicare per resident amount or the interim Medicare PRA;

(B) Multiplies the result in (A) by the GME Medicaid inpatient utilization percentage.

(4) No payment under this section is dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.
2. Effective for all accounting periods beginning on or after January 1, 1982, Title XIX providers will no longer be allowed to carry forward those unreimbursed costs attributed to lower of cost or charge limitations authorized by 42 CFR 413.13.

3. Obligations to provide free care made by a hospital under Hill Burton or any other arrangement as a condition to secure grants or loans are not recognized as a cost under the Texas Medical Assistance Program.

4. The contents of paragraphs 1 through 3 do not describe the amount, duration or scope of services provided to eligible recipients under the Texas Medical Assistance Program.
EPSDT DIAGNOSTIC AND TREATMENT SERVICES NOT OTHERWISE COVERED UNDER THE STATE PLAN

Inpatient psychiatric hospital services furnished to EPSDT recipients. The psychiatric hospital must be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). The single state agency or its designee reimburses psychiatric hospitals using Medicare principles of reasonable cost reimbursement found at 42 CFR 413, but without applying the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) rate of increase limits. The single state agency or its designee establishes interim payment rates. EPSDT recipients will be given the free choice of qualified providers and the requirements of 42 CFR 441 Subpart D will be met.

Except for payment as described in this attachment for inpatient hospital services, payment for authorized medically necessary services required to diagnose and treat a condition found on EPSDT medical screening will be based on existing Medicare and Medicaid reimbursement methodologies.
Reimbursement Methodology: The Health and Human Services Commission (HHSC) or its designee determines reimbursement rates at least biennially. The statewide prospective rate for inpatient hospital services provided to individuals aged 65 and older in institutions for mental disease (IMD) will be available to all qualified and enrolled IMD service providers. This rate includes all allowable costs under Medicare payment principles.

Rate Periods

The rate period begins September 1st and ends August 31st of the following year. Annually, each participating hospital (hereafter referred to as an “IMD provider” is required to submit to HHSC or its designee a copy of its Medicare cost report for its most recent fiscal year ending prior to September 1st. Each IMD provider is required to identify in its cost report as a subunit those Medicare-certified units on which IMD services were provided (hereafter referred to as “IMD units”). The Medicare cost reports are reviewed by HHSC or its designee to assure that the costs to be used for calculating each provider’s average per diem cost for IMD services are allowable under Medicare payment principles and are only those costs incurred for care and treatment provided to persons 65 years of age and older and occupying a Medicare-certified bed.

Upon completion of the reviews of cost reports, and prior to calculating average per diem costs for each provider, both cost reports and prior payment histories are reviewed. To insure the integrity of the data and avoid bias in the resulting rate due to low volume and other inefficiencies, providers will be eliminated from the database for any one or more of the following reasons: (a) being in operation fewer than 90 calendar days during the previous cost reporting period; (b) having an occupancy rate on its IMD units of less than 90% for 50% or more of the days covered during the previous cost reporting period; (c) or individually accounting for fewer than 5% of the total days of care reimbursed by Medicaid as IMD services during the previous cost reporting period.
For those IMD providers left in the database after the review of cost reports and deletion for the above-named reasons, HHSC or its designee, using the Medicare cost report, calculates for each IMD provider an average per diem cost for IMD services (the "historical per diem cost").

HHSC or its designee then adjusts each IMD provider's historical per diem cost for IMD services to the future rate period by applying a cost-of-living index. The index used to adjust the per diem cost of each IMD provider is the Centers for Medicare and Medicaid Services (CMS) Market Basket Forecast Excluded Hospital Input Price Index (as reported in the Dallas Regional Medical Services Letter for the federal fiscal quarter ending in December of the year preceding the future rate period). The percentage used for adjustments to each IMD provider's average per diem cost is prorated for the future rate period, using $\frac{1}{3}$rd of the forecast for the calendar year in which the rate period begins (September through December) plus $\frac{2}{3}$rd of the forecast for the next calendar year (January through August).

After adjusting the average per diem cost for each IMD provider, the average per diem costs of all IMD providers remaining in the database are arrayed from high to low. The median ($50^{th}$ percentile) average per diem cost is selected as the prospective reimbursement for the future reimbursement period. If the $50^{th}$ percentile falls between IMD providers, then the immediately higher average per diem cost will be selected as the reimbursement. The prospective reimbursement rate is compared to the Support, Maintenance and Treatment (SMT) rate. The SMT rate is calculated for each provider, the rate is calculated by taking the total cost of care and dividing it by the total days of service for each provider. All IMD providers will be paid the lower of the prospective rate or SMT rate for each day during the next reimbursement period that IMD services are provided to an eligible individual.
Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 of the Social Security Act with respect to non-payment for provider-preventable conditions.

In compliance with 42 CFR 447.26(c), the Medicaid Agency provides:

a) That no reduction in payment for a provider preventable condition (PPC) will be imposed on a provider when the condition identified existed prior to the initiation of treatment by that provider. Reductions are only applied to claims if the present on admission (POA) indicates that the condition occurred during the hospital stay. Claims indicating that conditions are present at the time of admission are not subject to reductions.

b) That reductions in provider payment may be limited to the extent that the following apply:

1. The identified provider preventable conditions would otherwise result in an increase in payment. The claim payment is only reduced if the disallowance of the diagnosis results in a downgrade to the APR-DRG.

2. The State can reasonably isolate, for non-payment, the portion of the payment directly related to the treatment of a PPC. The State reduces the payment only if the treatment of the PPC would increase the APR-DRG payment. The payment is based on the disallowance of the diagnosis codes that are considered to be acquired while the patient is in the hospital.

c) Assurance that non-payment for PPC does not prevent access to services for Medicaid beneficiaries. Claims with PPCs are still reimbursed by the Medicaid program. The only impact to the claim is to lower the payment to eliminate payment for the acquired condition.

The State does not impose reductions on Institutes for Mental Disease (IMD) hospitals as these hospitals are paid a per diem rate. The payment is not increased to IMDs when a PPC occurs. If an acute care need arises, the patient is sent to an acute care hospital and any cost to care for that patient is reimbursed to the acute care facility by the IMD, not by the Medicaid program.

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Supersedes TN: SUPERSESDES: NONE - NEW PAGE
Disproportionate Share Hospital (DSH) Reimbursement Methodology

(a) Introduction. Hospitals participating in the Texas Medicaid program that meet the conditions of participation and that serve a disproportionate share of low-income patients are eligible for reimbursement from the disproportionate share hospital (DSH) fund. HHSC will establish each hospital's eligibility for and amount of reimbursement using the methodology described in this appendix.

(b) Definitions.

(1) Adjudicated claim – A hospital claim for payment for a covered Medicaid service that is paid or adjusted by HHSC or another payer.

(2) Available DSH funds – The annual federal DSH allotment of funds that may be reimbursed to all DSH-eligible providers.

(3) Bad debt – A debt arising when there is nonpayment on behalf of an individual who has third-party coverage.

(4) Centers for Medicare & Medicaid Services (CMS) – The federal agency within the United States Department of Health and Human Services responsible for overseeing and directing Medicare and Medicaid.

(5) Charity care – The unreimbursed cost to a hospital of providing, funding, or otherwise financially supporting health care services on an inpatient or outpatient basis to indigent individuals, either directly or through other nonprofit or public outpatient clinics, hospitals, or health care organizations.

(6) Charity charges – Total amount of hospital charges for inpatient and outpatient services attributed to charity care in a DSH data year. These charges do not include bad debt charges, contractual allowances, or discounts given to other legally liable third-party payers.
Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)
Definitions (continued)

(7) Children's hospital – A hospital within Texas that is recognized by Medicare as a children's hospital and is exempted by Medicare from the Medicare prospective payment system.

(8) Disproportionate share hospital (DSH) – A hospital identified by HHSC that meets the DSH program conditions of participation and that serves a disproportionate share of Medicaid or indigent patients.

(9) DSH data year – A twelve-month period, two years before the DSH program year, from which HHSC will compile data to determine DSH program qualification and payment.

(10) DSH program year – The twelve-month period beginning October 1 and ending September 30.

(1) DSH survey – The HHSC data collection tool completed by each DSH hospital and used by HHSC to calculate the interim and final hospital-specific limit, and to estimate the hospital's DSH payments for the program year.

(2) Dually eligible patient – A patient who is simultaneously eligible for Medicare and Medicaid.

(3) Governmental entity – A state agency or political subdivision of the state. A governmental entity includes a hospital authority, hospital district, city, county or state entity.

(4) HHSC – The Texas Health and Human Services Commission or its designee.

(5) Hospital-specific limit – The maximum payment amount applicable to a DSH program year that a hospital may receive in reimbursement for the cost of providing Medicaid-allowable services to individuals who are Medicaid eligible or uninsured. The term does not apply to payment for costs of providing services to non-Medicaid-eligible individuals who have third-party coverage; costs associated with pharmacies, clinics and physicians; or costs associated with Delivery System Reform and Incentive Payment projects.

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Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)

Definitions (continued)

(A) Interim hospital-specific limit. Applies to payments that will be made during the DSH program year and is calculated using interim cost and payment data from the DSH data year.

(B) Final hospital-specific limit. Applies to payments made during a prior DSH program year and is calculated using actual cost and payment data from the DSH program year.

(16) Independent certified audit – An audit that is conducted by an auditor that operates independently from the Medicaid agency and the audited hospitals and that is eligible to perform the DSH audit required by CMS.

(17) Indigent individual – An individual classified by a hospital as eligible for charity care.

(18) Inflation update factor – Cost-of-living index based on the annual CMS prospective payment system hospital market basket index.

(19) Inpatient day – Each day that an individual is an inpatient in the hospital, whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere. The term includes observation days, rehabilitation days, psychiatric days, and newborn days. The term does not include swing bed days or skilled nursing facility days.

(20) Inpatient revenue – Amount of gross inpatient revenue derived from the most recent completed Medicaid cost report or reports related to the applicable DSH data year. Gross inpatient revenue excludes revenue related to the professional services of hospital-based physicians, swing bed facilities, skilled nursing facilities, intermediate care facilities, other nonhospital revenue, and revenue not identified by the hospital.

(21) Institution for mental diseases (IMD) – A hospital that is primarily engaged in providing psychiatric diagnosis, treatment, or care of individuals with mental illness.

(22) Low-income days – Number of inpatient days attributed to indigent patients.
Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)
Definitions (continued)

(23) Low-income utilization rate – A ratio calculated as described in subsection (c)(2) that represents a hospital’s volume of inpatient charity care relative to total inpatient services.

(24) Mean Medicaid inpatient utilization rate – The average of Medicaid inpatient utilization rates for all hospitals that have received a Medicaid payment for an inpatient claim, other than a claim for a dually eligible patient, that was adjudicated during the relevant DSH data year.

(25) Medicaid contractor – Fiscal agents and managed care organizations with which HHSC contracts to process data related to the Medicaid program.

(26) Medicaid cost-to-charge ratio (inpatient and outpatient) – A Medicaid cost report derived cost center ratio calculated for each ancillary cost center that covers all applicable hospital costs and charges relating to inpatient and outpatient care for that cost center. This ratio is used in calculating the hospital-specific limit and does not distinguish between payer types such as Medicare, Medicaid, or private pay.

(27) Medicaid cost report – Hospital and Hospital Health Care Complex Cost Report, also known as the Medicare cost report.

(28) Medicaid hospital – A hospital meeting the qualifications to participate in the Texas Medicaid program, as determined by the agency listed on page 43 of the basic state plan (relating to provider participation requirements).

(29) Medicaid inpatient utilization rate – A ratio calculated as described in (c)(1) that represents a hospital’s volume of Medicaid inpatient services relative to total inpatient services.

(30) MSA – Metropolitan Statistical Area as defined by the United States Office of Management and Budget. MSAs with populations greater than or equal to 137,000, according to the most recent decennial census, are considered "the largest MSAs."

(31) Non-urban public hospital – A rural public-financed hospital, as defined in (b)(39), or a hospital owned and operated by a non-state governmental entity other than hospitals in Urban public hospital – Class one or Urban public hospital – Class two.
Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)

Definitions (continued)

(32) Obstetrical services – The medical care of a woman during pregnancy, delivery, and the post-partum period provided at the hospital listed on the DSH application.

(33) Outpatient charges – Amount of gross outpatient charges related to the applicable DSH data year and used in the calculation of the hospital specific limit.

(34) PMSA – Primary Metropolitan Statistical Area as defined by the United States Office of Management and Budget.

(35) Program year – The 12-month period beginning October 1 and ending September 30.

(36) Public funds – Funds derived from taxes, assessments, levies, investments, and other public revenues within the sole and unrestricted control of a governmental entity. Public funds do not include gifts, grants, trusts, or donations, the use of which is conditioned on supplying a benefit solely to the donor or grantor of the funds.

(37) Ratio of cost-to-charges (inpatient only) – A ratio that covers all applicable hospital costs and charges relating to inpatient care. This ratio does not distinguish between payer types such as Medicare, Medicaid, or private pay.

(38) Rural public hospital – A hospital owned or operated by a non-state governmental entity that is located in a county with 500,000 or fewer persons, based on the most recent decennial census.

(39) Rural public-financed hospital – A non-state hospital operating under a lease from a governmental entity in which the hospital and governmental entity are both located in the same county with 500,000 or fewer persons, based on the most recent decennial census.

(40) State chest hospital – A state-owned public health facility operated by the Department of State Health Services and designated for the care and treatment of patients with tuberculosis.

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Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)
Definitions (continued)

(41) State-owned teaching hospital – A hospital owned and operated by a state university or other state agency.

(42) The waiver – The Texas Healthcare Transformation and Quality Improvement Program, a Medicaid demonstration waiver under §1115 of the Social Security Act that was approved by CMS on December 12, 2011.

(43) Third-party coverage – Creditable insurance coverage consistent with the definitions in 45 Code of Federal Regulations (CFR) Parts 144 and 146, or coverage based on a legally liable third-party payer.

(44) Total Medicaid inpatient days – Total number of inpatient days based on adjudicated claims data for covered services for the relevant DSH data year.

(A) The term includes:
(i) Medicaid-eligible days of care adjudicated by managed care organizations;
(ii) days that were denied payment for spell-of-illness limitations;
(iii) days attributable to individuals eligible for Medicaid in other states, including dually eligible patients;
(iv) days with adjudicated dates during the period; and
(v) days for dually eligible patients for purposes of the calculation in (c)(1).

(B) The term excludes:
(i) days attributable to Medicaid-eligible patients ages 21 through 64 in an IMD;
(ii) days denied for late filing and other reasons; and
(iii) days for dually eligible patients for purposes of the calculation in (c)(3) and (g)(4).

(45) Total Medicaid inpatient hospital payments – Total amount of Medicaid funds that a hospital received for adjudicated claims for covered inpatient services during the DSH data year. The term includes payments that the

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Definitions (continued)

hospital received:

(A) for covered inpatient services from managed care organizations; and

(B) for patients eligible for Medicaid in other states.

(46) Total state and local payments – Total amount of state and local payments that a hospital received for inpatient and outpatient care during the DSH data year. The term includes payments under state and local programs that are funded entirely with state general revenue funds and state or local tax funds. The term excludes payment sources that include federal dollars and contractual discounts and allowances.

(47) Uncompensated-care waiver payments – Payments to hospitals participating in the waiver that are intended to defray the uncompensated costs of eligible services provided to eligible individuals.

(48) Uninsured cost – The cost to a hospital of providing inpatient and outpatient hospital services to uninsured patients as defined by CMS.

(49) Urban public hospital – Any of the non-state urban public hospitals listed in (b)(50) or (b)(51).

(50) Urban public hospital – Class one – A hospital that is operated by or under a lease contract with one of the following non-state government entities: the Dallas County Hospital District, the El Paso County Hospital District, the Harris County Hospital District, the Tarrant County Hospital District, the Travis County Healthcare District, or the University Health System of Bexar County. A hospital’s classification as an Urban public hospital – Class one is not subject to change.

(51) Urban public hospital – Class two – A hospital that is operated by or under a lease contract with one of the following non-state government entities: the Ector County Hospital District or the Lubbock County Hospital District. A hospital’s classification as an Urban public hospital – Class two is not subject to change.

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Qualification

(c) Qualification. For each DSH program year, applicants must meet at least one of the following qualification criteria, which are determined using information from a hospital's application, from HHSC, or from HHSC's Medicaid contractors, as specified by HHSC:

(1) Medicaid inpatient utilization rate. A hospital's inpatient utilization rate is calculated by dividing the hospital's total Medicaid inpatient days by its total inpatient census days for the DSH data year.

   (A) A hospital located outside an MSA or PMSA must have a Medicaid inpatient utilization rate greater than the mean Medicaid inpatient utilization rate for all Medicaid hospitals.

   (B) A hospital located inside an MSA or PMSA must have a Medicaid inpatient utilization rate that is at least one standard deviation above the mean Medicaid inpatient utilization rate for all Medicaid hospitals.

(2) Low-income utilization rate. A hospital must have a low-income utilization rate greater than 25 percent.

   (A) The low-income utilization rate is the sum (expressed as a percentage) of the fractions calculated in (c)(2)(A)(i) and (ii):

      (i) The sum of the total Medicaid inpatient hospital payments and the total state and local payments paid to the hospital for inpatient care in the DSH data year, divided by a hospital's gross inpatient revenue multiplied by the hospital's ratio of cost-to-charges (inpatient only) for the same period: (total Medicaid inpatient hospital payments + total state and local payments)/(gross inpatient revenue x ratio of costs to charges (inpatient only)).

      (ii) Inpatient charity charges in the DSH data year minus the amount of payments for inpatient hospital services received directly from state and local governments, excluding all Medicaid payments, in the DSH data year, divided by the gross inpatient revenue in the same period: (total inpatient charity charges – total state and local payments)/gross inpatient revenue).
(B) HHSC will determine the ratio of cost-to-charges (inpatient only) by using information from the appropriate worksheets of each hospital's Medicaid cost report or reports that correspond to the DSH data year. In the absence of a Medicaid cost report for that period, HHSC will use the latest available submitted Medicaid cost report or reports.

(3) Total Medicaid inpatient days.

(A) A hospital must have total Medicaid inpatient days at least one standard deviation above the mean total Medicaid inpatient days for all hospitals participating in the Medicaid program, except;

(B) A hospital in a county with a population of 290,000 persons or fewer, according to the most recent decennial census, must have total Medicaid inpatient days at least 70 percent of the sum of the mean total Medicaid inpatient days for all hospitals in this subset plus one standard deviation above that mean.

(C) Days for dually eligible patients are not included in the calculation of total Medicaid inpatient days under (c)(3).

(4) Children's hospitals, state-owned teaching hospitals, and state chest hospitals. Children's hospitals, state-owned teaching hospitals, and state chest hospitals that do not otherwise qualify as disproportionate share hospitals will be deemed disproportionate share hospitals.

(5) Merged hospitals. HHSC will aggregate the data used to determine qualification under this subsection from the merged hospitals to determine whether the single Medicaid provider that results from the merger qualifies as a Medicaid disproportionate share hospital.

(6) Hospitals that held a single Medicaid provider number during the DSH data year, but later added one or more Medicaid provider numbers. Upon request, HHSC will apportion the Medicaid DSH funding determination attributable to a hospital that held a single Medicaid provider number during the DSH data year (data year hospital), but subsequently added one or more Medicaid provider numbers (new program year hospital(s)) between the data year hospital and its associated new program year
Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)

Conditions of participation

hospital(s). In these instances, HHSC will apportion the Medicaid DSH funding determination for the data year hospital and the new program year hospital(s) based on estimates of the division of Medicaid inpatient and low income utilization between the data year hospital and the new program year hospital(s) for the program year, so long as all affected providers satisfy the Medicaid DSH conditions of participation and qualify as separate hospitals based on HHSC’s Medicaid DSH qualification criteria in the applicable Medicaid DSH program year.

(d) Conditions of participation. HHSC will require each hospital to meet and continue to meet for each DSH program year the following conditions of participation:

(1) Two-physician requirement.
   (A) In accordance with Social Security Act §1923(e)(2), a hospital must have at least two licensed physicians (doctor of medicine or osteopathy) who have hospital staff privileges and who have agreed to provide nonemergency obstetrical services to individuals who are entitled to medical assistance for such services.
   (B) The requirement in (d)(1)(A) does not apply if the hospital:
      (i) Serves inpatients who are predominately under 18 years of age;
      or
      (ii) Was operating but did not offer nonemergency obstetrical services as of December 22, 1987.
   (C) A hospital must certify on the DSH application that it meets the conditions of either (d)(1)(A) or (B), as applicable, at the time the DSH application is submitted.

(2) Medicaid inpatient utilization rate. At the time of qualification and during the DSH program year, a hospital must have a Medicaid inpatient utilization rate, as calculated in (c)(1), of at least one percent.
Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)
Conditions of participation (continued)

(3) Trauma system.

(A) The hospital must be in active pursuit of designation or have obtained a trauma facility designation as defined in the Texas Health and Safety Code. A hospital that has obtained its trauma facility designation must maintain that designation for the entire DSH program year.

(B) HHSC will receive an annual report from the Office of EMS/Trauma Systems Coordination regarding hospital participation in regional trauma system development, application for trauma facility designation, and trauma facility designation or active pursuit of designation status before final qualification determination for interim DSH payments. HHSC will use this report to confirm compliance with this condition of participation by a hospital applying for DSH funds.

(4) Maintenance of local funding effort. A hospital district in one of the State's largest MSAs or in a PMSA must not reduce local tax revenues to its associated hospitals as a result of disproportionate share funds received by the hospital. For this provision to apply, the hospital must have more than 250 licensed beds.

(5) Retention of and access to records. A hospital must retain and make available to HHSC records and accounting systems related to DSH data for at least five years from the end of each DSH program year in which the hospital qualifies or until an open audit is completed, whichever is later.

(6) Compliance with audit requirements. A hospital must agree to comply with the audit requirements described in (i).

(7) Merged hospitals. If HHSC receives documents verifying the merger status with Medicare prior to the deadline for submission of the DSH application, the merged entity must meet all conditions of participation. If HHSC does not receive the documents verifying the merger status with Medicare prior to the deadline for submission of the DSH application, any proposed merging hospitals that are receiving DSH payments must continue to meet all conditions of participation as individual hospitals to
Calculating a hospital-specific limit

continue receiving DSH payments for the remainder of the DSH program year.

(e) Calculating a hospital-specific limit. Using information from each hospital's DSH survey, Medicaid cost report and from HHSC's Medicaid contractors, HHSC will determine the interim hospital-specific limit for each hospital applying for DSH funds in compliance with (e)(1)(A) - (E). HHSC will also determine the final hospital-specific limit in compliance with (e)(2).

(1) Interim Hospital-Specific Limit

(A) Uninsured charges and payments.

(i) Each hospital will report in its survey its inpatient and outpatient charges for services that would be covered by Medicaid that were provided to uninsured patients discharged during the DSH data year. In addition to the charges in the previous sentence, an IMD may report charges for Medicaid allowable services that were provided during the DSH data year to Medicaid-eligible and uninsured patients ages 21 through 64.

(ii) Each hospital will report in its survey all payments received during the data year, regardless of when the service was provided, for services that would be covered by Medicaid and were provided to uninsured patients.

(l) For purposes of this paragraph, a payment received is any payment from an uninsured patient or from a third party (other than an insurer) on the patient's behalf, including payments received for emergency health services furnished to undocumented aliens under section 1011 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, except as described in (e)(1)(A)(ii)(II);
Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)
Calculating a hospital-specific limit (continued)

(II) State and local payments to hospitals for indigent care are not included as payments made by or on behalf of uninsured patients.

(A) Medicaid charges and payments.

(i) HHSC will request from its Medicaid contractors the inpatient and outpatient charge and payment data for claims for services provided to Medicaid-enrolled individuals that are adjudicated during the DSH data year for all active Medicaid participating hospitals.

(I) The requested data includes but is not limited to:

(-a-) Claims associated with the care of dually eligible patients, including Medicare charges and payments;

(-b-) Claims or portions of claims that were not paid because they exceeded the spell-of-illness limitation; and

(-c-) Claims for which the hospital received payment from a third-party payor for a Medicaid-enrolled patient.
Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)
Calculating a hospital-specific limit (continued)

(II) HHSC will exclude charges and payments for:

(-a-) Claims for services not covered by Medicaid, including

(-1-) Claims from the Children's Health Insurance Program; and

(-2-) Inpatient claims associated with the Women's Health Program; and

(-b-) Claims submitted after the 95-day filing deadline.

(ii) HHSC will request from its Medicaid contractors the inpatient and outpatient Medicaid cost settlement payment or recoupment amounts attributable to the cost report period determined in (e)(1)(C)(i).

(iii) Each hospital will report on the survey the inpatient and outpatient Medicaid days, charges and payment data for out-of-state claims adjudicated during the data year.

(iv) HHSC may apply an adjustment factor to Medicaid payment data to more accurately approximate Medicaid payments following a rebasing or other change in reimbursement rates.
Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)
Calculating a hospital-specific limit (continued)

(C) Calculation of in-state and out-of-state Medicaid and uninsured total costs for the data year.

(i) Cost report period for data used to calculate cost-per-day amounts and cost-to-charge ratios. HHSC will use information from the Medicaid cost report for the hospital's fiscal year that ends during the calendar year that falls two years before the end of the program year for the calculations described in (e)(1)(C)(ii)(I) and (iii)(I). For example, for program year 2013, the cost report year is the provider's fiscal year that ends between January 1, 2011, and December 31, 2011.

(ii) For hospitals that do not have a full year cost report that meets this criteria, a partial year cost report for the hospital's fiscal year that ends during the calendar year that falls two years before the end of the program year will be used if the cost report covers a period greater than or equal to six months in length.

(ii) The partial year cost report will not be prorated. If the provider's cost report that ends during this time period is less than six months in length, the most recent full year cost report will be used.

(ii) Determining inpatient routine costs.

(I) Medicaid inpatient cost per day for routine cost centers. Using data from the Medicaid cost report, HHSC will divide the allowable inpatient costs by the inpatient days for each routine cost center to determine a Medicaid inpatient cost per day for each routine cost center.

(II) Inpatient routine cost center cost. For each Medicaid payor type and the uninsured, HHSC will multiply the Medicaid inpatient cost per day for each routine cost center from (e)(1)(C)(ii)(I) times the number of inpatient days for each routine cost center from the data year to determine the inpatient routine cost for each cost center.
Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)
Calculating a hospital-specific limit (continued)

(III) Total inpatient routine cost. For each Medicaid payor type and the uninsured, HHSC will sum the inpatient routine costs for the various routine cost centers from (e)(1)(C)(ii)(II) to determine the total inpatient routine cost.

(iii) Determining inpatient and outpatient ancillary costs.

(I) Inpatient and outpatient Medicaid cost-to-charge ratio for ancillary cost centers. Using data from the Medicaid cost report, HHSC will divide the allowable ancillary cost by the sum of the inpatient and outpatient charges for each ancillary cost center to determine a Medicaid cost-to-charge ratio for each ancillary cost center.

(II) Inpatient and outpatient ancillary cost center. For each Medicaid payor type and the uninsured, HHSC will multiply the cost-to-charge ratio for each ancillary cost center from (e)(1)(C)(iii)(I) by the ancillary charges for inpatient claims and the ancillary charges for outpatient claims from the data year to determine the inpatient and outpatient ancillary cost for each cost center.

(III) Total inpatient and outpatient ancillary cost. For each Medicaid payor type and the uninsured, HHSC will sum the inpatient and outpatient costs for the various ancillary cost centers from (e)(1)(C)(iii)(II) to determine the total ancillary cost.

(iv) Determining total Medicaid and uninsured cost. For each Medicaid payor type and the uninsured, HHSC will sum the result of (e)(1)(C)(ii)(III) and the result of (e)(1)(C)(iii)(III) plus organ acquisition costs to determine the total cost.

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Calculating a hospital-specific limit (continued)

(D) Calculation of the interim hospital-specific limit.

(i) Total hospital cost. HHSC will sum the total cost by Medicaid payor type and the uninsured from (e)(1)(C)(iv) to determine the total hospital cost for Medicaid and the uninsured.

(ii) Interim hospital-specific limit

(I) HHSC will reduce the total hospital cost under (e)(1)(D)(i) by total payments from all payor sources for inpatient and outpatient claims, including but not limited to, graduate medical services and out-of-state payments.

(II) HHSC will not reduce the total hospital cost under (e)(1)(D)(i) by supplemental payments (including upper payment limit payments), or uncompensated-care waiver payments for the data year to determine the interim hospital-specific limit. HHSC may reduce the total hospital cost by supplemental payments or uncompensated-care waiver payments (excluding payments associated with pharmacies, clinics, and physicians) attributed to the hospital for the program year if necessary to prevent total interim payments to a hospital for the program year from exceeding the interim hospital-specific limit for that program year.

(E) Inflation adjustment.

(i) HHSC will trend each hospital's interim hospital-specific limit using the inflation update factor.

(ii) HHSC will trend each hospital's-specific limit from the midpoint of the DSH data year to the midpoint of the DSH program year.
Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)

Calculating a hospital-specific limit (continued)

(1) Final hospital-specific limit.

(A) HHSC will calculate the individual components of a hospital's final hospital-specific limit using the calculation set out in (e)(1)(A)-(D), except that HHSC will:

(i) Use information from the hospital's Medicaid cost report(s) that cover the program year and from cost settlement payment or recoupment amounts attributable to the program year for the calculations described in (e)(1)(C)(ii)(I) and (e)(1)(C)(iii)(I). If a hospital has two or more Medicaid cost reports that cover the program year, the data from each cost report will be pro-rated based on the number of months from each cost report period that fall within the program year;

(ii) Include supplemental payments (including upper payment limit payments) and uncompensated-care waiver payments (excluding payments associated with pharmacies, clinics, and physicians) attributable to the hospital for the program year when calculating the total payments to be subtracted from total costs as described in (e)(1)(D)(ii);

(iii) Use the hospital's charge and payment data for claims for services described in (e)(1)(A) and (B) provided to Medicaid-enrolled and uninsured patients that were adjudicated during the program year; and

(iv) Include charges and payments for claims submitted after the 95-day filing deadline for Medicaid-allowable services provided during the program year unless such claims were submitted after the Medicare filing deadline.

(B) The final hospital-specific limit will be calculated at the time of the independent audit conducted under (i).
Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)
Distribution of available DSH funds

(f) Distribution of available DSH funds. HHSC will distribute the available DSH funds as defined in (b)(2) among eligible, qualifying DSH hospitals using the following priorities:

1. State-owned teaching hospitals, state-owned IMDs, and state chest hospitals. HHSC may reimburse state-owned teaching hospitals, state-owned IMDs, and state chest hospitals an amount less than or equal to their interim hospital-specific limits, except that aggregate payments to IMDs statewide may not exceed federally mandated reimbursement limits for IMDs.

2. Other hospitals. HHSC distributes the remaining available DSH funds, if any, to other qualifying hospitals using the methodology described in (g). The remaining available DSH funds equal the lesser of the funds as defined in (b)(2) less funds expended under (f)(1) or the sum of remaining qualifying hospitals' interim hospital-specific limits.
Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)

(g) DSH payment calculation.

(1) Establishment of DSH funding pools. From the amount of remaining DSH funds determined in (f)(2), HHSC will establish three DSH funding pools.

(A) Pool One.

(i) Pool One is equal to or less than $388,000,000; and

(ii) Pool One payments are available to all non-state-owned hospitals, including non-state-owned public hospitals.

(B) Pool Two.

(i) Pool Two is equal to or less than $600,000,000; and

(ii) Pool Two payments are available to all non-state-owned hospitals, including non-state-owned public hospitals.

(C) Pool Three.

(i) Pool Three is equal to or less than $420,000,000; and

(ii) Pool Three payments are available to Urban public hospitals – Class one and Class two and non-urban public hospitals.

(2) Weighting factors.

(A) HHSC will assign each non-urban public hospital a weighting factor of 1.21.
Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)

(B) HHSC will assign all other DSH hospitals not described in (g)(2)(A) a weighting factor of 1.00.

(3) Pass One distribution and payment calculation for Pools One and Two.

(A) HHSC will calculate each hospital’s total DSH days as follows:

(i) Weighted Medicaid inpatient days are equal to the hospital’s Medicaid inpatient days multiplied by the appropriate weighting factor from (g)(2).

(ii) Weighted low-income days are equal to the hospital’s low-income days multiplied by the appropriate weighting factor from (g)(2).

(iii) Total DSH days equal the sum of weighted Medicaid inpatient days and weighted low-income days.

(B) Using the results from (g)(3)(A), HHSC will:

(i) Divide each hospital’s total DSH days from (g)(3)(A)(iii) by the sum of total DSH days for all non-state-owned DSH hospitals to obtain a percentage.

(ii) Multiply each hospital’s percentage as calculated in (g)(3)(B)(i) by the amount determined in (g)(1)(A) to determine each hospital’s Pass One projected payment amount from Pool One.

(iii) Multiply each hospital’s percentage as calculated in (g)(3)(B)(i) by the amount determined in (g)(1)(B) to determine each hospital’s Pass One projected payment amount from Pool Two.
Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)

(iv) Sum each hospital’s Pass One projected payment amount from Pool One and Pool Two, as calculated in (g)(3)(B)(ii) and (iii) respectively. The result of this calculation is the hospital’s Pass One projected payment amount from Pools One and Two combined.

(v) Divide the Pass One projected payment amount from Pool Two as calculated in (g)(3)(B)(iii) by the hospital’s Pass One projected payment amount from Pools One and Two combined as calculated in (g)(3)(B)(iv). The result of this calculation is the percentage of the hospital’s total Pass One projected payment amount accruing from Pool Two.

(4) Pass Two – Redistribution of amounts in excess of hospital-specific limits from Pass One for Pools One and Two combined. In the event that the projected payment amount calculated in (g)(3)(B)(iv) plus any previous payment amounts for the program year exceeds a hospital’s interim hospital-specific limit, the payment amount will be reduced such that the sum of the payment amount plus any previous payment amounts is equal to the interim hospital-specific limit. HHSC will sum all resulting excess funds and redistribute that amount to qualifying non-state-owned hospitals that have projected payments, including any previous payment amounts for the program year, below their interim hospital-specific limits. For each such hospital, HHSC will:

(A) Subtract the hospital’s projected DSH payment from (g)(3)(B)(iv) plus any previous payment amounts for the program year from its interim hospital-specific limit;

(B) Sum the results of (g)(4)(A) for all hospitals; and

(C) Compare the sum from (g)(4)(B) to the total excess funds calculated for all non-state-owned hospitals.

(i) If the sum of (g)(4)(B) is less than or equal to the total excess funds, HHSC will pay all such hospitals up to their interim hospital-specific limit.

(ii) If the sum of (g)(4)(B) is greater than the total excess funds, HHSC will calculate payments to all such hospitals as follows:
Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)

(I) Divide the result of (g)(4)(A) for each hospital by the sum from (g)(4)(B);

(II) Multiply the ratio from (g)(4)(C)(i)(I) by the sum of the excess funds from all non-state-owned hospitals;

(III) Add the result of (g)(4)(C)(ii)(II) to the projected DSH payment for that hospital to calculate a revised projected payment amount from Pools One and Two after Pass Two.

(5) Pass One distribution and payment calculation for Pool Three.

(A) HHSC will calculate the initial payment from Pool Three as follows:

(i) For each Urban public hospital – Class one and Class two –

(I) Multiply its total Pool One and Pool Two payments after Pass Two from (g)(4) by the percentage of the hospital's total Pass One projected payment amount accruing from Pool Two from (g)(3)(B)(v);

(II) Divide the result from (g)(5)(A)(i)(I) by the Federal Medical Assistance Percentage for the program year; and

(III) Multiply the result from (g)(5)(A)(i)(II) by the non-federal percentage. The result is the Pass One initial payment from Pool Three for these hospitals.

(ii) For each Non-urban public hospital –

(I) Multiply its total Pool One and Pool Two payments after Pass Two from (g)(4) by the percentage of the hospital's total Pass One projected payment amount accruing from Pool Two from (g)(3)(B)(v);

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Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)

(II) Divide the result from (g)(5)(A)(ii)(I) by the Federal Medical Assistance Percentage for the program year; and

(III) Multiply the result from (g)(5)(A)(ii)(II) by the non-federal percentage and multiply by 0.50. The result is the Pass One initial payment from Pool Three for these hospitals.

(iii) For all other hospitals, the Pass One initial payment from Pool Three is equal to zero.

(B) HHSC will calculate the secondary payment from Pool Three for each Urban public hospital – Class one as follows:

(i) Sum the interim hospital-specific limits for all Urban public hospitals – Class one;

(ii) For each Urban public hospital – Class one, divide its individual interim hospital-specific limit by the sum of the interim hospital-specific limits for all Urban public hospitals – Class one from (g)(5)(B)(i);

(iii) Sum all Pass One initial payments from Pool Three from (g)(5)(A);

(iv) Subtract the sum from (g)(5)(B)(iii) from the total value of Pool Three; and

(v) Multiply the result from (g)(5)(B)(ii) by the result from (g)(5)(B)(iv) for each Urban public hospital – Class One. The result is the Pass One secondary payment from Pool Three for that hospital.

(vi) For all other hospitals, the Pass One secondary payment from Pool Three is equal to zero.

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Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)

(C) HHSC will calculate each hospital’s total Pass One payment from Pool Three by adding its Pass One initial payment from Pool Three and its Pass One secondary payment from Pool Three.

(6) Pass Two – Secondary redistribution of amounts in excess of hospital-specific limits for Pool Three. For each hospital that received a Pass One initial or secondary payment from Pool Three, HHSC will sum the results from (g)(4) and (g)(5) to determine the hospital’s total projected DSH payment. In the event this sum plus any previous payment amounts for the program year exceeds a hospital’s interim hospital-specific limit, the payment amount will be reduced such that the sum of the payment amount plus any previous payment amounts is equal to the interim hospital-specific limit. HHSC will sum all resulting excess funds and redistribute that amount to qualifying non-state-owned hospitals eligible for payments from Pool Three that have projected payments, including any previous payment amounts for the program year, below their interim hospital-specific limits. For each such hospital, HHSC will:

(A) Subtract the hospital’s projected DSH payment plus any previous payment amounts for the program year from its interim hospital-specific limit;

(B) Sum the results of (g)(6)(A) for all hospitals; and

(C) Compare the sum from (g)(6)(B) to the total excess funds calculated for all non-state-owned hospitals.

(i) If the sum of (g)(6)(B) is less than or equal to the total excess funds, HHSC will pay all such hospitals up to their interim hospital-specific limit.

(ii) If the sum of (g)(6)(B) is greater than the total excess funds, HHSC will calculate payments to all such hospitals as follows:

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- (l) Divide the result of (g)(6)(A) for each hospital by the sum from (g)(6)(B);
- (II) Multiply the ratio from (g)(6)(C)(ii)(l) by the sum of the excess funds from all non-state-owned hospitals; and
Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)

(III) Add the result of (g)(6)(C)(ii)(II) to the projected total DSH payment for that hospital to calculate a revised projected payment amount from Pools One, Two and Three after Pass Two.

(7) Additional allocation of DSH funds for rural public and rural public-financed hospitals. Rural public hospitals or rural public-financed hospitals may be eligible for DSH funds in addition to the projected payment amounts calculated in (g)(3)-(6).

(A) For each rural public hospital or rural public-financed hospital, HHSC will determine the projected payment amount plus any previous payment amounts for the program year calculated in accordance with (g)(3)-(6);

(B) Subtract each hospital's projected payment amount plus any previous payment amounts for the program year from (g)(7)(A) from each hospital's interim hospital-specific limit to determine the maximum additional DSH allocation;

(C) Prior to processing any DSH payment that includes an additional allocation of DSH funds as described in (g)(7), HHSC will determine if such a payment would cause total DSH payments to exceed the available DSH funds for the payment as described in subsection (b)(2) of this section. If HHSC makes such a determination, it will reduce the DSH payment amounts rural public and rural public-financed hospitals are eligible to receive through the additional allocation as required to remain within the available DSH funds for the payment. This reduction will be applied proportionally to all additional allocations. HHSC will:

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Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)

(i) determine remaining DSH funds by subtracting payment amounts for all DSH hospitals calculated in (g)(3)-(6) from the amount in (f)(2).

(ii) determine the total additional allocation for all hospitals eligible for an additional allocation.

(iii) determine an available proportion statistic by dividing the remaining DSH funds from (g)(7)(C)(i) by the total additional allocation from (g)(7)(C)(ii); and

(iv) multiply each eligible hospital's payment amount by the proportion statistic determined in (g)(7)(C)(iii). The resulting product will be the additional allowable allocation for the payment.

(8) Reallocating funds if a hospital closes, loses its license or eligibility. If a hospital that is receiving DSH funds closes, loses its license, or loses its Medicare or Medicaid eligibility during a DSH program year, HHSC will reallocate that hospital's disproportionate share funds going forward among all DSH hospitals in the same category that are eligible for additional payments.

(9) The sum of the annual payment amounts for state-owned and non-state-owned IMDs are summed and compared to the federal IMD limit. If the sum of the annual payment amounts exceeds the federal IMD limit, the state-owned and non-state owned IMDs are reduced on a pro-rata basis so that the sum is equal to the federal IMD limit.
Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)

(10) Hospital located in a federal natural disaster area. If a hospital is located in a county that is declared a federal natural disaster area and that was participating in the DSH program at the time of the natural disaster, that hospital may request that HHSC determine its DSH qualification and interim reimbursement payment amount under this subsection for subsequent DSH program years. The final hospital specific limit will be computed based on the actual data for the DSH program year.

(11) HHSC will make DSH payments on a quarterly basis, unless factors outside of HHSC’s control require a different payment schedule.

(12) DSH payments are final unless an overpayment is identified or a hospital becomes eligible for additional payments through the methodology described in (i)(3).

(13) No payment under this section is dependent on any agreement or arrangement that HHSC is aware of for providers or related entities to donate money or services to a governmental entity.

(h) Recovery of DSH funds. Notwithstanding any other provision of this section, HHSC will recoup any overpayment of DSH funds made to a hospital, including an overpayment that results from HHSC error or that is identified in an audit.

(i) Audit process.

(1) HHSC is required by the Social Security Act to annually complete an independent certified audit of each hospital participating in the DSH program in Texas.

(2) A hospital that fails to provide requested information or to otherwise comply with the independent certified audit requirements will be subject to a withholding of Medicaid disproportionate share payments or other appropriate sanctions.

(3) HHSC will recoup any overpayment of DSH funds made to a hospital that is identified in the independent certified audit and will redistribute the recouped funds to DSH providers that are eligible for additional payments subject to their final hospital-specific limits as described in (e)(2). Recouped funds will be redistributed as follows:
Disproportionate Share Hospital (DSH) Reimbursement Methodology (continued)

(A) HHSC will distribute recouped funds to hospitals that shared the same source of non-federal funds in the program year as the hospital from which the funds were recouped.

(B) The amount distributed to each hospital is the lesser of:

(i) A proportionate share of the recouped amount based on the hospital's percentage of total remaining final hospital-specific limits for all hospitals in that group; or

(ii) An amount equal to the hospital's remaining final hospital-specific limit.
Payment Adjustment for Potentially Preventable Readmissions

a) Introduction. The Health and Human Services Commission (HHSC) may reward or penalize a hospital under this section based on the hospital's performance with respect to exceeding or failing to meet outcome and process measures relative to all Texas Medicaid and CHIP hospitals regarding the rates of potentially preventable events.

b) Definitions:

1. Actual-to-Expected Ratio-A ratio that measures the impact of potentially preventable readmissions (PPRs) by deriving an actual hospital rate compared to an expected hospital rate based on a methodology defined by HHSC.

2. Adjustment time period-The state fiscal year (September through August) that a hospital's claims are adjusted in accordance with subsection (f) of this section. Adjustments will be done on an annual basis.

3. All Patient Refined Diagnosis-Related Group (APRDRG)-A diagnosis and procedure code classification system for inpatient services.

4. Candidate admission-An admission that is at risk of a PPR.

5. Case-mix-A measure of the clinical characteristics of patients treated during the reporting time period and measured using APR-DRG or its replacement classification system, severity of illness, patient age, and the presence of a major mental health or substance abuse comorbidity.

6. Claims during the reporting time period-Includes Medicaid traditional fee-for-service (FFS), Children's Health Insurance Program (CHIP), and managed care inpatient hospital claims filed for reimbursement by a hospital that:

   A. had a date of admission occurring within the reporting period;

   B. were adjudicated and approved for payment during the reporting period and the six-month grace period that immediately followed, except for claims that had zero inpatient days;

   C. were not claims for patients who are covered by Medicare;

   D. were not claims for individuals classified as undocumented immigrants; and

   E. were not subject to other exclusions as determined by HHSC.

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Payment Adjustment for Potentially Preventable Readmissions (continued)

7. Children's Health Insurance Program or CHIP-The Texas State Children's Health Insurance Program established under Title XXI of the federal Social Security Act (42 U.S.C. Chapter 7, Title XXI).

8. Clinically related-A requirement that the underlying reason for readmission be plausibly related to the care rendered during or immediately following the initial admission. A clinically related admission occurs within a specified readmission time interval resulting from the process of care and treatment during the initial admission or from a lack of post admission follow-up, but not from unrelated events occurring after the initial admission.

9. HHSC-The Health and Human Services Commission or its designee.

10. Hospital-A public or private institution licensed or run by the state to provide medical, surgical, or psychiatric treatment.

11. Initial admission-A candidate admission followed by one or more readmissions that are clinically related.

12. Managed care organization (MCO)--A provider or organization under contract with HHSC to provide services to Medicaid or CHIP recipients using a health care delivery system or dental services delivery system in which provider or organization coordinates the patient's overall care.

13. Medicaid program-A jointly funded state-federal health care program established under Title XIX of the federal Social Security Act (42 U.S.C. Chapter 7, Title XIX).

14. Potentially preventable event (PPE)-A potentially preventable admission, a potentially preventable ancillary service, a potentially preventable complication, a potentially preventable emergency room visit, a potentially preventable readmission, or a combination of these events.

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Payment Adjustment for Potentially Preventable Readmissions (continued)

15. Potentially preventable readmission (PPR)-A return hospitalization of a person within a time period specified by HHSC that may have resulted from deficiencies in the care or treatment provided to the person during a previous hospital stay or from deficiencies in post-hospital discharge follow-up. The term does not include a hospital readmission necessitated by the occurrence of unrelated events after the discharge. The term includes the readmission of a person to a hospital for:

   A. the same condition or procedure for which the person was previously admitted;
   B. an infection or other complication resulting from care previously provided;
   C. a condition or procedure that indicates that a surgical intervention performed during a previous admission was unsuccessful in achieving the anticipated outcome; or
   D. another condition or procedure of a similar nature, as determined by HHSC.

16. Readmission chain-A sequence of PPRs that are all clinically related to the Initial Admission. A readmission chain may contain an Initial Admission and only one PPR or may contain multiple PPRs following the Initial Admission.

17. Reporting time period-The period of time that includes hospital claims that are assessed for PPRs. This is a state fiscal year (September through August). PPR Reports will consist of statewide and hospital-specific reports and will be done at least on an annual basis, using the most complete data period available to HHSC.

18. Safety-net hospital-An urban or children’s hospital that meets the eligibility and qualification requirements (relating to Disproportionate Share Hospital Reimbursement Methodology) for the most recent federal fiscal year for which such eligibility and qualification determinations have been made.

c) Calculating a PPR rate. Using claims during the reporting time period and HHSC designated software and methodology, HHSC calculates an actual PPR rate and an expected PPR rate for each hospital in the analysis. The methodology for inclusion of hospitals in the analysis will be described in the statewide and hospital-specific reports.
Payment Adjustment for Potentially Preventable Readmissions (continued)

c) Calculating a PPR rate. Using claims during the reporting time period and HHSC designated software and methodology, HHSC calculates an actual PPR rate and an expected PPR rate for each hospital in the analysis. The methodology for inclusion of hospitals in the analysis will be described in the statewide and hospital-specific reports. The Actual-to-Expected Ratio is rounded to two decimal places and used to determine reimbursement adjustments described in subsection (f).

1. The actual PPR rate is the number of readmission chains divided by the number of candidate admissions.

2. The expected PPR rate is the expected number of readmission chains divided by the number of candidate admissions. The expected number of readmission chains is based on the hospital's case-mix relative to the case-mix of all hospitals included in the analysis during the reporting period.

3. HHSC uses unweighted PPR results for hospital performances.

d) Comparing the PPR performance of all hospitals included in the analysis. Using the rates determined in subsection (c) of this section, HHSC calculates a ratio of Actual-to-Expected PPR rates.

e) Reporting results of PPR rate calculations. HHSC provides a confidential report to each hospital included in the analysis regarding the hospital's performance with respect to potentially preventable readmissions, including the PPR rates calculated as described in subsection (c) of this section and the hospital's actual-to-expected ratio calculated as described in subsection (d) of this section.

1. A hospital may request the underlying data used in the analysis to generate the report via an email request to the HHSC email address found on the report.

2. The underlying data contains patient-level identifiers, information on all hospitals where the readmissions occurred, and other information deemed relevant by HHSC

f) Hospitals subject to reimbursement adjustment and amount of adjustment.

1. A hospital with an actual-to-expected PPR ratio equal to or greater than 1.10 and equal to or less than 1.25 is subject to a reimbursement adjustment of negative 1 percent;
Payment Adjustment for Potentially Preventable Readmissions (continued)

2. The reimbursement adjustments for a hospital will cease in the adjustment time period that is after the hospital receives a confidential report indicating an actual-to-expected ratio of less than 1.10.

3. On an annual basis and based on review of the data quality and accuracy, HHSC may determine if reimbursement adjustments are appropriate.

h) Targeted incentive payments for safety-net hospitals.

4. HHSC determines annually whether a safety-net hospital will receive an incentive payment for performance on PPR incidence.

5. The appropriated funds for the targeted incentive payments are split in half, 50 percent for PPRs and 50 percent for potentially preventable complications. HHSC can change the allocated percentages based on review of data and the changing needs of the program.

6. The dataset used in the incentive analysis is the same as the dataset used in the PPR reimbursement adjustments.

7. Hospitals that are eligible for a targeted incentive payment must meet the following requirements:
   
   A. be a safety-net hospital;
   B. have an actual-to-expected ratio of at least 10 percent lower than the statewide average (actual-to-expected ratio is less than or equal to 0.90);
   C. have not received a penalty for either PPRs or potentially preventable complications; are not low volume, as defined by HHSC.
Payment Adjustment for Potentially Preventable Readmissions (continued)

5. Calculation of targeted incentive payments.

   A. Calculate base allocation: Each eligible hospital is awarded a base allocation not to exceed $100,000.

   B. Calculate variable allocation: Each eligible hospital is awarded a variable allocation, which are calculated from remaining funds after distribution of base allocations to all eligible hospitals. The variable allocation has the following components:

      i. Hospital size score: Each eligible hospital's size divided by the average size of the whole group of hospitals within each incentive pool. Size is calculated based on total inpatient facility claims paid to each eligible hospital. Each eligible hospital's size calculation is capped at 2.00.

      ii. Hospital Performance score: Each eligible hospital's performance divided by the average performance of the whole group of hospitals within each incentive pool. Performance is calculated by actual to expected ratio.

      iii. Composite score: Each eligible hospital receives a composite score, which is the hospital's size score multiplied by the hospital's performance score.

      iv. Each hospital’s composite score divided by the sum of all eligible hospitals’ composite scores is multiplied by the remaining incentive funds, after distribution of base allocations.

   C. Calculate final allocation: The final allocation to each eligible hospital is equal to the eligible hospital's base allocation plus the eligible hospital's variable allocation.

6. Each eligible hospital's PPR incentive payment will be divided between FFS and MCO reimbursements based on the percentage of its total paid FFS and MCO Medicaid inpatient hospital reimbursements for the reporting time period accruing from FFS.

7. PPR incentive payments will be made as lump sum payments or tied to particular claims or recipients, at HHSC's discretion.

8. HHSC will post the methodology for calculating and distributing incentives on its public website at [http://www.hhsc.state.tx.us/hhsc_projects/ECI/Potentially-Preventable-Events.shtml](http://www.hhsc.state.tx.us/hhsc_projects/ECI/Potentially-Preventable-Events.shtml).

9. Targeted incentive payments for safety-net hospitals are not included in the calculation of a hospital's hospital-specific limit or low-income utilization rate.
Payment Adjustment for Potentially Preventable Complications

(a) Introduction. The Health and Human Services Commission (HHSC) may reward or penalize a hospital under this section based on the hospital’s performance with respect to exceeding or failing to achieve outcome and process measures relative to all Texas Medicaid and CHIP hospitals regarding the rates of potentially preventable events.

(b) Definitions.

(1) Actual-to-Expected Ratio–The ratio of actual potentially preventable complications (PPCs) within an inpatient stay compared with expected PPCs within an inpatient stay. The expected number depends on the all patient refined diagnosis-related group at the time of admission (APRDRG or its replacement classification system). HHSC calculates the expected number based on the statewide norms, and it is derived from Medicaid traditional fee-for-service (FFS), Children’s Health Insurance Program (CHIP), and managed care data.

HHSC adjusts the ratio to account for the patient’s severity of illness. HHSC, at its discretion, determines the relative weights of PPCs when calculating the actual-to-expected ratio.

(2) Adjustment time period–The state fiscal year (September through August) that a hospital’s claims are adjusted in accordance with subsection (f) or (g)(4) of this section. Adjustments will be done on an annual basis.

(3) All Patient Refined Diagnosis-Related Group (APRDRG)–A diagnosis and procedure code classification system for inpatient services.

(4) Case-mix–A measure of the clinical characteristics of patients treated during the reporting time period based on diagnosis and severity of illness. "Higher" case-mix refers to sicker patients who require more hospital resources.

(5) Children’s Health Insurance Program or CHIP–The Texas State Children’s Health Insurance Program established under Title XXI of the federal Social Security Act (42 U.S.C. Chapter 7, Title XXI).
Payment Adjustment for Potentially Preventable Complications (continued)

(6) HHSC—The Health and Human Services Commission or its designee.

(7) Inpatient claims during the reporting time period—Includes Medicaid traditional FFS, CHIP, and, if available, managed care data for inpatient hospital claims filed for reimbursement by a hospital that:

(A) had a date of admission occurring within the reporting time period;

(B) were adjudicated and approved for payment during the reporting time period and the six-month grace period that immediately followed, except for such claims that had zero inpatient days;

(C) were not inpatient stays for patients who are covered by Medicare;

(D) were not claims for patients diagnosed with major metastatic cancer, organ transplants, human immunodeficiency virus (HIV), or major trauma; and

(E) were not subject to other exclusions as determined by HHSC.

(8) Hospital—A public or private institution licensed or run by the state to provide medical, surgical, or psychiatric treatment.

(9) Managed care organization (MCO)— Managed care is a health care delivery system or dental services delivery system in which the overall care of a patient is coordinated by or through a single provider or organization. MCO refers to such a provider or organization under contract with HHSC to provide services to Medicaid recipients.

(10) Medicaid program—A jointly funded state-federal health care program established under Title XIX of the federal Social Security Act (42 U.S.C. Chapter 7, Title XIX).

(11) Norm—The Texas statewide average or the standard by which hospital PPC performance is compared.

(12) Potentially preventable complication (PPC)—A harmful event or negative outcome with respect to a person, including an infection or surgical complication, that:

(A) occurs after the person’s admission to an inpatient acute care hospital; and

(B) may have resulted from the care, lack of care, or treatment provided during the hospital stay rather than from a natural progression of an underlying disease.
Payment Adjustment for Potentially Preventable Complications (continued)

(13) Potentially preventable event (PPE)—A potentially preventable admission, a potentially preventable ancillary service, a potentially preventable complication, a potentially preventable emergency room visit, a potentially preventable readmission, or a combination of those events.

(14) Present on Admission (POA) Indicators—A coding system that requires hospitals to accurately submit principal and secondary diagnoses that are present at the time of admission. POA codes are essential for the accurate calculation of PPC rates and consist of the current coding set approved by CMS.

(15) Reporting time period—The period of time that includes hospital claims that are assessed for PPCs. This may be a state fiscal year (September through August) or other specified time frame as determined by HHSC. PPC Reports will consist of statewide and hospital-specific reports and will be done at least on an annual basis, using the most complete data period available to HHSC.

(16) Safety-net hospital—An urban or children’s hospital that meets the eligibility and qualification requirements (relating to Disproportionate Share Hospital Reimbursement Methodology) for the most recent federal fiscal year for which such eligibility and qualification determinations have been made.
Payment Adjustment for Potentially Preventable Complications (continued)

(c) Calculating a PPC rate. Using inpatient claims during the reporting time period and HHSC-designated software and methodology, HHSC calculates an actual PPC rate and an expected PPC rate for each hospital included in the analysis. The methodology for inclusion of hospitals in the analysis will be described in the statewide and hospital-specific reports. HHSC will determine at its discretion the relative weights of PPCs when calculating the actual-to-expected ratio. The Actual-to-Expected Ratio is rounded to two decimal places and used to determine reimbursement adjustments described in subsection (f).

(d) Comparing the PPC performance of all hospitals included in the analysis. Using the rates determined in subsection (c) of this section, HHSC calculates a ratio of actual-to-expected PPC rates.

(e) Reporting results of PPC rate calculations. HHSC provides a confidential report to each hospital included in the analysis regarding the hospital's performance with respect to potentially preventable complications, including the PPC rates calculated as described in subsection (c) of this section and the hospital's actual-to-expected ratio calculated as described in subsection (d) of this section.

1. A hospital can request the underlying data used in the analysis to generate the report via an email request to the HHSC email address found on the report.

2. The underlying data contains patient-level identifiers and other information deemed relevant by HHSC.

(f) Hospitals subject to reimbursement adjustment and amount of adjustment.

1. A hospital with an actual-to-expected PPC ratio equal to or greater than 1.10 and equal to or less than 1.25 is subject to a reimbursement adjustment of negative 2 percent;

2. A hospital with an actual-to-expected PPC ratio greater than 1.25 is subject to a reimbursement adjustment of negative 2.5 percent.
Payment Adjustment for Potentially Preventable Complications (continued)

(g) Claims subject to reimbursement adjustment.

1. The reimbursement adjustments described in subsection (f) of this section apply to all Medicaid fee-for-service claims beginning November 1, 2013 and after.

2. The reimbursement adjustments will occur after the confidential report on which the reimbursement adjustments are based is made available to hospitals.

3. The reimbursement adjustments for a hospital will cease in the adjustment time period that is after the hospital receives a confidential report indicating an actual-to-expected ratio of less than 1.10.

4. On an annual basis and based on review of the data quality and accuracy, HHSC may determine if reimbursement adjustments are appropriate.

5. Based on HHSC-approved POA data screening criteria, HHSC may implement automatic payment reductions to hospitals who fail POA screening. The POA screening criteria and methodology will be described in the statewide and hospital-specific reports. At its discretion, HHSC applies the following adjustments based on POA screening criteria:

   A. Failure to meet POA screening criteria, first reporting period violation: 2 percent reduction applied to all Medicaid fee-for-service claims in the corresponding adjustment period.

   B. Failure to meet POA screening criteria, two or more violations in a row: 2.5 percent applied to all Medicaid fee-for-service claims in the corresponding adjustment period.

   C. If a hospital passes POA screening criteria during a reporting time period, any future violations of the POA screening criteria will be considered a first violation.

6. The reimbursement adjustments based on POA screening criteria will cease when the hospital passes HHSC-approved POA screening criteria for an entire reporting time period, at which point the hospital will be subject to reimbursement adjustments, if applicable, based on criteria outlined in subsection (f) of this section.

7. Hospitals that receive a reimbursement adjustment based on POA screening criteria outlined in paragraph (4) of this section will not concurrently receive reductions outlined in subsection (f) of this section.
Payment Adjustment for Potentially Preventable Complications (continued)

(h) Targeted incentive payments for safety-net hospitals.

(1) HHSC determines annually whether a safety-net hospital will receive an incentive payment for performance on PPC incidence.

(2) The appropriated funds for the targeted incentive payments are split in half, 50 percent for PPCs and 50 percent for potentially preventable readmissions. HHSC can change the allocated percentages based on review of data and the changing needs of the program.

(3) The dataset used in the incentive analysis is the same as the dataset used in the PPC reimbursement adjustments.

(4) Hospitals that are eligible for a targeted incentive payment must meet the following requirements:

(A) be a safety-net hospital;

(B) have an actual-to-expected ratio of at least 10 percent lower than the statewide average (actual-to-expected ratio is less than or equal to 0.90);

(C) have not received a penalty for either PPCs or potentially preventable readmissions;

(D) are not low-volume, as defined by HHSC.
(5) Calculation of targeted incentive payments.

(A) Calculate base allocation: Each eligible hospital is awarded a base allocation not to exceed $100,000.

(B) Calculate variable allocation: Each eligible hospital is awarded a variable allocation, which are calculated from remaining funds after distribution of base allocations to all eligible hospitals. The variable allocation has the following components:

(i) Hospital size score: Each eligible hospital’s size divided by the average size of the whole group of hospitals within each incentive pool. Size is calculated based on total inpatient facility claims paid to each eligible hospital. Each eligible hospital’s size calculation is capped at 2.00.

(ii) Hospital Performance score: Each eligible hospital’s performance divided by the average performance of the whole group of hospitals within each incentive pool. Performance is calculated by actual to expected ratio.

(iii) Composite score: Each eligible hospital receives a composite score, which is the hospital’s size score multiplied by the hospital’s performance score.

(iv) Each hospital’s composite score divided by the sum of all eligible hospitals’ composite scores is multiplied by the remaining incentive funds, after distribution of base allocations.

(C) Calculate final allocation: The final allocation to each eligible hospital is equal to the eligible hospital’s base allocation plus the eligible hospital’s variable allocation.

(6) Each eligible hospital’s PPC incentive payment will be divided between FFS and MCO reimbursements based on the percentage of its total paid FFS and MCO Medicaid inpatient hospital reimbursements for the reporting time period accruing from FFS.

(7) PPC incentive payments will be made as lump sum payments or tied to particular claims or recipients, at HHSC’s discretion.

(8) HHSC will post the methodology for calculating and distributing incentives on its public website at http://www.hhsc.state.tx.us/hhsc_projects/ECI/Potentially-Preventable-Events.shtml.

(9) Targeted incentive payments for safety-net hospitals are not included in the calculation of a hospital’s hospital-specific limit or low income utilization rate.
Hospital Augmented Reimbursement Program (HARP) Methodology for Non-state government-owned and operated hospitals (Inpatient Payments)

(a) Introduction. Non-state government-owned and operated hospitals participating in the Texas Medicaid program that meet the conditions of participation and serve fee-for-service patients are eligible for reimbursement. The non-federal share of the payments is funded through intergovernmental transfer (IGT). The Health and Human Services Commission (HHSC) will establish each hospital's eligibility for an amount of reimbursement using the methodology described in this appendix.

(b) Definitions

(1) Fee-for-Service (FFS)--A system of health insurance payment in which a health care provider is paid a fee by HHSC through the contracted Medicaid claims administrator directly for each service rendered. For Texas Medicaid purposes, fee-for-service excludes any service rendered under a managed care program through a managed care organization.

(2) Inpatient hospital services--Services ordinarily furnished in a hospital for the care and treatment of inpatients under the direction of a physician or dentist, or a subset of these services identified by HHSC. Inpatient hospital services do not include those furnished in a skilled nursing facility, intermediate care facility services furnished by a hospital with swing-bed approval, or any other services that HHSC determines should not be subject to payment.

(3) Intergovernmental transfer (IGT)--A transfer of public funds from another state agency or a non-state governmental entity to HHSC.

(4) Medicare payment gap--The difference between what Medicare is estimated to pay for the services and what Medicaid actually paid for the same services from the most recent FFS upper payment limit (UPL) demonstration.

(5) Non-state government-owned and operated hospital--A hospital that is owned and operated by a local government entity, including but not limited to a city, county, or hospital district.

(6) Program period--Each program period is equal to a federal fiscal year beginning October 1 and ending September 30 of the following year.
(7) Prospective Payment System--A method of reimbursement in which payment is made based on a predetermined, fixed amount.

(8) Sponsoring governmental entity--A state or non-state governmental entity that agrees to transfer to HHSC some or all of the non-federal share of program expenditures.

(9) State government-owned hospital--Any hospital owned by the state of Texas that is not considered an IMD.

(c) Participation requirements. As a condition of participation, all hospitals participating in the program must allow for the following.

   (1) The hospital must submit a properly completed enrollment application by the due date determined by HHSC. The enrollment period must be no less than 15 business days, and the final date of the enrollment period will be at least nine days prior to the intergovernmental transfer (IGT) notification.

   (2) If a provider has changed ownership in the past five years in a way that impacts eligibility for this program, the provider must submit to HHSC, upon demand, copies of contracts it has with third parties with respect to the transfer of ownership or the management of the provider and which reference the administration of, or payment from, this program.

(d) Payments for non-state government-owned and operated hospitals.

   (1) Eligible hospitals. Payments under this subsection will be limited to hospitals defined as a "non-state government-owned and operated hospital" that are enrolled in Medicare and participate in Texas Medicaid fee-for-service.

   (2) Non-federal share of program payments. The non-federal share of the payments is funded through IGTs from sponsoring governmental entities. No state general revenue is available to support the program.

      (A) HHSC will communicate suggested IGT responsibilities. Suggested IGT responsibilities will be based on the maximum dollars to be available under the program for the program period as determined by HHSC. HHSC will also communicate estimated revenues each enrolled hospital could earn under the program for the program period with those estimates based on HHSC’s suggested IGT responsibilities.

      (B) HHSC will issue an IGT notification to specify the date that IGT is requested to be transferred not fewer than 14 business days before IGT transfers are due. HHSC may post the IGT deadlines and other associated information on HHSC’s website, send
the information through the established Medicaid notification procedures used by HHSC's fiscal intermediary, send through other direct mailings, send through GovDelivery, or provide the information to the hospital associations to disseminate to their member hospitals.

(3) Payment Methodology. To determine each participating non-state government-owned and operated hospital's inpatient HARP payment, HHSC will use the inpatient FFS Medicare payment gap.

(e) Changes in operation. If an enrolled hospital closes voluntarily or ceases to provide hospital services in its facility, the hospital must notify the HHSC Provider Finance Department by hand delivery, United States (U.S.) mail, or special mail delivery within 10 business days of closing or ceasing to provide hospital services. Notification is considered to have occurred when the HHSC Provider Finance Department receives the notice.

(f) Reconciliation. HHSC will reconcile the amount of the non-federal funds expended under this section during the program period with the amount of funds transferred to HHSC by the sponsoring governmental entities for that same period. If the amount of non-federal funds expended under this section is less than the amount transferred to HHSC, HHSC will refund the balance proportionally to how it was received.

(g) Payments under this section will be made on a semi-annual basis.

For fiscal year 2022, the following providers are eligible for a HARP payment:

<table>
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<tr>
<th>Master Texas Provider Identifier (TPI)</th>
<th>Master National Provider Identifier (NPI)</th>
<th>Hospital Name</th>
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TN#: 21-0035
Supersedes: NEW
Effective Date: 10/01/2021
Approval Date: August 30, 2022
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Hospital Augmented Reimbursement Program (HARP) Methodology for Private Hospitals

(a) Introduction. Private Hospitals participating in the Texas Medicaid program that meet the conditions of participation and that serve fee-for-service patients are eligible for reimbursement. The non-federal share of the payments is funded through intergovernmental transfer (IGT). The Health and Human Services Commission (HHSC) will establish each hospital's eligibility for an amount of reimbursement using the methodology described in this appendix.

(b) Definitions

(1) Fee-for-Service (FFS)--A system of health insurance payment in which a health care provider is paid a fee by HHSC through the contracted Medicaid claims administrator directly for each service rendered. For Texas Medicaid purposes, fee-for-service excludes any service rendered under a managed care program through a managed care organization.

(2) Inpatient hospital services--Services ordinarily furnished in a hospital for the care and treatment of inpatients under the direction of a physician or dentist, or a subset of these services identified by HHSC. Inpatient hospital services do not include those furnished in a skilled nursing facility, intermediate care facility services furnished by a hospital with swing-bed approval, or any other services that HHSC determines should not be subject to payment.

(3) Intergovernmental transfer (IGT)--A transfer of public funds from another state agency or a non-state governmental entity to HHSC.

(4) Medicare payment gap--The difference between what Medicare is estimated to pay for the services and what Medicaid actually paid for the same services from the most recent FFS upper payment limit (UPL) demonstration.

(5) Outpatient hospital services--Preventive, diagnostic, therapeutic, rehabilitative, palliative services or a subset of these services identified by HHSC that are furnished to outpatients of a hospital under the direction of a physician or dentist.

(6) Private hospital--Any hospital that is not government-owned and operated.
(7) Program period--Each program period is equal to a federal fiscal year beginning October 1 and ending September 30 of the following year.

(8) Sponsoring governmental entity--A state or non-state governmental entity that agrees to transfer to HHSC some or all of the non-federal share of program expenditures.

(c) Participation requirements. As a condition of participation, all hospitals participating in the program must allow for the following.

(1) The hospital must submit a properly completed enrollment application by the due date determined by HHSC. The enrollment period must be no less than 15 business days, and the final date of the enrollment period will be at least nine days prior to the intergovernmental transfer (IGT) notification.

(2) If a provider has changed ownership in the past five years in a way that impacts eligibility for this program, the provider must submit to HHSC, upon demand, copies of contracts it has with third parties with respect to the transfer of ownership or the management of the provider and which reference the administration of, or payment from, this program.

(d) Payments for private hospitals.

(1) Eligible hospitals. Payments under this subsection will be limited to hospitals defined as a "private hospital" in subsection (b) that are enrolled in Medicare and participate in Texas Medicaid fee-for-service.

(2) Non-federal share of program payments. The non-federal share of the payments is funded through IGTs from sponsoring governmental entities. No state general revenue is available to support the program.

(A) HHSC must receive the non-federal portion of reimbursement for HARP through a method approved by HHSC and Centers for Medicare & Medicaid Services (CMS) for reimbursement through this program.

(B) A hospital under this subsection must designate a single local governmental entity to provide the non-federal share of the payment through a method determined by HHSC. If the single local governmental entity transfers less than the full non-federal share of a hospital's payment amount calculated under this subsection, HHSC will recalculate that specific hospital's payment based on the amount of the non-federal share transferred.

(C) HHSC will communicate suggested IGT responsibilities. Suggested IGT responsibilities will be based on the maximum dollars to be available under the program for the program period as determined by HHSC. HHSC will also communicate estimated
revenues each enrolled hospital could earn under the program for the program period with those estimates based on HHSC's suggested IGT responsibilities.

(D) HHSC will issue an IGT notification to specify the date that IGT is requested to be transferred not fewer than 14 business days before IGT transfers are due. HHSC may post the IGT deadlines and other associated information on HHSC’s website, send the information through the established Medicaid notification procedures used by HHSC's fiscal intermediary, send through other direct mailings, send through GovDelivery, or provide the information to the hospital associations to disseminate to their member hospitals.

(3) Payment Methodology. To determine each participating private hospital’s payment, HHSC will sum the hospital’s inpatient FFS Medicare payment gap and the hospital’s outpatient FFS Medicare payment gap.

(e) Changes in operation. If an enrolled hospital closes voluntarily or ceases to provide hospital services in its facility, the hospital must notify the HHSC Provider Finance Department by hand delivery, United States (U.S.) mail, or special mail delivery within 10 business days of closing or ceasing to provide hospital services. Notification is considered to have occurred when the HHSC Provider Finance Department receives the notice.

(f) Reconciliation. HHSC will reconcile the amount of the non-federal funds expended under this section during the program period with the amount of funds transferred to HHSC by the sponsoring governmental entities for that same period. If the amount of non-federal funds expended under this section is less than the amount transferred to HHSC, HHSC will refund the balance proportionally to how it was received.

(g) Payments under this section will be made on a semi-annual basis.
Rates and fees can be found by accessing

The rates accessed at these websites 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.

To ensure access to care and prompt provider reimbursement, the Texas Health and Human Services Commission (HHSC) will establish reimbursement rates for nondiscretionary items or services, to include: new Healthcare Common Procedure Coding System Updates, federally mandated reimbursement rates, and/or physician-administered drugs or biological products.

For new Healthcare Common Procedure Coding System Updates, reimbursement will be established based on:
1. the Medicare RVU multiplied by the state defined conversion factor(s);
2. in the absence of a Medicare RVU, a percentage of the Medicare fee;
3. in the absence of the Medicare fee, the established Medicaid rate for a similar service;
4. in the absence of the established Medicaid rate for a similar service, the Medicaid rate for other states; or
5. in the absence of the Medicaid rates for other states, a percentage of commercial payor rates.

For physician-administered drugs or biological products, reimbursement will be established based on:
1. a percentage of the published Medicare reimbursement rate;
2. in the absence of a Medicare reimbursement rate, a percentage of the average wholesale price (AWP),
3. in the absence of AWP, a percentage of the Manufacturer’s Suggested Retail Price (MSRP),
4. in the absence of MSRP, the established Medicaid rate for a similar service, or
5. in the absence of a Medicaid rate for a similar service, the Medicaid rate for other states.

For federally mandated reimbursement rates, reimbursement will be established based on the federally mandated rate.
1. Physicians and Other Practitioners

(a) Subject to the qualifications, limitations, and exclusions in the amount, duration and scope of benefits as provided elsewhere in the State Plan, payment to eligible providers of laboratory services, including x-ray services, radiation therapy services, physical and occupational therapists' services, physician services (including anesthesia and physician-administered drugs), podiatry services, chiropractic services, optometric services, dentists' services, psychologists' services, certified respiratory care practitioners' services, maternity clinics' services, tuberculosis clinic services, certified nurse midwife services, and advanced telecommunication services (including telemedicine, telehealth, and telemonitoring services) are reimbursed based on an uniform, statewide, prospective payment system.

(1) Services delivered by a psychologist are paid at 100 percent of the fee schedule.

(2) Services delivered by a licensed psychological associate (LPA) or Provisionally Licensed Psychologist (PLP) under the supervision of a psychologist are paid at 70 percent of the fee schedule.

(b) The fees for covered services provided by physicians and other practitioners are based upon the determination of adequacy of access to health care services by the Texas Health and Human Services Commission (HHSC), as described in this section.

(1) There shall be no geographical or specialty reimbursement differential for individual services.

(2) The fees for individual services will be reviewed at least every two years and include:
(A) resource-based fees (RBFs) and
(B) access-based fees (ABFs).

The fee schedule is published quarterly.

(3) Measures of adequacy of access to health care services include, but are not limited to, the following determinations:
(A) adequate participation in the Medicaid program by physicians and other practitioners; and/or
(B) the ability of Medicaid recipients to receive adequate health care services in an appropriate setting.
1. Physicians and Other Practitioners (continued)

(c) Resource-based fees (RBFs) are based on actual resources required by an economically efficient provider to deliver each individual service and are calculated by multiplying the applicable relative value unit (RVU) times a conversion factor.

(1) A relative value unit (RVU) is the relative value assigned to each of the three individual components that comprise the cost of providing individual Medicaid services. The three cost components are intended to reflect the work, overhead and the professional liability expense required to provide each individual service. HHSC will review any changes to or revisions of the various Medicare RVUs and, if applicable, adopt the changes as part of the RBF fee schedule.

(2) The conversion factor is the dollar amount by which the sum of the three cost component RVUs is multiplied in order to obtain an RBF for each individual service. HHSC may develop and apply multiple conversion factors for various classes of service, such as obstetrics, pediatrics, general surgeons, and/or primary care services. The following conversion factors are applied and are reflected on the fee schedule for services provided by physicians and other practitioners on the agency's website:

A. $26.7305 – Effective April 1, 2012, for RBFs for physicians and other practitioners.

B. $28.0672 – Effective April 1, 2012, for RBFs for physicians and other practitioners.

C. $27.276 – Effective September 1, 1999, for RBFs for physicians and other practitioners.

D. $28.640 – Effective September 1, 2007, for increases to certain RBFs for services provided by physicians and other practitioners. Implemented with respect to recipients under age 21 pursuant to the order of the court in Frew v. Hawkins, Civil Action #3:93/CV65 (Eastern District – Paris Division) on April 27, 2007 (Corrective Action Order: Adequate Supply of Healthcare Providers).

E. $30.000 – Effective April 1, 2010, for increases to certain RBFs for services provided by physicians and other practitioners. Implemented with respect to maintaining access to care for Medicaid clients for certain necessary medical services.
1. Physicians and Other Practitioners (continued)

F. Conversion factor equal to the current Medicare conversion factor – Effective April 1, 2010, for increases to certain RBFs for services provided by physicians and other practitioners. Implemented with respect to maintaining access to care for Medicaid clients for certain necessary medical services.

G. $25.60 – Effective November 1, 2017, for anesthesia services to clients under age 21.

H. $24.32 – Effective November 1, 2017, for anesthesia services to clients 21 years of age and older.

I. $34.00 – Effective March 1, 2019, for anesthesia services to clients under 21 years of age and paid to children’s hospitals when the care team model is utilized, and the following criteria are met:
   • Level I/Level II trauma facility at separately-licensed children’s hospital, and
   • Level IV NICU, and
   • Not-for-profit, and
   • A minimum Medicaid utilization rate of 40 percent.

(d) Access-based fees (ABFs) are developed to account for deficiencies in RBFs relating to adequacy of access to health care services for Medicaid clients and are based upon: (1) historical charges; (2) current total Medicare fee (i.e., RVU times Conversion Factor) for the individual service; (3) review of Medicaid fees paid by other states; (4) survey of providers’ costs to provide the individual service; (5) Medicaid fees for similar services; (6) an analysis of wage and/or labor statistic data for providers; and/or (7) some combination or percentage thereof.

(e) General guidelines used when updating Medicaid fees for services provided by physicians and other practitioners, include, but not limited to the following: updating the Medicaid relative value units (RVUs) to those currently in effect for Medicare and multiplying the updated RVUs by the current Medicaid conversion factor to result in an updated resource-based fee (RBF); increasing the Medicaid conversion factor to increase RBFs for which no RVU update is required in order to increase access to services; changing an existing RBF to an access-based fee (ABF) when the RBF methodology does not provide sufficient access to care; and changing an existing ABF to a RBF as appropriate.

TN: 21-0045 Approval Date: January 18, 2022
Supersedes TN: 19-0007 Effective Date: 10/01/2021

State: Texas
Date Received: 03-22-19
Date Approved: 05-07-19
Date Effective: 03-01-19
Transmittal Number: 19-0007
1. Physicians and Other Practitioners (continued)

(f) When a procedure code is nationally discontinued, a replacement procedure code is nationally assigned for the discontinued procedure code, Medicaid implements the replacement procedure code, and a state plan amendment will not be submitted since the fee for the service has not changed.

(g) All fee schedules are available through the agency’s website, as outlined in Attachment 4.19-B, page 1.

(h) The agency’s fee schedule was revised with new fees for services provided by physicians and other practitioners affiliated with tuberculosis clinics or employed by tuberculosis clinics, effective July 1, 2018. This fee schedule was posted on the agency’s website on July 6, 2018.

(i) The agency’s fee schedule was revised with new fees for therapy assistants. Effective September 1, 2019, the reimbursement for therapy assistants will equal 80 percent of the payment to a therapist.

(j) The agency’s fee schedule was revised with new fees to include peer specialists, effective March 1, 2022. This fee schedule will be posted on the agency’s website on or prior to March 15, 2022.

(k) For dates of service on or after February 1, 2021, the reimbursement for services provided by a licensed assistant behavioral analyst will be reimbursed at 80 percent of the rate paid to a licensed behavior analyst.

(l) The agency’s fee schedule was revised with new fees for physicians and other practitioners effective July 1, 2023. The fee schedule will be posted on the agency website by September 15, 2023.
Reimbursement Template - Physician Services

Increased Primary Care Service Payment 42 CFR 447.405, 447.410, 447.415

Attachment 4.19-B: Physician Services 42 CFR 447.405 Amount of Minimum Payment

The state reimburses for services provided by physicians meeting the requirements of 42 CFR 447.400(a) at the Medicare Part B fee schedule rate using the Medicare physician fee schedule rate in effect in calendar years 2013 and 2014 or, if greater, the payment rates that would be applicable in those years using the calendar year 2009 Medicare physician fee schedule conversion factor. If there is no applicable rate established by Medicare, the state uses the rate specified in a fee schedule established and announced by CMS.

☐ The rates reflect all Medicare site of service and locality adjustments.

☒ The rates do not reflect site of service adjustments, but reimburse at the Medicare rate applicable to the office setting.

☐ The rates reflect all Medicare geographic/locality adjustments.

☒ The rates are statewide and reflect the mean value over all counties for each of the specified evaluation and management and vaccine billing codes.

The following formula was used to determine the mean rate over all counties for each code: The State is using the March, 2013 Deloitte fee schedule. The enhanced fee schedule will be updated annually to account for changes to the Medicare rate.

Method of Payment

☐ The state has adjusted its fee schedule to make payment at the higher rate for each E&M and vaccine administration code.

☒ The state reimburses a supplemental amount equal to the difference between the Medicaid rate in effect on July 1, 2009 and the minimum payment required at 42 CFR 447.405.

Supplemental payment is made: ☐ monthly ☒ quarterly

STATE Texas
DATE REC'D 3-29-13
DATE APPV'D 6-21-13
DATE EFF 1-1-13
11:28A 179 13-11

TN: 13-12 Approval Date: 6-21-13 Effective Date: 1-1-13

Supersedes TN: None - new page

SUPERSEDES. NONE - NEW PAGE
Reimbursement Template - Physician Services

Increased Primary Care Service Payment (continued)

Primary Care Services Affected by this Payment Methodology

☐ This payment applies to all Evaluation and Management (E&M) billing codes 99201 through 99499.

☒ The State did not make payment as of July 1, 2009 for the following codes and will not make payment for those codes under this SPA (specify codes).

99288, 99360, 99363, 99364, 99366, 99368, 99401, 99402, 99403, 99404, 99408, 99409, 99411, 99412, 99420, 99429, 99441, 99442, 99443, 99444, 99450, 99455, 99456, 99466, 99467, 99485, 99486, 99487, 99488, 99489, 99495, and 99496.

(Primary Care Services Affected by this Payment Methodology – continued)

☒ The state will make payment under this SPA for the following codes which have been added to the fee schedule since July 1, 2009 (specify code and date added).

Added 1/1/2010: 99385, 99386, 99387, 99395, 99396, 99397
Added 1/1/2011: 99224, 99225, 99226
Added 1/1/2012: 99406, 99407

Physician Services – Vaccine Administration

For calendar years (CYs) 2013 and 2014, the state reimburses vaccine administration services furnished by physicians meeting the requirements of 42 CFR 447.400(a) at the lesser of the state regional maximum administration fee set by the Vaccines for Children (VFC) program or the Medicare rate in effect in CYs 2013 and 2014 or, if higher, the rate using the CY 2009 conversion factor.

☐ Medicare Physician Fee Schedule rate

☒ State regional maximum administration fee set by the Vaccines for Children program - $22.06

☐ Rate using the CY 2009 conversion factor
Increased Primary Care Service Payment (continued)

Documentation of Vaccine Administration Rates in Effect 7/1/09

The state uses one of the following methodologies to impute the payment rate in effect at 7/1/09 for code 90460, which was introduced in 2011 as a successor billing code for billing codes 90465 and 90471.

☒ The imputed rate in effect at 7/1/09 for code 90460 equals the rate in effect at 7/1/09 for billing codes 90465 and 90471 times their respective claims volume for a 12 month period which encompasses July 1, 2009. Using this methodology, the imputed rate in effect for code 90460 at 7/1/09 is: $8.80.

☐ A single rate was in effect on 7/1/09 for all vaccine administration services, regardless of billing code. This 2009 rate is: ________________________________.

☐ Alternative methodology to calculate the vaccine administration rate in effect 7/1/09:

_________________________________________________________________________

Note: This section contains a description of the state’s methodology and specifies the affected billing codes.

Effective Date of Payment

E & M Services
This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on December 31, 2014, but not prior to December 31, 2014. All rates are published at (http://public.tmhp.com/FeeSchedules/StaticFeeSchedule/FeeSchedules.aspx).

Vaccine Administration
This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on December 31, 2014, but not prior to December 31, 2014. All rates are published at (http://public.tmhp.com/FeeSchedules/StaticFeeSchedule/FeeSchedules.aspx).

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(a) Ground and air ambulance services are reimbursed based on the lesser of the provider’s billed charges or fees established by the Texas Health and Human Services Commission (HHSC). Fees established by HHSC are based on a review of the Medicare fee schedule and/or an analysis of other data available to HHSC such as relevant fee schedules.

(b) All fee schedules are available through the agency’s website as outlined on Attachment 4.19-B, page 1.

(c) The agency’s fee schedule was revised with new fees for providers of ambulance services effective September 1, 2018, and this fee schedule was posted on the agency’s website on September 5, 2018.
3. Clinical Diagnostic Laboratory Services

Medicaid providers of clinical diagnostic laboratory (CDL) services are reimbursed based on fee schedules as follows:

(a) The Texas Department of State Health Services (DSHS) Laboratory provides Early and Periodic Screening, Diagnostic and Treatment (EPSDT) medical and newborn screening services through a federal freedom-of-choice exemption as well as any other laboratory services provided that are not covered by this exemption.

The DSHS laboratory is reimbursed for all laboratory services provided at a percentage of the Medicare fees.

(b) Sole community hospitals are reimbursed the lesser of their billed charges or the fee determined by HHSC, which is a percentage of the Medicare fee. Under Medicare, the fee schedule amount paid to sole community hospitals is three and one third percent higher than the fee schedule amount paid to other types of providers of CDL service.

The Medicaid fee for any new procedure codes added during the year will be based on a percentage of the Medicare fees in effect as of January 1 of that same year.

(c) The remaining providers of these services are reimbursed the lesser of their billed charges or the fee determined by HHSC, which is a percentage of the Medicare fee.

The Medicaid fee for any new procedure codes added during the year will be based on a percentage of the Medicare fees in effect as of January 1 of that same year.

(d) The reimbursement methodologies in (a) – (c) ensure that Medicaid payments to these providers for these services meet the upper payment limit requirements in Section 1903(i)(7) of the Social Security Act by requiring that Medicaid payments for clinical laboratory services must not exceed the Medicare fee for the service on a per test basis. This provision does not apply to the DSHS laboratory reimbursement, Rural Hospitals, or Sole Community Hospitals, which will be established at a percentage of the Medicare fee.

(e) All fee schedules are available through the agency's website as outlined on Attachment 4.19-B, Page 1.

(f) For services related to testing of Covid-19 (coronavirus), CDL services provided outside of the DSHS Laboratory are reimbursed at 100% of the Medicare rate.

(g) The agency's fee schedule was revised with new fees for clinical diagnostic laboratory services effective January 1, 2021, and was posted on the agency's website on March 19, 2021.
4. Outpatient Hospital Services

(a) Introduction. The Health and Human Services Commission (HHSC) or its designee reimburses outpatient hospital services under the reimbursement methodology described in this section. Except as described in subsections (c) and (d) of this section, HHSC will reimburse for outpatient hospital services based on a percentage of allowable charges and an outpatient interim rate.

(b) Interim reimbursement.

(1) HHSC will determine a percentage of allowable charges, which are charges for covered Medicaid services determined through claims adjudication.

(A) For high volume providers that received Medicaid outpatient payments equaling at least $200,000 during calendar year 2004.

(i) For children's hospitals and state-owned teaching hospitals as defined in Attachment 4.19-A (relating to Inpatient Hospital Reimbursement), the percentage of allowable charges is 76.03 percent.

(ii) For rural hospitals as defined in Attachment 4.19-A of the Texas Medicaid State Plan the percentage of allowable charges is 100 percent.

(iii) For all other providers, the percentage of allowable charges is 72.00 percent.

(B) For all providers not considered high volume providers as determined in paragraph (1)(A) of this subsection.

(i) For children's hospitals and state-owned teaching hospitals as defined in Attachment 4.19-A the percentage of allowable charges is 72.27 percent.

(ii) For rural hospitals as defined in Attachment 4.19-A of the Texas Medicaid State Plan, the percentage of allowable charges is 100 percent.

(iii) For all other providers, the percentage of allowable charges is 68.44 percent.

(C) For outpatient emergency department (ED) services that do not qualify as emergency visits, which are listed in the Texas Medicaid Provider Procedures Manual and other updates on the claims administrator's website, HHSC will reimburse:

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Date Received: 9-23-2015
Date Approved: 1-12-2016
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Transmittal Number: 15-0026

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Supersedes TN: 15-0026 Effective Date: 09/01/2021
4. Outpatient Hospital Services

(i) rural hospitals an amount not to exceed 65.00 percent of allowable charges after application of the methodology in paragraph (2)(C) of this section, which will result in a payment that does not exceed 65.00 percent of allowable cost, for claims with a date of service on or after September 1, 2015; and

(ii) all other hospitals, a flat fee set at a percentage of the Medicaid acute care physician office visit amount for adults.

(2) HHSC will determine an outpatient interim rate for each non-rural hospital, which is the ratio of Medicaid allowable outpatient costs to Medicaid allowable outpatient charges derived from the hospital's Medicaid cost report.

(A) For a non-rural hospital with at least one tentative cost report settlement completed prior to September 1, 2013, the interim rate is the rate in effect on August 31, 2013, except the hospital will be assigned the interim rate calculated upon completion of any future cost report settlement if that interim rate is lower.

(B) For a non-rural new hospital that does not have at least one tentative cost report settlement completed prior to September 1, 2013, the interim rate is 50 percent until the interim rate is adjusted as follows:

(i) If the non-rural hospital files a short-period cost report for its first cost report, the hospital will be assigned the interim rate calculated upon completion of the hospital's first tentative cost report settlement.

(ii) The hospital will be assigned the interim rate calculated upon completion of the hospital's first full-year tentative cost report settlement.

(iii) The hospital will retain the interim rate calculated as described in clause (ii) of this subparagraph, except it will be assigned the interim rate calculated upon completion of any future cost report settlement if that interim rate is lower.
4. Outpatient Hospital Services

(C) Cost settlement. Interim claim reimbursement determined in subparagraph (C) of this paragraph will be cost-settled at both tentative and final audit of a non-rural hospital's cost report. The calculation of allowable costs will be determined based on the amount of allowable charges after applying any reductions to allowable charges made under paragraph (1) of this subsection.

(i) Interim payments for claims with a date of service prior to September 1, 2013, will be cost settled.

(ii) Interim payments for claims with a date of service on or after September 1, 2013, will be included in the cost report interim rate calculation, but will not be adjusted due to cost settlement unless settlement calculation indicates an overpayment.

(iii) HHSC will calculate an interim rate at tentative and final cost settlement for the purposes described in subparagraph (B) of this paragraph.

(iv) If a hospital's interim claim reimbursement for all outpatient services, excluding imaging, clinical lab and outpatient emergency department services that do not qualify as emergency visits, for the hospital's fiscal year exceeded the allowable costs for those services, HHSC will recoup the amount paid to the hospital in excess of allowable costs.

(v) If a hospital's interim claim reimbursement for all outpatient services, excluding imaging, clinical lab and outpatient emergency department services that do not qualify as emergency visits, for the hospital's fiscal year was less than the allowable costs for those services, HHSC will not make additional payments through cost settlement to the hospital for service dates on or after September 1, 2013.

(3) HHSC will determine an outpatient interim rate for each rural hospital, which is the ratio of Medicaid allowable outpatient costs to Medicaid allowable outpatient charges derived from the hospital's Medicaid cost report.

(A) For a rural hospital with at least one tentative cost report settlement completed prior to September 1, 2021, the interim rate effective on September 1, 2021, is the rate calculated in the latest initial cost report with an additional percentage increase, not to exceed an interim rate of 100 percent. After September 1, 2021, a rural hospital will be assigned the interim rate calculated upon completion of initial cost report, with an additional percentage increase, on an interim rate of 100 percent.
4. Outpatient Hospital Services (continued)

(c) Outpatient hospital imaging.

(1) For all hospitals except rural hospitals, as defined in Attachment 4.19-A, page 3, of the Texas Medicaid State Plan, outpatient hospital imaging services for claims with a date of service on or after September 1, 2013, are not reimbursed under the outpatient reimbursement methodology described in subsection (b) of this section. Outpatient hospital imaging services are reimbursed according to an outpatient hospital imaging service fee schedule that is based on a percentage of the Medicare fee schedule for similar services. If a resulting fee for a service provided to any Medicaid beneficiary is greater than 125 percent of the Medicaid adult acute care fee for a similar service, the fee is reduced to 125 percent of the Medicaid adult acute care fee.

(2) For rural hospitals, outpatient hospital imaging services for claims with a date of service on or after February 1, 2017, are reimbursed based on a percentage of the Medicare Outpatient Prospective Payment System fee schedule for similar services.

5. Hospital Ambulatory Surgical Centers (HASC) are reimbursed in accordance with Attachment 4.19-B, page 7(f), relating to the reimbursement methodology for Ambulatory Surgical Centers (ASCs).
Pharmacy Reimbursement Methodology

1. General

The upper limit for payment for prescribed drugs, whether legend or nonlegend items, will be based on the lower of the actual acquisition cost (AAC) plus a professional dispensing fee or the usual and customary charge, as defined and determined by the Texas Health and Human Services Commission (HHSC) or its designee. These provisions do not apply to payment for drugs included in a provider's reimbursement formula, such as inpatient or bundled payments.
Pharmacy Reimbursement Methodology (continued)

2. **Reimbursement Methodology:**

   HHSC or its designee reimburses contracted Medicaid pharmacy providers according to the professional dispensing fee formula defined in this section.

   The professional dispensing fee is determined by the following formula: Professional Dispensing Fee = (((Actual Acquisition Cost + fixed component) divided by (1 – the percentage used to calculate the variable component)) - AAC) + delivery incentive + preferred generic incentive.

   (a) **Drug Ingredient Cost**

   AAC is defined in Section IIC (Legend and Nonlegend Medications).

   (b) **Professional Dispensing Fee Determination**

   1. The fixed component is $7.93.

   2. The variable component is 1.96%.

   3. The total professional dispensing fee shall not exceed $200 per prescription.

   4. A delivery incentive shall be paid to approve providers who certify a form prescribed by HHSC or its designee that the delivery services meet minimum conditions for payment of the incentive. These conditions include: making deliveries to individuals rather than just to institutions, such as nursing homes; offering no-charge prescription delivery to all Medicaid recipients requesting delivery in the same manner as to the general public; and publicly displaying the availability of prescription delivery services at no charge. The delivery incentive is $0.15 per prescription and is to be paid on all Medicaid prescriptions filled. This delivery incentive is not to be paid for over-the-counter drugs, which are prescribed as a benefit of this program.

   5. A preferred generic incentive of $0.50 per prescription shall be paid on all Medicaid prescriptions filled for preferred generic drugs for which a manufacturer has agreed to pay a supplemental rebate. Preferred generic drugs are subject to the requirements for placement on the Preferred Drug List (PDL).
Pharmacy Reimbursement Methodology (continued)

(c) **Legend and Nonlegend Medications**

For all medications, legend and nonlegend, covered by the Vendor Drug Program (VDP) and appearing in the Texas Drug Code Index (TDCI) and updates, the following requirements must be met:

1. A participating pharmacy is reimbursed based on the lesser of AAC plus a Professional Dispensing Fee per prescription, or the usual and customary price charged the general public.

2. AAC is defined as the Texas Retail Pharmacy Acquisition cost (RetailPAC); long-term care pharmacy acquisition cost (LTCPAC); specialty pharmacy acquisition cost (SPAC); or the 340B price (see subsection (F) of this section). Pharmacies subject to LTCPAC are "Long-term care (LTC) pharmacies." LTC Pharmacies serve LTC Patients, as determined by the Single State Agency, and must be "closed door pharmacies." Closed door pharmacies do not have public-facing operations and do not accept outpatient walk-in patients.

   (A) AAC is verifiable by invoice audit conducted by HHSC to include necessary supporting documentation that will verify the final cost to the provider.

   (B) The RetailPAC, LTCPAC, and SPAC will be based on the National Average Drug Acquisition Cost (NADAC) as defined here:

   - RetailPAC: Ingredient cost = NADAC
   - LTCPAC: Ingredient cost = (NADAC - 2.4%)
   - SPAC: Ingredient cost = (NADAC - 1.7%)

   (C) If NADAC is not available for a specific drug, the RetailPAC, LTCPAC, and SPAC will be defined as follows:

   - RetailPAC: Ingredient cost = (WAC - 2%)
   - LTCPAC: Ingredient cost = (WAC - 3.4%)
   - SPAC: Ingredient cost = (WAC - 8%)

   (D) If NADAC OR WAC is not available for a specific drug, the ingredient cost will be based on pharmacy invoice.

   (E) In compliance with 42 Code of Federal Regulations (C.F.R.) §§447.512 and 447.514, reimbursement for drugs subject to Federal Upper Limits (FULs) may not exceed FULs in the aggregate.
Pharmacy Reimbursement Methodology (continued)

(c) Legend and Nonlegend Medications (continued)

(F) The reimbursement for 340B covered entities that fill prescriptions for Medicaid recipients with drugs purchased under Section 340B of the Public Health Services Act ("Section 340B") is AAC, up to the 340B ceiling price, plus a professional dispensing fee per prescription. The state defines AAC as follows:

NEW DRUG PRICING
BRAND/GENERIC: WAC minus 23.1 percent

ESTABLISHED DRUG PRICING

BRAND/GENERIC DRUGS (excluding HIV PRODUCTS and HEMOPHILIA PRODUCTS): WAC minus 57 percent

HIV PRODUCTS: WAC minus 40 percent
HEMOPHILIA PRODUCTS: WAC minus 32 percent

(G) 340B covered entities that fill prescriptions for Medicaid recipients with covered outpatient drugs not purchased under Section 340B are reimbursed at AAC, plus HHSC’s professional dispensing fee. AAC for covered outpatient drugs not purchased under Section 340B, as defined at Section 2(c)(2), is based on NADAC or WAC. If WAC is not available, the ingredients cost will be determined using pharmacy invoice.

(H) A contracted pharmacy under contract with a 340B covered entity described in section 1927(a)(5)(B) of the Social Security Act that fill prescriptions for Medicaid recipients with drugs purchased under Section 340B will be reimbursed at AAC, up to the 340B ceiling price, as defined as section 2(c)(2)(F), plus the professional dispensing fee.

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TN: ___17-0011______ Approval Date: September 22, 2017
Supersedes TN: __N/A - NEW__ Effective Date: April 1, 2017__
Pharmacy Reimbursement Methodology (continued)

(c) Legend and Nonlegend Medications (continued)

(I) Indian Health Service (IHS), Tribal, and Urban Indian Organizations (I/T/U) that fill prescriptions for Medicaid recipients are reimbursed AAC, plus HHSC’s professional dispensing fee per prescription. AAC for covered outpatient drugs not purchased under Section 340B, as defined at Section 2(c)(2), is based on NADAC or WAC. If WAC is not available, the ingredients cost will be determined using pharmacy invoice.

(J) Drugs acquired at the Federal Supply Schedule (FSS) are reimbursed AAC plus HHSC’s professional dispensing fee per prescription.

(K) Drugs acquired at the Nominal Price are reimbursed AAC plus HHSC’s professional dispensing fee per prescription.

(L) Reimbursement for physician-administered drugs and biologicals. In determining the reimbursement methodology for physician-administered drugs and biologicals, Reimbursement for physician-administered drugs and biologicals are based on the lesser of the billed amount, a percentage of the Medicare rate, or one of the following methodologies:

(1) If the drug or biological is considered a new drug or biological (that is, approved for marketing by the Food and Drug Administration within 12 months of implementation as a benefit of Texas Medicaid), it may be reimbursed at an amount equal to 89.5 percent of average wholesale price (AWP).

(2) If the drug or biological does not meet the definition of a new drug or biological, it may be reimbursed at an amount equal to 85 percent of AWP.

(3) Physician-administered drugs purchased under the 340B Drug Program are reimbursed as described under this section of the state plan. Drugs and infusion drugs, may be reimbursed at an amount equal to 106 percent of the average sales price (ASP). Additional information related to physician reimbursement may be found in Attachment 4.19-B, pages 1a to 1a.3 of the Texas Medicaid State Plan.

(M) Investigational drugs are not a current Texas Medicaid pharmacy benefit.
Pharmacy Reimbursement Methodology (continued)

(c) Legend and Nonlegend Medications (continued)

(1) Notice of a public hearing to receive comments on proposed changes to general pricing determinations derived under these policies shall be published in the Texas Register.

(2) Definitions. As used in Section IIC, these terms shall be defined as follows:

(N) Reported Manufacturer Price—Information on pricing submitted to VDP by the manufacturer, including Average Wholesale Prices, Average Manufacturer Price, wholesaler costs, direct prices and institutional or contract prices.

(O) Wholesale Costs—The net cost of a product to a drug wholesaler or distributor.
Page 2e (through 2l) was deleted by TN 97-15
7. Reimbursement Methodology for Family Planning Services

(a) Payment for Family Planning services is made in accordance with the provisions contained in items 1 (Physicians and Certain Other Practitioners), 3 (Clinical Labs), 35 (Certified Family and Pediatric Nurse Practitioners), and 41 (Certified Registered Nurse Anesthetists and Advanced Nurse Practitioners) depending on the service provided and the provider type. For other agencies which are physician-directed and are approved to provide family planning services under this state plan, the upper payment limits will not be in excess of a fee schedule, as approved by the Single State Agency, for each of the professional services authorized as benefits.

(b) All fee schedules are available through the agency's website as outlined in Attachment 4.19-B, page 1.

(c) The agency's fee schedule was revised with new fees for family planning providers effective April 1, 2023. The fee schedule was posted on the agency website on April 15, 2023.
8. Home Health Services

(a) Professional Services

(1) Home health agencies are reimbursed for authorized professional home health services, including skilled nursing visits and therapy visits, delivered to eligible Medicaid recipients, the lesser of the provider’s billed charges or the fee schedule established by HHSC.

(2) All fee schedules are available through the agency’s website as outlined on Attachment 4.19-B, Page 1.

(3) The agency’s fee schedule was revised with new fees for home health professional services and durable medical equipment, prosthetics, orthotics, and supplies effective September 1, 2021. This fee schedule was posted on the agency’s website on September 15, 2021.

(4) The agency’s fee schedule was revised with new fees for therapy assistants. Effective September 1, 2019, the reimbursement for therapy assistants will equal 80 percent of the payment to a therapist.
8. Home Health Services (continued)

(b) Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

(1) If the item of DMEPOS is covered by Medicare, the Medicaid fee will be equal to or a percentage of the Medicare fee schedule specific to Texas that is available at the time of the fee review, unless there is documentation that the Medicare fee is insufficient for the items covered under the procedure code and required by the Medicaid population.

(2) For items of DMEPOS not paid at the Medicare fee, the provider will either be reimbursed a fee determined by HHSC or through manual pricing. The fee determined by HHSC will be determined from cost information from providers, manufacturers, surveys of the Medicaid fees for other states, survey information from national fee analyzers, or other relevant fee-related information.

(3) Manual pricing is reasonable when one procedure code covers a broad range of items with a broad range of costs since a single fee may not be a reasonable fee for all items covered under the procedure code, resulting in access-to-care issues. Examples include 1) procedure codes with a description of “not otherwise covered,” “unclassified,” or “other miscellaneous;” and 2) procedure codes covering customized items. If manual pricing is used, the provider is reimbursed either the documented Manufacturer’s Suggested Retail Price (MSRP) less 18 percent, or the documented Average Wholesale Price (AWP) less 10.5 percent, whichever one is applicable. If one of these is not available, the provider's documented invoice cost is used as the basis for manual pricing. AWP pricing is used primarily for nutritional products and DMEPOS items sold in pharmacies.

(4) The Medicaid fees for oxygen equipment, oxygen, and oxygen-related supplies will not exceed the Medicare fee for the same procedure code.

(5) All fee schedules are available through the agency’s website as outlined in Attachment 4.19-B, page 1.

(6) The agency’s fee schedule was revised with new fees for durable medical equipment, prosthetics, orthotics, and supplies effective March 1, 2023, and was posted on the agency’s website March 15, 2023.
9. Hearing Aids and Audiometric Evaluations

(a) Providers of professional hearing and audiometric evaluation services are reimbursed based on the lesser of the provider’s billed charges or fees determined by HHSC in accordance with Item 1 of this attachment, relating to the reimbursement methodology for physicians and certain other practitioners.

(b) Providers of hearing aids are reimbursed the lesser of the provider’s billed charges or fees determined by HHSC, which are based on a review of data available to HHSC, such as cost information from providers or manufacturers, surveys of the Medicaid fees for other states, survey information from national fee analyzers, or other relevant fee-related information.

(c) All fee schedules are available through the agency’s website as outlined on Attachment 4.19-B, page 1.

(d) The agency’s fee schedule was revised with new fees for hearing aids and audiometric evaluation services effective March 1, 2023, and this fee schedule was posted on the agency’s website March 15, 2023.
10. Vision Care Services

(a) Providers of professional vision services are reimbursed based on the lesser of the provider's billed charges or fees determined by HHSC in accordance with Item 1 of this attachment, relating to the reimbursement methodology for physicians and certain other practitioners.

(b) Providers of eyeglasses and contact lenses are reimbursed the lesser of the provider's billed charges or fees determined by HHSC, which are based on a review of Medicare fees and/or other data available to HHSC, such as relevant cost or fee surveys.

(c) All fee schedules are available through the agency's website, as outlined on Attachment 4.19-B, page 1.

(d) The agency’s fee schedule was revised with new fees for vision care services effective September 1, 2022, and this fee schedule will be posted on the agency’s website by September 15, 2022.
12. Medical Transportation

(a) NEMT Demand Response Transportation Services
(1) NEMT Demand Response Transportation Services (DRTS) are reimbursed based on the lesser of the provider’s billed charges or fees established by the Texas Health and Human Services Commission (HHSC). Fees established by HHSC are based on 1) an analysis of historical claims data; 2) Medicare fees; 3) a review of the fees paid by other states; or 4) a fee for comparable procedure codes.

(2) Fees based off historical claims analysis were categorized into three county types based on population density: metro, micro, and rural. The three county types are identified by modifiers billed in conjunction with the payable procedure(s).

(3) All fee schedules are available through the agency’s website as outlined on Attachment 4.19-B, page 1.

(4) The agency’s fee schedule was revised with new reimbursement rates for NEMT Demand Response Transportation Services effective June 1, 2021, and this fee schedule was posted on the agency’s website on June 5, 2021.

(b) Other transportation services
The table below outlines the payments for each transportation service provided on or after June 1, 2021.

<table>
<thead>
<tr>
<th>Service</th>
<th>Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Air</td>
<td>HHSC pays general public airfare (non-refundable) at the best possible price to the location traveled at times that meet the client’s medical needs.</td>
</tr>
<tr>
<td>Commercial &amp; public fixed route transportation</td>
<td>HHSC pays the public fare price for the means of transportation that is most cost effective.</td>
</tr>
<tr>
<td>Individual Transportation Participant-Other</td>
<td>ITPs are paid the mileage reimbursement rate for State of Texas employees as adopted by the single state agency.</td>
</tr>
<tr>
<td>Individual Transportation Participant-Self</td>
<td>ITPs are paid the mileage reimbursement rate for State of Texas employees as adopted by the single state agency.</td>
</tr>
<tr>
<td>Lodging</td>
<td>HHSC negotiates the government rate when possible. HHSC pays the best rate that can be secured in the area that meets the client’s medical needs.</td>
</tr>
<tr>
<td>Meals</td>
<td>Meals are paid at $25.00 per day per person.</td>
</tr>
<tr>
<td>Advanced Funds</td>
<td>The rates are inclusive of mileage, hotels, meals, etc., and are determined as listed above.</td>
</tr>
</tbody>
</table>

Approval Date: 05-25-21
Effective Date: 06/01/2021
13. Rural Health Clinics (RHCs):

For services provided by an RHC and other ambulatory services that are covered under the plan and furnished by an RHC in accordance with Section 4231 of the State Medicaid Manual (HCFA Pub. 45-4).

For RHC facilities employing the Prospective Payment System (PPS) Methodology.

(a) In accordance with Section 1902(aa) of the Social Security Act as amended by the Benefits Improvement and Protection Act (BIPA) of 2000, effective for the RHC's fiscal year which includes dates of service occurring January 1, 2001, and after, RHCs will be reimbursed a PPS per visit rate for Medicaid-covered services. There will no longer be a cost settlement for RHCs for dates of services on or after January 1, 2001.

(b) The PPS per visit rate for both hospital-based and freestanding RHCs will be calculated based on one hundred percent (100%) of the average of the RHC's reasonable costs for providing Medicaid-covered services as determined from audited cost reports for the RHC's 1999 and 2000 fiscal years. The PPS per visit rates will be calculated by adding the total audited reimbursable costs as determined from the 1999 and 2000 cost reports and dividing by the total audited visits for these same two periods. In the event an audited cost report will not be received from the Medicare Intermediary, the PPS per visit rate for both hospital-based and freestanding RHCs will be calculated based on one hundred percent (100%) of the average of the RHC's reasonable costs for providing Medicaid-covered services as determined from audited or unaudited cost reports for the RHC's 1999 and 2000 fiscal years.

(c) For hospital-based RHCs, an interim PPS per visit rate for each RHC will be calculated based upon the encounter rate from the latest finalized cost report settlement, adjusted as provided for in Subsection (h). For freestanding RHCs, the interim PPS per visit rate for each RHC will be based upon the per visit rate in the Medicaid payment system as of December 31, 2000, adjusted as provided for in Subsection (h). When the commission has determined a final PPS rate, interim payments will be reconciled back to January 1, 2001.

(d) Reasonable costs, as used in setting the interim PPS rate, the PPS rate or any subsequent effective rate, is defined as those costs which are allowable under Medicare Cost Principles as outlined in 42 CFR part 413. The cost limits that were in place on December 31, 2000, shall be maintained in determining reasonable costs. Reasonable costs shall not include unallowable costs.

(e) Unallowable costs are expenses which are incurred by an RHC, and which are not directly or indirectly related to the provision of covered services according to applicable laws, rules, and standards. An RHC may expend funds on unallowable cost items, but those costs must not be included in the cost report/survey, and they are not used in calculating a rate determination. Unallowable costs include, but are not necessarily limited to, the following:
(1) Compensation in the form of salaries, benefits, or any form of compensation given to individuals who are not directly or indirectly related to the provision of covered services;

(2) Personal expenses not directly related to the provision of covered services;

(3) Management fees or indirect costs that are not derived from the actual cost of materials, supplies, or services necessary for the delivery of covered services, unless the operational need and cost effectiveness can be demonstrated;

(4) Advertising expenses other than those for advertising in the telephone directory yellow pages, for employee or contract labor recruitment, and for meeting any statutory or regulatory requirement;

(5) Business expenses not directly related to the provision of covered services. For example, expenses associated with the sale or purchase of a business or expenses associated with the sale or purchase of investments;

(6) Political contributions;

(7) Depreciation and amortization of unallowable costs, including amounts in excess of those resulting from the straight line depreciation method; capitalized lease expenses, less any maintenance expenses, in excess of the actual lease payment; and goodwill or any excess above the actual value of the physical assets at the time of purchase. Regarding the purchase of a business, the depreciable basis will be the lesser of the historical but not depreciated cost to the previous owner, or the purchase price of the assets. Any depreciation in excess of this amount is unallowable;

(8) Trade discounts and allowances of all types, including returns, allowances, and refunds, received on purchases of goods or services. These are reductions of costs to which they relate and thus, by reference, are unallowable;

(9) Donated facilities, materials, supplies, and services including the values assigned to the services of unpaid workers and volunteers whether directly or indirectly related to covered services, except as permitted in 42 CFR Part 413;

(10) Dues to all types of political and social organizations, and to professional associations whose functions and purpose are not reasonably related to the development and operation of patient care facilities and programs, or the rendering of patient care services;
(11) Entertainment expenses except those incurred for entertainment provided to the staff of the RHC as an employee benefit. An example of entertainment expenses is lunch during the provision of continuing medical education on-site;

(12) Board of Director's fees including travel costs and provided meals for these directors;

(13) Fines and penalties for violations of regulations, statutes, and ordinances of all types;

(14) Fund raising and promotional expenses except as noted in paragraph (4) of this subsection;

(15) Interest expenses on loans pertaining to unallowable items, such as investments. Also the interest expense on that portion of interest paid which is reduced or offset by interest income;

(16) Insurance premiums pertaining to items of unallowable cost;

(17) Any accrued expenses that are not a legal obligation of the provider or are not clearly enumerated as to dollar amount;

(18) Mileage expense exceeding the current reimbursement rate set by the federal government for its employee travel;

(19) Cost for goods or services which are purchased from a related party and which exceed the original cost to the related party;

(20) Out-of-state travel expenses not related to the provision of covered services, except out-of-state travel expenses for training courses which increase the quality of medical care and/or the operating efficiency of the RHC;

(21) Over-funding contributions to self-insurance funds which do not represent payments based on current liabilities;

(f) A visit is a face-to-face encounter between an RHC patient and a physician, physician assistant, advanced nurse practitioner, certified nurse-midwife, visiting nurse, or clinical nurse practitioner. Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit, except where one of the following conditions exist:
(1) After the first encounter, the patient suffers illness or injury requiring additional diagnosis or treatment; or

(2) The RHC patient has a medical visit and an “other” health visit.

(g) A visit is a face-to-face encounter between an RHC patient and a physician, physician assistant, advanced nurse practitioner, certified nurse mid-wife, visiting nurse, or clinical nurse practitioner. An “other” health visit includes, but is not limited to, a face-to-face encounter between an RHC patient and a clinical social worker.

(h) Effective for each RHC’s fiscal year which includes dates of services occurring on or after October 1, 2001, subsequent increases in an RHC’s PPS per visit rate or the effective rate shall be the rate of change in the Medicare Economic Index (MEI) for Primary Care.

(i) The effective rate is the rate paid to the RHC for the current fiscal year. The effective rate equals the base rate plus the MEI for each of the RHC’s fiscal years since the setting of its PPS rate. The effective rate shall be calculated at the start of each RHC’s fiscal year and shall be applied prospectively for that fiscal year.

(j) An adjustment shall be made to the effective rate if change is due to a change in scope. An RHC or the commission may request an adjustment of the effective rate equal to one hundred percent (100%) of reasonable costs by the filing of a cost report and the necessary documentation to support a claim that the RHC has undergone a change in scope. A cost report, filed to request an adjustment in the effective rate, may be filed at any time during an RHC’s fiscal year but no later than five (5) calendar months after the end of the RHC’s fiscal year. All requests for adjustment in the RHC’s effective rate must include at least 6 months of financial data. Any effective rate adjustment granted as a result of such a filing must be completed within sixty (60) days of receipt of a workable cost report and documentation supporting the RHC’s claim that it has undergone a change in scope. Within sixty (60) days of submitting a workable cost report, HHSC or its designee shall make a determination regarding a new effective rate. The new effective rate shall become effective the first day of the month immediately following its determination. All subsequent increases shall be calculated using the adjusted effective rate.

(k) Any request to adjust an effective rate must be accompanied by documentation showing that the RHC has had a change in scope.

(l) A change in scope of services provided by an RHC includes the addition or deletion of a service or a change in the magnitude, intensity or character of services.
currently offered by an RHC or one of the RHC’s sites. A change in scope includes:

(1) Increase in service intensity attributable to changes in the types of patients served, including but not limited to, HIV/AIDS, homeless, elderly, migrant, other chronic diseases or special populations;

(2) Any changes in services or provider mix provided by an RHC or one of its sites;

(3) Changes in operating costs which have occurred during the fiscal year and which are attributable to capital expenditures including new service facilities or regulatory compliance;

(4) Changes in operating costs attributable to changes in technology or medical practices at the center;

(5) Indirect medical education adjustments and a direct graduate medical education payment that reflects the costs of providing teaching services to interns and residents; or

(6) Any changes in scope approved by the Health Resources and Service Administration (HRSA).

(m) A workable cost report includes the following:

(1) For a hospital-based RHC, complete HCFA Form 2552 and HCFA Form 339 with Certification by an Officer or Administrator including:

(A) M-1 (Analysis of provider-based RHC costs).

(B) M-2 (Allocation of overhead to RHC services).

(C) M-3 (Calculation of reimbursement settlement for RHC services).

(D) M-5 (Analysis of payments to hospital-based RHC services rendered to program beneficiaries).

(E) S-8 (Statistical Data/Information Purposes).

(F) RHC net expenses for allocation of costs for services rendered on or after January 1, 1998, reported on the hospital’s worksheet A, column 7.
13. Rural Health Clinics (RHCs): (continued)

trace properly to the RHC’s total facility costs on line 32, column 7 on M-1 worksheet.

(G) Hospital’s overhead worksheet expenses allocated to each of the hospital-based RHC cost centers on worksheet B, Part I (column 27 minus column 0) trace properly to line 15, column 5 on M-2 worksheet for each hospital-based RHC.

(2) For a freestanding RHC, a complete HCFA 222 Form and HCFA 339 form with Certification by an Officer of Administrator.

(n) Once the base rate for an RHC has been calculated, the RHC shall be paid its effective rate without the need to file a cost report. Except as specified in subsection (o), a cost report shall only be required if the RHC is seeking to adjust its effective rate.

(o) New RHCs shall file a projected cost report within 90 days of their designation to establish an initial payment rate. The cost report will contain the RHC’s reasonable costs anticipated to be incurred during the RHC’s initial fiscal year. The RHC shall file a cost report within five (5) months of the end of the RHC’s initial fiscal year. The cost settlement must be completed within six (6) months of receipt of a cost report. The cost per visit rate established by the cost settlement process shall be the base rate. Any subsequent increases shall be calculated as provided herein. A new RHC location established by an existing RHC participating in the Medicaid program shall receive the same effective rate as the RHC establishing the new location. An RHC establishing a new location may request an adjustment to its effective rate as provided herein if its costs have increased as a result of establishing a new location.

(p) An RHC is paid its full per-visit rate by a state-contracted managed care organization when the RHC renders service.

(q) Submission of Audited Medicare Cost Reports. An RHC shall submit a copy of its audited Medicare cost report to the state within 15 days of receipt.
13. Rural Health Clinics (RHCs): continued

For services provided by an RHC and other ambulatory services that are covered under the plan and furnished by an RHC in accordance with Section 4231 of the State Medicaid Manual (HCFA Pub. 45-4).

RHCs may be reimbursed using an alternative methodology. Written and signed agreements will be obtained from all RHC providers agreeing to the alternative methodology.

(a) In accordance with Section 1902(aa) of the Social Security Act as amended by the Benefits Improvement and Protection Act (BIPA) of 2000, effective for the RHC's fiscal year which includes dates of service occurring January 1, 2001, and after, RHCs will be reimbursed a PPS per visit rate for Medicaid-covered services. There will no longer be a cost settlement for RHCs for dates of services on or after January 1, 2001.

(b) The PPS per visit rate for both hospital-based and freestanding RHCs will be calculated based on one hundred percent (100%) of the average of the RHC's reasonable costs for providing Medicaid-covered services as determined from audited cost reports for the RHC's 1999 and 2000 fiscal years. The PPS per visit rates will be calculated by adding the total audited reimbursable costs as determined from the 1999 and 2000 cost reports and dividing by the total audited visits for these same two periods. The per visit rate using this alternative methodology will provide reimbursement equal to or greater than what would have occurred under PPS. In the event an audited cost report will not be received from the Medicare Intermediary, the PPS per visit rate for both hospital-based and freestanding RHCs will be calculated based on one hundred percent (100%) of the average of the RHC's reasonable costs for providing Medicaid-covered services as determined from audited or unaudited cost reports for the RHC's 1999 and 2000 fiscal years.

(c) For hospital-based RHCs, an interim PPS per visit rate for each RHC will be calculated based upon the encounter rate from the latest cost report settlement, adjusted as provided for in Subsection (h). For freestanding RHCs, the interim PPS per visit rate for each RHC will be based upon the per visit rate in the Medicaid payment system as of December 31, 2000, adjusted as provided for in Subsection (h). When the commission has determined a final PPS rate, interim payments will be reconciled back to January 1, 2001. Adjustments will be made only if the interim payments are less than what would have occurred under PPS.

(d) Reasonable costs, as used in setting the interim PPS rate, the PPS rate or any subsequent effective rate, is defined as those costs which are allowable under Medicare Cost Principles as outlined in 42 CFR part 413. The cost limits that were in place on December 31, 2000, shall be maintained in determining reasonable costs. Reasonable costs shall not include unallowable costs.
(e) Unallowable costs are expenses which are incurred by an RHC, and which are not directly or indirectly related to the provision of covered services according to applicable laws, rules, and standards. An RHC may expend funds on unallowable cost items, but those costs must not be included in the cost report/survey, and they are not used in calculating a rate determination. Unallowable costs include, but are not necessarily limited to, the following:

1. Compensation in the form of salaries, benefits, or any form of compensation given to individuals who are not directly or indirectly related to the provision of covered services;

2. Personal expenses not directly related to the provision of covered services;

3. Management fees or indirect costs that are not derived from the actual cost of materials, supplies, or services necessary for the delivery of covered services, unless the operational need and cost effectiveness can be demonstrated;

4. Advertising expenses other than those for advertising in the telephone directory yellow pages, for employee or contract labor recruitment, and for meeting any statutory or regulatory requirement;

5. Business expenses not directly related to the provision of covered services. For example, expenses associated with the sale or purchase of a business or expenses associated with the sale or purchase of investments;

6. Political contributions;

7. Depreciation and amortization of unallowable costs, including amounts in excess of those resulting from the straight line depreciation method; capitalized lease expenses, less any maintenance expenses, in excess of the actual lease payment; and goodwill or any excess above the actual value of the physical assets at the time of purchase. Regarding the purchase of a business, the depreciable basis will be the lesser of the historical but not depreciated cost to the previous owner, or the purchase price of the assets. Any depreciation in excess of this amount is unallowable;

8. Trade discounts and allowances of all types, including returns, allowances, and refunds, received on purchases of goods or services. These are reductions of costs to which they relate and thus, by reference, are unallowable;
(9) Donated facilities, materials, supplies, and services including the values assigned to the services of unpaid workers and volunteers whether directly or indirectly related to covered services, except as permitted in 42 CFR Part 413;

(10) Dues to all types of political and social organizations, and to professional associations whose functions and purpose are not reasonably related to the development and operation of patient care facilities and programs, or the rendering of patient care services;

(11) Entertainment expenses except those incurred for entertainment provided to the staff of the RHC as an employee benefit. An example of entertainment expenses is lunch during the provision of continuing medical education on-site;

(12) Board of Director’s fees including travel costs and provided meals for these directors;

(13) Fines and penalties for violations of regulations, statutes, and ordinances of all types;

(14) Fund raising and promotional expenses except as noted in paragraph (4) of this subsection;

(15) Interest expenses on loans pertaining to unallowable items, such as investments. Also the interest expense on that portion of interest paid which is reduced or offset by interest income;

(16) Insurance premiums pertaining to items of unallowable cost;

(17) Any accrued expenses that are not a legal obligation of the provider or are not clearly enumerated as to dollar amount;

(18) Mileage expense exceeding the current reimbursement rate set by the federal government for its employee travel;

(19) Cost for goods or services which are purchased from a related party and which exceed the original cost to the related party;

(20) Out-of-state travel expenses not related to the provision of covered services, except out-of-state travel expenses for training courses which increase the quality of medical care and/or the operating efficiency of the RHC.
(21) Over-funding contributions to self-insurance funds which do not represent payments based on current liabilities;

(f) A visit is a face-to-face encounter between an RHC patient and a physician, physician assistant, advanced nurse practitioner, certified nurse-midwife, visiting nurse, or clinical nurse practitioner. Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit, except where one of the following conditions exist:

   (1) After the first encounter, the patient suffers illness or injury requiring additional diagnosis or treatment; or

   (2) The RHC patient has a medical visit and an “other” health visit.

(g) A visit is a face-to-face encounter between an RHC patient and a physician, physician assistant, advanced nurse practitioner, certified nurse mid-wife, visiting nurse, or clinical nurse practitioner. An “other” health visit includes, but is not limited to, a face-to-face encounter between an RHC patient and a clinical social worker.

(h) Effective for each RHC’s fiscal year which includes dates of services occurring on or after October 1, 2001, subsequent increases in an RHC’s PPS per visit rate or the effective rate shall be the rate of change in the Medicare Economic Index (MEI) for Primary Care.

(i) The effective rate is the rate paid to the RHC for the current fiscal year. The effective rate equals the base rate plus the MEI for each of the RHC’s fiscal years since the setting of its PPS rate. The effective rate shall be calculated at the start of each RHC’s fiscal year and shall be applied prospectively for that fiscal year.

(j) An adjustment shall be made to the effective rate if change is due to a change in scope. An RHC or the commission may request an adjustment of the effective rate equal to one hundred percent (100%) of reasonable costs by the filing of a cost report and the necessary documentation to support a claim that the RHC has undergone a change in scope. A cost report, filed to request an adjustment in the effective rate, may be filed at any time during an RHC’s fiscal year but no later than five (5) calendar months after the end of the RHC’s fiscal year. All requests for adjustment in the RHC’s effective rate must include at least 6 months of financial data. Any effective rate adjustment granted as a result of such a filing must be completed within sixty (60) days of receipt of a workable cost report and documentation.
supporting the RHC’s claim that it has undergone a change in scope. Within sixty (60) days of submitting a workable cost report, HHSC or its designee shall make a determination regarding a new effective rate. The new effective rate shall become effective the first day of the month immediately following its determination. All subsequent increases shall be calculated using the adjusted effective rate.

(k) Any request to adjust an effective rate must be accompanied by documentation showing that the RHC has had a change in scope.

(l) A change in scope of services provided by an RHC includes the addition or deletion of a service or a change in the magnitude, intensity or character of services currently offered by an RHC or one of the RHC’s sites. A change in scope includes:

(1) Increase in service intensity attributable to changes in the types of patients served, including but not limited to, HIV/AIDS, homeless, elderly, migrant, other chronic diseases or special populations;

(2) Any changes in services or provider mix provided by an RHC or one of its sites;

(3) Changes in operating costs which have occurred during the fiscal year and which are attributable to capital expenditures including new service facilities or regulatory compliance;

(4) Changes in operating costs attributable to changes in technology or medical practices at the center;

(5) Indirect medical education adjustments and a direct graduate medical education payment that reflects the costs of providing teaching services to interns and residents; or

(6) Any changes in scope approved by the Health Resources and Service Administration (HRSA).

(m) A workable cost report includes the following:

(1) For a hospital-based RHC, complete HCFA Form 2552 and HCFA Form 339 with Certification by an Officer or Administrator including:

(A) M-1 (Analysis of provider-based RHC costs).

(B) M-2 (Allocation of overhead to RHC services).
13. Rural Health Clinics (RHCs) (continued)

(C) M-3 (Calculation of reimbursement settlement for RHC services).

(D) M-5 (Analysis of payments to hospital-based RHC services rendered to program beneficiaries).

(E) S-8 (Statistical Data/Information Purposes).

(F) RHC net expenses for allocation of costs for services rendered on or after January 1, 1998, reported on the hospital's worksheet A, column 7 trace properly to the RHC’s total facility costs on line 32, column 7 on M-1 worksheet.

(G) Hospital's overhead worksheet expenses allocated to each of the hospital-based RHC cost centers on worksheet B, Part I (column 27 minus column 0) trace properly to line 15, column 5 on M-2 worksheet for each hospital-based RHC.

(2) For a freestanding RHC, a complete HCFA 222 Form and HCFA 339 form with Certification by an Officer of Administrator.

(n) Once the base rate for an RHC has been calculated, the RHC shall be paid its effective rate without the need to file a cost report. Except as specified in subsection (o), a cost report shall only be required if the RHC is seeking to adjust its effective rate.

(o) New RHCs shall file a projected cost report within 90 days of their designation to establish an initial payment rate. The cost report will contain the RHC’s reasonable costs anticipated to be incurred during the RHC’s initial fiscal year. RHC shall file a cost report within five (5) months of the end of RHC’s initial fiscal year. The cost settlement must be completed within six (6) months of receipt of a cost report. The cost per visit rate established by the cost settlement process shall be the base rate. Any subsequent increases shall be calculated as provided herein. A new RHC location, established by an existing RHC participating in the Medicaid program shall receive the same effective rate as the RHC establishing the new location. An RHC establishing a new location may request an adjustment to its effective rate as provided herein if its costs have increased as a result of establishing a new location.

(p) An RHC is paid its full per-visit rate by a state-contracted managed care organization when the RHC renders service.
(q) Submission of Audited Medicare Cost Reports. An RHC shall submit a copy of its audited Medicare cost report to the state within 15 days of receipt.
14. REIMBURSEMENT METHODOLOGY FOR PRIMARY HOME CARE SERVICES

I. Authority. The Texas Health and Human Services Commission (HHSC), the Single State Medicaid Agency, has final approval authority of Medicaid payment rates. HHSC determines Primary Home Care (PHC) Medicaid payment rates after consideration of analysis of financial and statistical information, and the effect of the payment rates on achievement of program objectives, including economic conditions and budgetary considerations.

II. General. HHSC reimburses PHC providers for services provided to eligible recipients. Prospective, uniform statewide payment rates are determined for each PHC service. HHSC uses a uniform rate methodology for both public and private providers of PHC services. Payment rates for attendant compensation are determined prospectively with a retrospective adjustment for failure to meet spending requirements as specified in X(6). Payment rates are determined for a period of two years.

III. Pro Forma Costing. When historical costs are unavailable, such as in the case of changes in program requirements, payment rates are based on a pro forma approach. This approach involves using historical costs of delivering similar services, where appropriate data are available, and determining the types and costs of products and services necessary to deliver services meeting federal and state requirements.

IV. Adjusting Payment Rates. HHSC will use the state plan amendment process when payment rates are adjusted to compensate for changes in laws, regulations, policies, guidelines, economic factors, or implementation of federal court orders or settlement agreements.

V. Cost Reports. In order to ensure adequate financial and statistical information upon which to base payment rates, each contracted provider is required to submit a cost report every other year and, if necessary, (a) supplemental report(s). It is the responsibility of the provider to submit accurate and complete information, in accordance with all pertinent cost report rules and cost report instructions.

VI. Audits and Desk Reviews. HHSC conducts desk reviews and field audits of provider cost reports in order to ensure that the financial and statistical information reported in the cost reports conforms to all applicable rules and instructions.

VII. Informal Reviews and Appeals. A contracted provider may request an informal review and, subsequently, an appeal of a desk review or field audit disallowance.

State: Texas
Date Received: 03-29-19
Date Approved: 06-24-19
Date Effective: 01-01-19
Transmittal Number: 19-0013
VIII. Projected Costs. HHSC projects PHC providers’ costs by accounting for changes in cost-related conditions anticipated to occur between the base period and the prospective rate period. Such changes include, but are not limited to, wage-and-price inflation or deflation, changes in program utilization, modifications of federal or state regulations and statutes, and implementation of federal court orders and settlement agreements. The base period is a single state fiscal year spanning from September 1 through August 31, and the prospective rate period is two state fiscal years beginning with the first day of a state fiscal year which is at least one fiscal year after the base period year. Inflation factors and multipliers that HHSC uses to project costs from the base period to the prospective rate period are determined per VIII (1) through VIII (4).

(1) General Inflation Index. For general inflation adjustments, HHSC uses the Personal Consumption Expenditures (PCE) chain-type price index published by the Bureau of Economic Analysis of the U.S. Department of Commerce. HHSC uses a PCE forecast published by IHS Markit or its successor.

(2) Item-specific and Program-specific Inflation Indices. HHSC uses specific indices in place of the general inflation index when appropriate item- or program-specific inflation indices are available from cost reports or other surveys, other Texas state agencies, nationally recognized public agencies, or independent private firms, and HHSC has determined that these specific inflation indices are derived from information that adequately represents the program(s) or cost(s) to which the specific index is to be applied.

(3) For inflation adjustments of costs pertaining to nursing wages and salaries, HHSC uses an employment cost index of wages and salaries for private industry workers in nursing and residential care facilities published by the U.S. Bureau of Labor Statistics. HHSC uses a forecast of this inflation index published by IHS Markit or its successor. Periodic reviews of the chosen inflation index will be performed based on cumulative cost report data on nursing wages and salaries.

(4) Adjustment of Tax Rates. HHSC includes Federal Insurance Contributions Act (FICA) payroll tax rates, such as for Social Security taxes and Medicare taxes, and federal and state unemployment tax rates in its projected costs of non-contracted staff salaries and wages. When a FICA tax rate or unemployment tax rate is amended per federal or state statute, HHSC adjusts its cost projections in accordance with the amended tax rate.
IX. Payment Rate Determination. HHSC determines payment rates in the following manner.

(1) Cost determination by cost area. Reported allowable costs for Primary Home Care are combined into three cost areas. Payroll taxes are allocated to each salary line item on the cost report on a pro rata basis based on the portion of that salary line item to the amount of total salary expense and employee benefits are applied directly to the corresponding salary line item.

(A) Service support cost area. This cost area includes field supervisors' salaries and wages, benefits, and mileage reimbursement expenses. This also includes building, building equipment costs, and operation and maintenance costs; administration costs; and other direct service costs. Administration expenses equal to $0.18 per Priority 1 unit of service are allocated to Priority 1. The administration costs remaining after this allocation are summed with the other service support costs.

(B) Nonpriority attendants cost area. This cost area is calculated as specified in X (relating to Attendant Compensation Rate Enhancement).

(C) Priority 1 attendants cost area. This cost area is calculated as specified in X (relating to Attendant Compensation Rate Enhancement).

(2) For the service support cost area described in IX (1)(A) the following is calculated:

(A) Projected costs. Allowable expenses are projected, excluding depreciation and mortgage interest, per unit of service from each provider agency's reporting period to the next ensuing payment rate period.

(B) Projected cost per unit of service. To determine the projected cost per unit of service for each contract, the total projected allowable costs for the service support cost area are divided by total units of service, including nonpriority services, Priority 1 services, and STAR + PLUS services in order to calculate the projected cost per unit of service.

(C) Projected cost arrays. Projected allowable costs per unit of service for each contract and each contract's corresponding total units of service are rank ordered from low to high for each cost area.
14. Reimbursement Methodology For Primary Home Care Services, continued

(D) Recommended payment rate for the service support cost area. The total units of service for each provider agency are summed until the median hour of service is reached. The corresponding projected expense is the weighted median cost component. The weighted median cost component is multiplied by 1.044 to calculate the recommended payment rate for the service support cost area.

(3) Total recommended payment rate.

(A) For non-priority clients. The recommended payment rate is determined by summing the service support cost area described in IX(1)(A) and the attendant cost area from IX(1)(B).

(B) For Priority 1 clients. The recommended payment rate is determined by summing the service support cost area described in IX(1)(A) and the attendant cost area from IX(1)(C).

(4) Increases to the attendant cost area. All rates are available through the agency’s website as outlined in Attachment 4.19-B, Page 1.

(A) For services provided on or after September 1, 2019, the non-priority attendant cost area described in IX(1)(B) is equal to the rate in effect August 31, 2019, plus $0.11. The priority attendant cost area described in IX(1)(C) is equal to the rate in effect August 31, 2019, plus $0.09. These rates were posted on the agency’s website on September 1, 2019.

(B) For services provided on or after January 1, 2022, the non-priority attendant cost area described in IX(1)(B) is equal to the rate in effect December 31, 2021, plus $0.01. The priority attendant cost area described in IX(1)(C) is equal to the rate in effect December 31, 2021, plus $0.01. These rates were posted on the agency’s website on January 1, 2022.
X. Attendant Compensation Rate Enhancement.

(1) Attendant compensation cost center. This cost center will include attendant employee salaries and/or wages (including payroll taxes, worker's compensation, or employee benefits), contract labor costs, and personal vehicle mileage reimbursement for attendants.

(2) Rate year. The rate year begins on the first day of September and ends on the last day of August of the following year.

(3) Open enrollment. Each contracted provider must notify HHSC in a manner specified by HHSC of its desire to participate or its desire not to participate in the Attendant Compensation Rate Enhancement and its desired level of participation.

(4) Determination of attendant compensation rate component for nonparticipating contracts. An attendant compensation rate component will be calculated separately for both Priority and Nonpriority services for nonparticipating contracts as follows:
   (A) Determine for each contract included in the cost report data base used in the determination of rates in effect on September 1, 1999, the attendant compensation cost center from X(1) for both Priority and Nonpriority services.
   (B) Adjust the cost center data from X(4)(A) to account for inflation utilizing the inflation factors used in the determination of the September 1, 1999 rates.
   (C) For Priority and Nonpriority separately, for each contract included in the cost report data base used in determination of rates in effect on September 1, 1999, divide the result from X(4)(B) by the units of service for Priority or Nonpriority as appropriate to calculate the projected cost per unit of service.
   (D) Provider projected costs per unit of service are rank ordered from low to high along with each provider's corresponding units of service separately for both Priority and Nonpriority services. The units of service are summed until the median hour of service is reached. The corresponding projected expense per unit of service is the weighted median cost component. This result is multiplied by 1.044.
   (E) The attendant compensation rate component will remain constant over time, except for adjustments necessitated by increases in the minimum wage. In such cases, adjustments to the nonparticipating rates are limited to ensuring that these rates are adequate to cover mandated minimum wage levels.
(5) Determination of attendant compensation rate component for participating contracts. HHSC will determine attendant compensation rate enhancement increments associated with each enhanced attendant compensation level. The attendant compensation rate enhancement increments will be determined by taking into consideration quality of care, labor market conditions, economic factors, and budget constraints. The attendant compensation rate enhancement increments will be determined on a per-unit-of-service basis applicable to each program or service. The rate enhancement increments were revised to add 10 new levels resulting in 35 total levels effective September 1, 2013.

(6) Spending requirements for participating contracts. Participating contracts are subject to a spending requirement with recoupment calculated separately for their Priority and Nonpriority services as follows:

(a) For the rate years beginning September 1, 2003, and September 1, 2004:

(1) The attendant compensation spending per unit of service will be multiplied by 1.10 to determine the adjusted attendant compensation per unit of service.

The adjusted attendant compensation per unit of service from X (6)(A)(i) will be subtracted from the accrued attendant compensation revenue to determine the amount to be recouped. If the adjusted attendant compensation per unit of service is greater than or equal to the attendant compensation revenue per unit of service, there is no recoupment.

(3) The amount paid for attendant compensation per unit of service after adjustments for recoupment must not be less than the amount determined for nonparticipating contracts.

(b) For the rate year beginning September 1, 2005, and thereafter, the accrued attendant compensation revenue per unit of service is multiplied by 0.90 to determine the spending requirement per unit of service. The unadjusted accrued attendant compensation spending per unit of service will be subtracted from the spending requirement per unit of service to determine the amount to be recouped. If the unadjusted accrued attendant compensation spending per unit of service is greater than or equal to the spending requirement per unit of service, there is no recoupment. The amount paid for attendant compensation per unit of service after adjustments for recoupment must not be less than the amount determined for nonparticipating contracts.
15. Reimbursement Methodology for Day Activity and Health Services

I. Authority. The Texas Health and Human Services Commission (HHSC), the Single State Medicaid Agency, has final approval authority of Medicaid payment rates. HHSC determines Day Activity and Health Services (DAHS) Medicaid payment rates after consideration of analysis of financial and statistical information, and the effect of the payment rates on achievement of program objectives, including economic conditions and budgetary considerations.

II. General. HHSC reimburses DAHS providers for services provided to eligible recipients. Prospective, uniform statewide payment rates are determined for DAHS. Payment rates for attendant compensation are determined prospectively with a retrospective adjustment for failure to meet spending requirements as specified in X(6). Payment rates will be determined for a period of two years.

III. Pro Forma Costing. When historical costs are unavailable, such as in the case of changes in program requirements, payment rates may be based on a pro forma approach. This approach involves using historical costs of delivering similar services, where appropriate data are available, and determining the types and costs of products and services necessary to deliver services meeting federal and state requirements.

IV. Adjusting Payment Rates. HHSC will follow the state plan amendment process when payment rates are adjusted to compensate for changes in laws, regulations, policies, guidelines, economic factors, or implementation of federal court orders or settlement agreements.

V. Cost Reports. To ensure adequate financial and statistical information upon which to base payment rates, each contracted provider is required to submit a cost report every other year and, if necessary, (a) supplemental report(s). It is the responsibility of the provider to submit accurate and complete information, in accordance with all pertinent cost report rules and cost report instructions.

VI. Audits and Desk Reviews. HHSC conducts desk reviews and field audits of provider cost reports to ensure that the financial and statistical information reported in the cost reports conforms to all applicable rules and instructions.

VII. Informal Reviews and Appeals. A contracted provider may request an informal review and, subsequently, an appeal of a desk review or field audit disallowance.
VIII. Projected Costs. HHSC projects DAHS providers’ costs by accounting for changes in cost-related conditions anticipated to occur between the base period and the prospective rate period. The base period is a single state fiscal year spanning from September 1 through August 31, and the prospective rate period is two state fiscal years beginning with the first day of a state fiscal year which is at least one fiscal year after the base period year. Inflation factors and multipliers that HHSC uses to project costs from the base period to the prospective rate period are determined per VIII(1) through VIII(4).

(1) General Inflation Index. For general inflation adjustments, HHSC uses the Personal Consumption Expenditures (PCE) chain-type price index published by the Bureau of Economic Analysis of the U.S. Department of Commerce. HHSC uses a PCE forecast published by IHS Markit or its successor.

(2) Item-specific and Program-specific Inflation Indices. HHSC uses specific indices in place of the general inflation index when appropriate item- or program-specific inflation indices are available from cost reports, other Texas state agencies, nationally recognized public agencies, or independent private firms or sources, and HHSC has determined that these specific inflation indices are derived from information that adequately represents the program(s) or cost(s) to which the specific index is to be applied.

(3) For inflation adjustments of costs pertaining to wages and salaries of licensed vocational nurses and nurse aides, HHSC uses an employment cost index of wages and salaries for private industry workers in nursing and residential care facilities published by the U.S. Bureau of Labor Statistics. HHSC uses a forecast of this inflation index published by IHS Markit or its successor. Periodic reviews of the chosen inflation index will be performed based on cumulative cost report data on nursing wages and salaries.

(4) Adjustment of Tax Rates. HHSC includes Federal Insurance Contributions Act (FICA) payroll tax rates, such as for Social Security taxes and Medicare taxes, and federal and state unemployment tax rates in its projected costs of non-contracted staff salaries and wages. When a FICA tax rate or unemployment tax rate is amended per federal or state statute, HHSC adjusts its cost projections in accordance with the amended tax rate.
IX. Payment Rate Determination. HHSC determines payment rates in the following manner.

(1) Cost determination by cost area. Reported allowable costs for DAHS are combined into four cost areas. Payroll taxes are allocated to each salary line item on the cost report on a pro rata basis based on the portion of that salary line item to the amount of total salary expense and employee benefits are applied directly to the corresponding salary line item.

(A) Attendant cost area. This cost area is calculated as specified in X (relating to Attendant Compensation Rate Enhancement).
(B) Other direct care costs. This cost area includes other direct care staff, food and food service costs; activity costs; and other direct service costs.
(C) Facility cost area. This cost area includes building, maintenance staff, and utility costs.
(D) Administration and transportation cost area. This cost area includes transportation, administrative staff, and other administrative costs.

(2) For each of the three cost areas described in IX (1)(B), (C) and (D) the following is calculated:

(A) Projected costs. Allowable expenses are projected, excluding depreciation and mortgage interest, per unit of service from each provider agency’s reporting period to the next ensuing payment rate period.
(B) Projected cost per unit of service. To determine the projected cost per unit of service for each contract, the total projected allowable costs for each cost area are divided by total units of service, in order to calculate the projected cost per unit of service for each cost area.
(C) Projected cost arrays. Projected allowable costs per unit of service for each contract are rank ordered from low to high for each cost area.
15. Reimbursement Methodology For Day Activity And Health Services, continued

(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 1.07 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).

(4) For services provided on or after September 1, 2014, the attendant cost area from X is equal to the rate in effect August 31, 2014, plus $0.15. These rates were posted on the agency's website on September 1, 2014. All rates are available through the agency's website as outlined on Attachment 4.19B, page 1.

(5) For services provided on or after September 1, 2015, the attendant cost area from X is equal to the rate in effect August 31, 2015, plus $0.06. These rates were posted on the agency's website on September 1, 2015. All rates are available through the agency's website as outlined on Attachment 4.19B, page 1.

(6) For services provided on or after September 1, 2019, the attendant cost area from X is equal to the rate in effect August 31, 2019, plus $0.11. These rates were posted on the agency’s website on September 1, 2019. All rates are available through the agency’s website as outlined on Attachment 4.19B, page 1.
X. **Attendant Compensation Rate Enhancement.**

1. Attendant compensation cost center. This cost center will include attendant and driver employee salaries and/or wages (including payroll taxes, worker's compensation, or employee benefits), contract labor costs, and personal vehicle mileage reimbursement for attendants.

2. Rate year. The rate year begins on the first day of September and ends on the last day of August of the following year.

3. Open enrollment. Each contracted provider must notify HHSC in a manner specified by HHSC of its desire to participate or its desire not to participate in the Attendant Compensation Rate Enhancement and its desired level of participation.

4. Determination of attendant compensation rate component for nonparticipating contracts. An attendant compensation rate component will be calculated as follows:

   A. Determine for each contract included in the cost report data base used in the determination of rates in effect on September 1, 1999, the attendant compensation cost center from X(1).

   B. Adjust the cost center data from X(4)(A) to account for inflation utilizing the inflation factors used in the determination of the September 1, 1999 rates.

   C. For each contract included in the cost report data base used in the determination of rates in effect on September 1, 1999, divide the result from X(4)(B) by the units of service to calculate the projected cost per unit of service.

   D. Provider projected costs per unit of service are rank ordered from low to high along with each provider's corresponding units of service. The median projected unit of service cost is then determined. This result is multiplied by 1.044.

   E. The attendant compensation rate component will remain constant over time, except for adjustments necessitated by increases in the minimum wage. In such cases, adjustments to the nonparticipating rates are limited to ensuring that these rates are adequate to cover mandated minimum wage levels.
Determination of attendant compensation rate component for participating contracts. HHSC will determine attendant compensation rate enhancement increments associated with each enhanced attendant compensation level. The attendant compensation rate enhancement increments will be determined by taking into consideration quality of care, labor market conditions, economic factors, and budget constraints. The attendant compensation rate enhancement increments will be determined on a per-unit-of-service basis applicable to each program or service. The rate enhancement increments were revised to add ten new levels resulting in 35 total levels effective September 1, 2013.

Spending requirements for participating contracts. Participating contracts are subject to a spending requirement as follows:

(a) For the rate years beginning September 1, 2003, and September 1, 2004:

   (1) The attendant compensation spending per unit of service will be multiplied by 1.10 to determine the adjusted attendant compensation per unit of service.

   (2) The adjusted attendant compensation per unit of service from $X(6)(A)(i)$ will be subtracted from the accrued attendant compensation revenue to determine the amount to be recouped. If the adjusted attendant compensation per unit of service is greater than or equal to the attendant compensation revenue per unit of service, there is no recoupment.

   (3) The amount paid for attendant compensation per unit of service after adjustments for recoupment must not be less than the amount determined for nonparticipating contracts.

(b) For the rate year beginning September 1, 2005, and thereafter, the accrued attendant compensation revenue per unit of service is multiplied by 0.90 to determine the spending requirement per unit of service. The unadjusted accrued attendant compensation spending per unit of service will be subtracted from the spending requirement per unit of service to determine the amount to be recouped. If the unadjusted accrued attendant compensation spending per unit of service is greater than or equal to the spending requirement per unit of service, there is no recoupment. The amount paid for attendant compensation per unit of service after adjustments for recoupment must not be less than the amount determined for nonparticipating contracts.
16. **Ambulatory Surgical Centers (ASCs)**

(a) Subject to specifications conditions and limitations established by the Texas Health and Human Services Commission (HHSC) or its designee, payment for ambulatory surgical center (ASC) facility services provided by freestanding ASCs will be made at a percentage of the Medicare Outpatient Prospective Payment System (OPPS) fee schedule. For ASC facility services not found on the Medicare OPPS fee schedule, HHSC will apply the reimbursement methodologies as outlined on Attachment 4.19-B, page 1. Procedure codes for durable medical equipment, supplies, drugs/biologicals, and other such services covered in an ASC are reimbursed in accordance with the specific reimbursement methodology applicable to each such procedure.

(b) HHSC or its designee reimburses high-volume public and private Medicaid ASCs an additional 5.2 percent in recognition of their vital contribution to the Texas Medicaid program. To be eligible for the high-volume provider payment add-on, an ASC must have been among those ASCs statewide who received Medicaid payments during the qualification period of state fiscal year (SFY) 2004. In the top 95 percent of all Medicaid payments made to ASCs during that qualification period.

(c) High-volume ASCs receive a 5.2 percent add-on payment for all Medicaid ASC facility services. Payments made to ASCs for durable medical equipment, supplies, drugs/biologicals and other such services are covered in and therefore are not subject to the high-volume provider payment add-on.

(d) Payment to a high-volume ASC for a facility service is made based on the lesser of the provider’s billed charges or the published Medicaid fee, with that amount becoming the allowed amount. Since Medicaid cannot pay a provider more than its billed charges, if the billed charges are greater than the published Medicaid fee plus the 5.2 percent high-volume provider payment add-on, the Medicaid fee plus the 5.2 percent high-volume provider payment add-on is the actual payment to the provider.

(e) Example 1:

1. Billed charges = $100.00
2. Medicaid published fee = $80.00
3. Lesser of billed charges or Medicaid published fee = $80.00 which becomes the allowed amount.
4. Since the billed charges are greater than the Medicaid fee plus the 5.2% high-volume provider payment add-on (i.e., $80.00 + $4.16 = $84.16), the actual payment to the provider is $84.16.

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Supersedes TN: 07-028 Effective Date: 06/01/23
16. Ambulatory Surgical Centers (ASCs) (Continued)

(f) Example 2:
1. Billed charges = $75.00
2. Medicaid published fee = $80.00
3. Lesser of billed charges or Medicaid published fee = $75.00, which becomes the allowed amount.
4. Since the billed charges are not greater than the Medicaid fee plus the 5.2 percent high-volume provider payment add-on (i.e., $80.00 + $4.16 = $84.16), no high-volume provider payment add-on is applied, resulting in the actual payment to the provider of $75.00.

(g) Example 3:
1. Billed charges = $82.00
2. Medicaid published fee = $80.00
3. Lesser of billed charges or Medicaid published fee = $80.00, which becomes the allowed amount.
4. Since the billed charges are not greater than the Medicaid fee plus the 5.2 percent high-volume provider payment add-on (i.e., $80.00 + $4.16 = $84.16), only part of the high-volume provider payment add-on is applied (i.e., up to the billed charges) resulting in the actual payment to the provider of $82.00.

(h) Medicaid payments for ASC services do not exceed Medicare payments for these same ASC services.

(i) The agency’s fee schedule was revised with new fees effective June 1, 2023, and is effective for services provided on or after that date. The fee schedule will be posted on the agency’s website on June 15, 2023.

(j) All fee schedules are available through the agency’s website as outlined on attachment 4.19-B, page 1.
17. **Birthing Center Facility Services.**

Medicaid providers of birthing center services are reimbursed based on fee schedules as follows:

(a) Subject to the specifications, conditions, requirements and limitations established by HHSC; payment for covered birthing center services provided by a participating, licensed birthing center is limited to the lesser of the customary charge or the allowable rates per established fee schedule by HHSC.

(b) The fee schedule established by HHSC is based upon: (1) survey of costs to provide the services; (2) review of Medicaid fees paid by other states; (3) Medicaid fees for similar services; (4) Medicare fees; (5) pricing data from commercial carriers; and/or (6) some combination or percentage thereof.

(c) The birth attendant must be a physician or Certified Nurse-Midwife (CNM). The physician or CNM who was the birth attendant must be identified on the birthing center’s claim. Prenatal, labor, delivery and postpartum services performed or provided by physicians or CNMs are not considered birthing center facility services.

(d) The birthing center must bill for the services that it provides. Unless approved by the State Agency or its designee, the birthing center may not bill for services provided by another type of provider. If the birthing center bills a single or itemized combined rate, charge, or amount for covered services for two or more providers, payment is the lesser of the single or itemized combined rate, charge or the amount that would have been paid had each performing provider billed separately.

(e) All fee schedules are available through the agency’s website as outlined on Attachment 4.19-B, Page 1.

(f) The agency's fee schedule was revised with new fees for providers of birthing center services effective for services on or after March 1, 2021. The fee schedule will be posted on March 19, 2021.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State: TEXAS

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19. **Hospice Care**

The TDHS Medicaid Hospice Program pays Medicaid hospice rates that are calculated by using the Medicare hospice methodology but adjusted to disregard cost offsets allowed for Medicare deductible/coinsurance amounts. TDHS does not apply/follow Medicare hospice rate freezes. The TDHS Medicaid Program also pays physician reimbursements for the physician’s professional, direct, patient care services related to the recipient’s terminal condition. Physician reimbursements are made according to usual Medicaid payment amounts for physician services under the Texas Medical Assistance Program. No cost sharing may be imposed for hospice services rendered to Medicaid recipients. TDHS uses the current Medicaid reimbursement cap (a maximum) per year (November 1 through October 31) for the Hospice Program.

TDHS pays an additional rate to take into account the room and board furnished by the facility for Medicaid hospice recipients residing in nursing facilities or intermediate care facilities for persons with mental retardation. TDHS pays the Medicaid hospice provider who, in turn, pays the nursing facility or intermediate care facility for persons with mental retardation. To be paid, the hospice provider and the nursing facility or intermediate care facility for persons with mental retardation must have a contract that includes the following agreements.

1. The hospice is fully responsible for the professional management of the recipient’s hospice care; and
2. The nursing facility or intermediate care facility for persons with mental retardation agrees to provide room and board to the Medicaid hospice recipient.
For recipients eligible for both Medicaid and Medicare (dually eligible recipients) who elect the Medicare and Medicaid hospice programs, the Texas Medicaid Hospice Program pays the hospice provider:

1. a Medicare coinsurance of 5% (not to exceed $5 per prescription) of the cost of drugs and biologicals determined according to a drug copayment schedule established by the hospice;

2. a Medicare coinsurance of 5% for each day of respite care (not to exceed the inpatient hospital deductible that applies to the year in which the coinsurance period began); and

3. an additional rate to take into account the room and board furnished by the facility for each day a dually eligible recipient resides in a nursing facility or intermediate care facility for persons with mental retardation.
19. Hospice Care (continued)

The 42 U.S.C. §1396(a)(13)(B) requires Medicaid to pay a per diem amount that takes into account "the room and board furnished by the facility, equal to at least 95 percent of the rate that would have been paid by the State under the plan for facility services in that facility for that individual." To comply with this federal statute, effective September 1, 2011, the Texas Department of Aging and Disability Services (DADS) pays a Medicaid hospice room and board per diem amount that is 95 percent of the appropriate case mix class of service rate for each Medicaid recipient residing in a nursing facility and that is 95 percent of the appropriate level of need service rate for each Medicaid recipient residing in an intermediate care facility for persons with mental retardation.

DADS pays the Medicaid hospice room and board rate to Medicaid hospice providers who in turn pay nursing facilities and intermediate care facilities for persons with mental retardation at least that same amount for room and board services provided to Medicaid hospice recipients residing in that facility.

The nursing facility case mix class of service rates are determined in accordance with the Medicaid state plan reimbursement methodology for nursing facilities. The intermediate care facility for persons with mental retardation rates are determined in accordance with the Medicaid state plan reimbursement methodology for intermediate care facilities for persons with mental retardation.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State: TEXAS

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21. Case Management for Persons with Chronic Mental Illness

Reimbursement for case management services for individuals with chronic mental illness is subject to the specifications, conditions and limitations required by the Health and Human Services Commission (HHSC). Providers are reimbursed based on a 15-minute face-to-face unit of service by type of service that is prospective and uniform statewide.

The prospective and uniform statewide reimbursement rates will be determined by summing the total agency expenditures for each type of case management service for the most recent cost-reported fiscal year and dividing by the total number of units of each type of service provided during that fiscal year. The following provider costs will be collected for use as a basis for updating reimbursement rates:

(1) Inclusion of certain reported expenses. Providers must ensure that all requested costs are included in the cost reporting system.

(2) Several different kinds of data are collected. The collected data will include the number of units of service provided. The cost data include direct costs, programmatic indirect costs, and general and administrative costs including salaries, benefits, and non-labor costs. Programmatic indirect costs include salaries, benefits and other costs of this case management program that are indirectly related to the delivery of case management services to clients. General and administrative overhead costs include the salaries, benefits and other costs that, while not directly part of the case management services program, constitute costs that support the operations of the case management services program.

(3) Providers must eliminate unallowable expenses from the cost report. Unallowable expenses included in the cost report are omitted from the cost report database and appropriate adjustments are made to expenses and other information reported by providers. The purpose is to ensure that the database reflects costs and other information which are consistent with efficiency, economy, and quality of care; are necessary for the provision of covered case management services; and are consistent with federal and state Medicaid regulations. If there is doubt as to the accuracy or allowableness of a significant part of the information reported, individual cost reports may be eliminated from the database.
21. Case Management for Persons with Chronic Mental Illness (continued).

(4) Total costs are projected from the historical reporting period to the prospective rate period. Cost projections adjust the allowable historical costs for significant changes in cost related conditions anticipated to occur between the historical cost period and the prospective rate period. Significant conditions include, but are not necessarily limited to, wage and price inflation or deflation, changes in program utilization and efficiency, modification of federal or state regulations and statutes. The Personal Consumption Expenditures (PCE) Chain-Type Index, which is based on data from the US Department of Commerce, is the most general measure of inflation is used to project costs.

The reimbursement for services effective September 1, 2010 through January 31, 2011 will be equal to the reimbursement on August 31, 2010, less one percent. The reimbursement for services effective February 1, 2011 will be equal to the reimbursement on August 31, 2010, less two percent. The agency's fee schedule was revised with new fees effective for services on or after February 1, 2011. The fee schedule was posted by April 8, 2011.
22. Case Management for individuals with Mental Retardation or a Related Condition or Pervasive Developmental Disability

(a) Two statewide encounter rates are established for a comprehensive encounter and a follow-up encounter. The statewide encounter rate is a prospective rate without adjustment for individual provider cost. The encounter unit of service is established as follows:

(1) Comprehensive Encounter. A comprehensive encounter is an in person, synchronous audio-only, or synchronous audio-visual technology contact with the client. This comprehensive encounter rate is based on an average time of 45 minutes per contact to provide for assessment, monitoring of progress towards outcomes, plan review, and/or plan revision. A comprehensive encounter is limited to one billable encounter per client per calendar month.

(2) Follow-up Encounter. A follow-up encounter is an in person, synchronous audio-only, or synchronous audio-visual technology contact which involves interface with the client or a collateral. This follow-up encounter rate is based on an average time of 15 minutes per contact. Activities on a follow-up encounter include follow-up activities related to the comprehensive encounter. The provider agency is allowed up to three follow-up encounters per calendar month for each comprehensive encounter that has occurred within the calendar month. They do not have to be provided to the client for whom the comprehensive encounter was provided.

(3) Cap and Rollover. A monthly cap will be established on the total number of follow-up encounters that can be billed by each provider agency during the calendar month. The monthly cap that the provider can bill is equal to three follow-up encounters for each comprehensive encounter delivered in the month. Any allowed follow-up encounters not billed during the calendar month will be rolled over to the following calendar month. The rollover of follow-up encounters will begin on September 1st and will end on July 31st with the final rollover into the month of August of each year.

Example:
Client A and Client B both had a comprehensive encounter in a calendar month. As a result, the agency is allowed and may bill up to six follow-up encounters for
22. Case Management for Individuals with Mental Retardation or a Related Condition or Pervasive Developmental Disability (continued)

(b) The initial encounter rates are determined by dividing the current annual cost to deliver the service divided by the maximum number of comprehensive and follow-up encounters anticipated to be delivered for the first year of implementation, with comprehensive encounters counting as three units and follow-up encounters counting as one unit.

(c) Provider costs will be collected for use as a basis for updating reimbursement rates.

(1) Inclusion of certain reported expenses. Provider agencies must ensure that all requested costs are included in the cost reporting system.

(2) Several different kinds of data are collected. These include the number of units of service. The cost data include direct costs, programmatic indirect costs, and general and administrative costs including salaries, benefits, and non-labor costs. Programmatic indirect costs include salaries, benefits and other costs of this case management program that are indirectly related to the delivery of case management services to clients. General and administrative overhead costs include the salaries, benefits and other costs that, while not directly part of the case management services program, constitute costs that support the operations of the case management services program.

(3) Provider agencies must eliminate unallowable expenses from the cost report. Unallowable expenses included in the cost report are omitted from the cost report database and appropriate adjustments are made to expenses and other information reported by providers. The purpose of the omission is to ensure that the database reflects costs and other information that are consistent with efficiency, economy, and quality of care; are necessary for the provision of covered case management services; and are consistent with federal and state Medicaid regulations. If there is doubt as to the accuracy or allowableness of a significant part of the information reported, individual cost reports may be eliminated from the database.

(4) Total costs are projected from the historical reporting period to the rate period. Cost projections adjust the allowable historical costs for significant changes in cost-related conditions anticipated to occur between the historical cost period and the prospective rate period. Significant conditions include, but are not necessarily limited to, wage and price inflation for deflation, changes in program utilization and efficiency, and modification of federal or state regulations and statutes. The Personal Consumption Expenditures (PCE) Chain-Type Index, which is based on data from the U.S. Department of Commerce, is the most general measure used to project costs.

(d) All fee schedules are available through the agency's website as outlined on Attachment 4.19-B, Page 1.
24. Rate-Setting Methodology for ICF/MR Dental Services

Reimbursement for comprehensive dental diagnostic and treatment services, as described in Item 15b of Appendix 1 to Attachment 3.1-A and Item 15b of Appendix 1 to Attachment 3.1-B. TDH reimburses enrolled dental providers for authorized and allowable dental services provided to ICF/MR consumers. Providers of dental services must be enrolled with TDH and accept, as payment in full, TDH's reimbursement. Reimbursement is made for four categories of service: Emergency, Preventive, Therapeutic, and Orthodontic. Emergency dental services for ICF/MR consumers are reimbursed exclusively under the above mentioned Emergency Service Category. Payment for dental services will be the lowest of: (a) the provider's usual fee; (b) the maximum fee listed on the program fee schedule (derived from the State's Texas Health Steps fee schedule); (c) the adjusted, authorized fee.
Page 18 (TN 07-018) was deleted by Amendment No. 856 TX 09-010,
Deleted page covered 25. Prosthetic Devices – In-home Services for Total Parenteral
Hyperalimentation
13.a. Diagnostic Services for Persons with a Potential of Mental Retardation
Not Provided

6-16-98
9-10-98
5-1-98
98-08
27. Mental Health Rehabilitative Services

(a) Reimbursement for rehabilitative services for individuals with chronic mental illness is subject to the specifications, conditions, and limitations required by the Health and Human Services Commission (HHSC). Providers are reimbursed based on a unit of service defined as 15 continuous minutes for crisis intervention services, medication training and support, psychosocial rehabilitative services, and skills training and development and 45-60 continuous minutes for day programs for acute needs that is prospective and uniform statewide.

(b) The prospective and uniform statewide reimbursement rates will be determined by summing the total agency expenditures for each type of rehabilitative service for the most recent cost-reported fiscal year and dividing by the total number of units of each type of service provided during that fiscal year. The following provider costs will be collected for use as a basis for updating reimbursement rates:

(1) Inclusion of certain reported expenses. Providers must ensure that all requested costs are included in the cost reporting system.

(2) Several different kinds of data are collected. The collected data will include the number of units of service provided. The cost data include direct costs, programmatic indirect costs, and general and administrative costs including salaries, benefits, and non-labor costs. Programmatic indirect costs include salaries, benefits and other costs of this rehabilitative services program that are indirectly related to the delivery of rehabilitative services to clients. General and administrative overhead costs include the salaries, benefits and other costs that, while not directly part of the rehabilitative services program, constitute costs that support the operations of the rehabilitative services program.

(3) Providers must eliminate unallowable expenses from the cost report. Unallowable expenses included in the cost report are omitted from the cost report database and appropriate adjustments are made to expenses and other information reported by providers. The purpose is to ensure that the database reflects costs and other information which are consistent with efficiency, economy, and quality of care; are necessary for the provision of covered rehabilitative services; and are consistent with federal and state Medicaid regulations. If there is doubt as to the accuracy or allowableness of a significant part of the information reported, individual cost reports may be eliminated from the database.

SUPERSEDES: TN- 11-06

TN 11-93 Approval Date 10-20-11 Effective Date 9-1-11
Supersedes TN 11-06
27. Mental Health Rehabilitative Services (continued)

(4) Total costs are projected from the historical reporting period to the prospective rate period. Cost projections adjust the allowable historical costs for significant changes in cost related conditions anticipated to occur between the historical cost period and the prospective rate period. Significant conditions include, but are not necessarily limited to, wage and price inflation or deflation, changes in program utilization and efficiency, modification of federal or state regulations and statutes. The Personal Consumption Expenditures (PCE) Chain-Type Index, which is based on data from the US Department of Commerce, is the most general measure of inflation is used to project costs.

(c) The reimbursement for services effective September 1, 2010 through January 31, 2011 will be equal to the reimbursement on August 31, 2010, less one percent.

(d) The reimbursement for services effective February 1, 2011 will be equal to the reimbursement on August 31, 2010, less two percent.

(e) The agency's fee schedule was revised with new fees effective for services on or after February 1, 2011. The fee schedule was posted by April 8, 2011.
28. **Rehabilitative Chemical Dependency Treatment Facility Services**

Medicaid providers of rehabilitative substance abuse and dependency treatment services are reimbursed based on fee schedules as follows:

(a) Payment for covered rehabilitative substance abuse and dependency treatment services provided by a participating treatment facility is limited to the lesser of the customary charge or the allowable rates per established fee schedule by the single state agency. Room and board costs are excluded from the calculation of these chemical dependency facilities.

(b) The fee schedule established by HHSC is based upon: (1) analysis of the Department of State Health Services Mental Health Block Grant Substance Abuse Services fees; (2) review of Medicaid fees paid by other states; (3) Medicaid fees for similar services; and/or (4) some combination or percentage thereof.

(c) All fee schedules are available through the agency’s website as outlined on Attachment 4.19-B, Page 1.

(d) The agency’s fee schedule was revised with new fees for providers of rehabilitative substance abuse and dependency treatment services effective for services on or after March 1, 2022. The fee schedule was posted on the agency’s website by April 15, 2022.
29. Peer Specialist Services (13.d. Rehabilitative Services)

The agency’s fee schedule was revised with new fees for peer specialists. Effective January 1, 2019, peer specialists will be reimbursed in an individual and group setting. The reimbursement can be found in the physician’s fee schedule.
30. Reserved
(a) FQHCs may choose between two prospective payment methodologies for reimbursement purposes. The two methodologies are the Prospective Payment System (PPS) Methodology and the Alternative Prospective Payment System (APPS) Methodology. Both methods are in accordance with section 1902(bb) of the Social Security Act, as amended by the Benefits Improvement and Protection Act (BIPA) of 2000 (42 U.S.C. §1396a(bb)), effective for the FQHC's fiscal year that includes dates of service occurring January 1, 2001 and after. FQHCs will be reimbursed a prospective per visit encounter rate for a visit for Medicaid covered services if the visit meets the requirements of section (31)(b)(10) and (31)(b)(11).

(1) Definitions:

(A) Effective rate - The encounter rate paid to an FQHC during the FQHC's fiscal year. The effective rate is updated by the applicable rate of change described in (31)(b)(4) per the prescribed methodology for each of the FQHC's fiscal years since the setting of its final base rate.

(B) Interim base rate - The encounter rate determined on the first full fiscal year as-filed Medicare cost report for a new FQHC based on 100% of reasonable costs. Interim rates will be adjusted prospectively until the final audited Medicare cost report is processed and used to determine the final base rate.

(C) Initial interim base rate - The encounter rate paid to a new FQHC determined on a short period cost report or projected cost report. After one full fiscal year as-filed Medicare cost report is filed, the rate is updated to the interim base rate.

(D) Final base rate - The encounter rate determined for an FQHC existing in the year 2000 by calculating 100 percent of the average of the FQHC's reasonable costs for providing Medicaid covered services as determined from audited cost reports for the FQHC's 1999 and 2000 fiscal years. The final base rate was calculated by adding the total audited reimbursable costs as determined from the 1999 and 2000 cost reports and dividing by the total audited visits for these same two periods. For an FQHC formed after the year 2000, the final base rate is calculated on the first full fiscal year audited Medicare cost report based on 100% of the reasonable costs. The final base rate for an FQHC formed after the year 2000 is applied to claims back to the beginning of the FQHC's existence and the payments are reconciled. A change in the effective rate under (31)(b)(6) will result in a new final base rate. The final base rate is the effective rate for each subsequent FQHC fiscal year.

(2) The reimbursement methodologies described in section (31)(b) apply equally to the APPS and PPS methodologies, except for the following:

(A) The effective rate for the APPS methodology described in section (31)(b)(4) does not apply to PPS. For an FQHC reimbursed under PPS, annual increases in the final base rate or effective rate are the rate of change in the Medicare Economic Index (MEI) for primary care.

(B) State-initiated reviews, described in (b)(8)(D), are not applicable for providers who select the PPS methodology.
(31) Federally Qualified Health Centers (FQHC) (continued)
(b) Alternate Prospective Payment System (APPS) Methodology (continued).

(1) Prior to HHSC setting a final base rate for each FQHC existing in 2000, each FQHC was reimbursed on the basis of an interim base rate. The interim base rate for each FQHC was calculated from the latest finalized cost report settlement, adjusted as provided for in (b)(4). When HHSC determined a final base rate, interim payments were reconciled back to the beginning of the interim period. For FQHCs that agreed to the APPS methodology prior to August 31, 2010, adjustments were made to the FQHCs' interim payments only if the interim payments were less than what would have occurred under the final base rate. In section (31)(b)(8)(A) of this section the interim and final base rate methodology for new FQHCs is described. The final base rate, as adjusted, applies prospectively from the date of the final approval. Payments made under the APPS methodology will be at least equal to the amount that would be paid under PPS.

(2) Reasonable costs, as used in setting the interim or final base rate or any subsequent effective rate, is defined as those costs that are allowable under Medicaid cost principles, as required in 45 CFR 92.22(b) and the applicable OMB Circular, with no productivity screens and no per visit payment limit. Administrative costs will be limited to 30 percent of total costs in determining reasonable costs. Reasonable costs do not include unallowable costs.

(3) Unallowable costs are expenses that are incurred by an FQHC and that are not directly or indirectly related to the provision of covered services, according to applicable laws, rules, and standards.

(4) The effective rate for APPS is the rate paid to the FQHC for the FQHC's fiscal year. The effective rate shall be updated by the rate of change in the MEI plus 0.5 percent for each of the FQHC's fiscal years since the setting of its final base rate. If the increase in an FQHC's costs is greater than the MEI plus 0.5 percent for APPS, an FQHC may request an adjustment of its effective rate as described in (b). The effective rate shall be calculated at the start of each FQHC's fiscal year and shall be applied prospectively for that fiscal year. The effective rate for PPS is described in section (31)(a)(2)(A).

(5) PPS and APPS reimbursement methodology selection is determined as follows:
(A) Each new in-state FQHC will receive a letter from HHSC upon enrollment as a new Medicaid provider along with a FQHC prospective payment system form. The FQHC must indicate on the form the selection as either the PPS or APPS reimbursement methodology and return the form to HHSC.
(B) Each out-of-state FQHC will receive the PPS reimbursement methodology. HHSC will compute an effective rate based on reasonable costs provided by the FQHC on its most recent Medicare cost report. The effective rate will reflect the rate that would have been calculated for an in-state FQHC based on the approved scope of services that an in-state FQHC could provide in Texas.
(31) Federally Qualified Health Centers (FQHC) (continued)

(b) Alternate Prospective Payment System (APPS) Methodology (continued).

(C) After a change to the reimbursement methodology, the state may require the reselection of the APPS or PPS methodology following the requirements of section (31)(b)(5)(A).

(6) A change of the effective rate is determined as follows:

(A) An adjustment, as described in section (31)(b)(8)(C), will be made to the effective rate if the FQHC can show that it is operating in an efficient manner, or show that the adjustment is warranted due to a change in scope of services. Any request to adjust an effective rate must be accompanied by documentation showing that the FQHC is operating in an efficient manner or that it has had a change in scope. A change in scope provided by an FQHC includes the addition or deletion of a service or a change in the magnitude, intensity or character of services currently offered by an FQHC or one of the FQHC’s sites.

(i) A change in the scope of services is a change in the type, intensity, duration or amount of services. A change in the cost of a service is not considered in and of itself a change in the scope of services.
(31) Federally Qualified Health Centers (FQHC) (continued)

(b) Alternative Prospective Payment System (APPS) Methodology (continued).

(ii) Operating in an efficient manner includes:

(I) showing that the FQHC has implemented an outcome-based delivery system that includes prevention and chronic disease management. Prevention includes, but is not limited to, programs such as immunizations and medical screens. Disease Management must include, but not be limited to, programs such as those for diabetes, cardiovascular conditions, and asthma that can demonstrate an overall improvement in patient outcome;

(II) paying employees' salaries that do not exceed the rates of payment for similar positions in the area, taking into account experience and training as determined by the Texas Workforce Commission;

(III) providing fringe benefits to its employees that do not exceed fifteen percent of the FQHC's total costs;

(IV) implementing cost saving measures for its pharmacy and medical supplies expenditures by engaging in group purchasing; and

(V) employing the concept of a "prudent buyer" in purchasing its contracted medical services.

(B) HHSC also may adjust the effective rate of an FQHC on its own initiative, in accordance with section (31)(b)(8)(D), if it is determined that a change in scope has occurred and an adjustment to the effective rate is warranted based on the audit of the cost report.

(7) Each provider is required to submit Medicare cost reports and supplemental worksheets and supporting information as required by HHSC. In addition, the following cost reports may be required:

(A) As-filed Medicare cost report to include Texas Medicaid supplemental worksheets.

(B) Final audited Medicare cost report to include Texas Medicaid supplemental worksheets.

(C) Change of effective rate cost report. The change of effective rate cost report is used by in-state or out-of-state FQHCs that are requesting a change in their effective rate due to a change in scope or operating in an efficient manner. The cost report must contain at least six months of financial information.
(31) Federally Qualified Health Centers (FQHC) (continued)
   (b) Alternative Prospective Payment System (APPS) Methodology (continued).

   (D) Projected cost report. The projected cost report is used by in-state or out-of-state FQHCs that are requesting an initial interim rate. The cost report must contain at least twelve months of projected financial information.

   (E) Low Medicare Utilization Cost Report. The low Medicare utilization cost report is used by in-state and out-of-state providers to meet the annual filing requirements for providers not required to file a full cost report with Medicare.

(8) FQHC rate determination process.

   (A) New FQHC.

      (i) If the owner of a new FQHC facility owns one or more FQHC facilities in Texas and will include the new facility on the Medicare cost report of another FQHC facility, then HHSC will apply the rate assigned to the other FQHC as the interim base rate of the new FQHC. If the owner of a new FQHC facility does not include the new facility on the Medicare cost report of another FQHC facility, the new FQHC must file a projected cost report to establish an initial interim base rate. The cost report must contain the FQHC's reasonable costs anticipated to be incurred during the FQHC's initial fiscal year. The initial interim base rate for a new FQHC shall be set at the lesser of 80 percent of the anticipated reasonable costs determined from the projected cost report or 80 percent of the average rate paid to FQHCs on January 1 of the calendar year during which the FQHC first applies as a new FQHC.

      (ii) Each new FQHC must submit to HHSC or its designee an as-filed Medicare cost report after the end of the FQHC's first full fiscal year. HHSC will determine an updated interim base rate based on 100 percent of the reasonable costs contained in the as-filed Medicare cost report. Interim rates will be adjusted prospectively until the final audited Medicare cost report is processed. An as-filed Medicare cost report must reflect twelve months of continuous service.

      (iii) Each new FQHC must submit to HHSC or its designee a final audited Medicare cost report, reflecting twelve months of continuous service. The rate established shall be the final base rate. HHSC will reconcile payments back to the beginning of the interim period applying the final base rate. If the final base rate is greater than the interim base rate, HHSC will compute and pay the FQHC a settlement payment that represents the difference in rates for the services provided during the interim period. If the final base rate is less than the interim base rate, HHSC will compute and recoup from the FQHC any overpayment resulting from the difference in rates for the services provided during the interim period. The final base rate is adjusted in accordance with section (31)(b)(4) to determine the effective rate.
(8) FQHC rate determination process (continued)

(iv) If a new FQHC cost report described in (ii) or (iii) of this section does not meet the requirement of reflecting twelve months of continuous service, HHSC will prospectively establish the interim rate based on the lesser of the interim rate determined by the cost report or 80 percent of the average rate paid to FQHCs on January 1 of the calendar year during which the FQHC first applies as a new FQHC or for a change in scope, if applicable, adjusted by applicable increases.
(31) Federally Qualified Health Centers (FQHC) (continued)
(b) Alternative Prospective Payment System (APPS) Methodology (continued).

(B) Change of ownership. If an existing FQHC facility changes ownership, the new owner must notify HHSC of the ownership change.

(i) If the new owner of an FQHC facility owns no other FQHC facility in Texas, HHSC will treat the FQHC facility as a new FQHC. HHSC will set an initial interim base rate equal to 100 percent of the previous owner’s effective rate, and will then follow the procedures under sections (31)(b)(8)(A)(ii) and (31)(b)(8)(A)(iii).

(ii) If the new owner of an FQHC facility owns one or more FQHC facilities in Texas, and will include the new facility on the Medicare cost report of another FQHC facility, then HHSC will apply the rate assigned to the other FQHC.

(iii) If the new owner of an FQHC facility owns one or more FQHC facilities in Texas, but will not include the new facility on the Medicare cost report of another FQHC facility, then HHSC will determine a rate for the facility in accordance with (i) of this section.

(iv) If the new owner of an FQHC facility is ultimately not allowed by Medicare to include its new FQHC facility on the Medicare cost report of the other FQHC facility that it owns, then HHSC will determine a rate for the facility in accordance with section (31)(b)(8)(A).

(C) Request for change of effective rate.

(i) An FQHC that requests an adjustment of its effective rate (due to a change in scope or operating in an efficient manner) must file a change of effective rate cost report. The FQHC must include the necessary documentation to support a claim that the FQHC has undergone a change in scope or is operating in an efficient manner.

(ii) If HHSC determines through the review of the information provided in (i) of this section that an adjustment to the effective rate is warranted, HHSC will determine an interim base rate based on 100 percent of the reasonable costs contained in the change of effective rate cost report. Interim payments will be adjusted prospectively until the final audited cost report is processed.

(iii) The FQHC must submit to HHSC or its designee an as-filed Medicare cost report. HHSC and the FQHC will then follow the procedures under subsections (31)(b)(8)(A)(ii) and (31)(b)(8)(A)(iii).
(31) Federally Qualified Health Centers (FQHC) (continued)

(b) Alternative Prospective Payment System (APPS) Methodology (continued).

(D) State-initiated review.

(i) For an in-state FQHC that has chosen the APPS methodology, HHSC may prospectively reduce the FQHC's effective rate to reflect 100 percent of its reasonable costs or the PPS effective rate, whichever is greater. After reviewing the final audited Medicare cost report, HHSC will determine if an in-state FQHC is being reimbursed more than 100 percent of its reasonable cost or the PPS effective rate, whichever is greater, through the following steps:

(I) Determine the reasonable cost per encounter from the final audited Medicare cost report;

(II) Determine the effective PPS rate per encounter as would have been applied to the FQHC if the FQHC had chosen PPS as described in (a) for the same time period corresponding to the FQHC's final audited Medicare cost report;

(III) Select the greater of (I) or (II) of this section;

(IV) If the result in (III) of this section is less than the APPS effective rate for this period, HHSC will set the result in (III) of this section as the new final base rate for this period;

(V) The prospective rate described in section (31)(b)(8)(D)(iii) will be determined by adjusting the new final base rate from (IV) in accordance with section (31)(b)(4) to determine the effective rate.

(VI) The new final base rate from (IV) and subsequent effective rates will not apply to claims for services provided prior to the implementation date described in section (31)(b)(8)(D)(iii).

(ii) State-initiated reviews will be based on a determined 12 month time period and the most recent cost data received:

(iii) HHSC will apply the state-initiated rate reduction prospectively beginning on the first day of the month following 45 days after the date of the final case rate notification letter. The final base rate is adjusted in accordance with section (31)(b)(4) to determine the effective rate.
(31) Federally Qualified Health Centers (FQHC) (continued)

(b) Alternate Prospective Payment System (APPS) Methodology (continued)

(iv) HHSC will not increase the effective rate for an FQHC based on the outcome of a state-initiated cost report audit. It is the responsibility of the FQHC to request HHSC to adjust the effective rate.

(v) For PPS, the state-initiated review is not applicable.

(D) Final base rate notification letter. HHSC will provide to an FQHC written notification of any determined final base rate.

(E) Request for review of final base rate. The FQHC may submit a written request for a review of the final base rate if:

(i) The FQHC believes that HHSC made a mathematical error or data entry error in calculating the FQHC’s reasonable cost. If HHSC determines the request for review merits a change in the final base rate, HHSC will adjust the final base rate to the effective date of the final base rate notification letter.

(ii) The FQHC believes that the FQHC made an error in reporting its cost or data in the final audited Medicare cost report or the Texas Medicaid Supplemental Worksheets that would result in a different calculation of the FQHC’s reasonable cost. If HHSC determines the request for review merits a change in the final base rate, HHSC may adjust the final base rate to the effective date of the final base rate notification letter.

(iii) If the FQHC disagrees with the results of the review, the FQHC may request a formal appeal.

(9) A managed care organization or dental maintenance organization will pay to an FQHC the full amount the FQHC should receive under PPS or APPS for covered services performed by the FQHC. The state will reimburse the managed care organization the difference between the amount the managed care organization paid the FQHC and the amount the managed care organization has contracted to pay the FQHC. The state’s supplemental payment obligation to the managed care organization will be determined by subtracting the baseline payment under the contract for services being provided from the effective PPS or APPS rate without regard to the effects of financial incentives that are linked to utilization outcomes, reductions in patient costs, or bonuses. In the event that the contracted amount paid to an FQHC by a managed care organization or dental maintenance organization is less than the amount the FQHC would receive under PPS or APPS, whichever is applicable, the state will ensure the FQHC is reimbursed the difference on at least a quarterly basis.
(31) Federally Qualified Health Centers (FQHC) (continued)
(b) Alternate Prospective Payment System (APPS) Methodology (continued)

(A) For purposes of this section, the term “APPS” is an alternative payment methodology under 42 U.S.C. §1396a(bb)(6).

(B) As stated in (31)(a) of this attachment, an FQHC may choose between payment under the PPS or APPS methodology.

(C) As stated in (31)(b)(1) of this attachment, a payment made under the APPS methodology must be at least equal to the amount that would be paid under PPS
(31) Federally Qualified Health Centers (FQHC) (continued)

(b) Alternative Prospective Payment System (APPS) Methodology (continued).

(10) A visit is a face-to-face, telemedicine, or telehealth encounter between an FQHC patient and a physician, physician assistant, nurse practitioner, certified nurse-midwife, visiting nurse, psychologist, clinical social worker, other health professional for mental health services, dentist, dental hygienist, or optometrist if the visit is within the scope of practice for the provider. Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit, except where one of the following conditions exist:

(A) after the first encounter, the patient suffers illness or injury requiring additional diagnosis or treatment; or

(B) the FQHC patient has a medical visit and an "other" health visit, as defined in section (31)(b)(11).

(11) A medical visit is a face-to-face, telemedicine, or telehealth encounter between an FQHC patient and a physician, physician assistant, nurse practitioner, certified nurse-midwife, or visiting nurse. An "other" health visit includes, but is not limited to, a face-to-face, telemedicine, or telehealth encounter between an FQHC patient and a psychologist, clinical social worker, other health professional for mental health services, dentist, dental hygienist, or optometrist, as well as an Early and Periodic Screening, Diagnosis and Treatment medical checkup if the visit is within the scope of practice for the provider.

TN: 20-0022   Approval Date: 11/18/20
Supersedes TN: 10-0061   Effective Date: 9/1/20
32. Reimbursement Methodologies for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services

1) Except as otherwise specified, payment for authorized medically necessary services required to diagnose and treat a condition under Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services will be based on existing Medicaid reimbursement methodologies.

a) In Texas, EPSDT services are known as Texas Health Steps (THSteps). Medicaid services provided only to clients under age 21 are part of the THSteps-Comprehensive Care Program (CCP) and the reimbursement methodologies are included in this item. The reimbursement methodologies for services provided to all Medicaid-eligible clients, including clients under age 21, are located elsewhere in the Texas Medicaid State Plan and are referenced in this item.

b) The reimbursement for durable medical equipment, prosthetics, orthotics and supply services, effective September 1, 2011 will be equal to the reimbursement on August 31, 2010, less 12.5 percent.

SUPERSEDES: TN: 11-38
32. Reimbursement Methodologies for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services -continued

2) Counseling and psychological services reimbursable only for Medicaid-eligible clients under age 21 include school districts in accordance with Item 32 (17) of Attachment 4.19-B of this State Plan, relating to the reimbursement methodology for School Health and Related Services (SHARS).

SUPERSEDES: TN- 06-08

TN No. 10-17 Approval Date 7-26-10 Effective Date 9-1-10

Supersedes TN No. 06-08
32. Reimbursement Methodologies for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services - continued

3) Durable medical equipment, prosthetics, orthotics, and supplies reimbursable only for Medicaid-eligible clients under age 21.

   a) All fee schedules are available through the agency’s website as outlined on Attachment 4.19-B, page 1.

   b) The agency’s fee schedule was revised with new fees for providers of EPSDT durable medical equipment prosthetics, orthotics, and supplies effective September 1, 2010. The fee schedule was posted on the agency website on September 3, 2010.

   c) The reimbursement for services, excluding SHARS, effective September 1, 2010, will be equal to the reimbursement on August 31, 2010, less one percent.
32. Reimbursement Methodologies for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services - continued

4) Medicaid nursing services reimbursable only for Medicaid-eligible clients under age 21 include nursing services provided on a restorative basis under 42 CFR §440.130(d) by school districts, in accordance with Item 32(17) of Attachment 4.19-B of this State Plan, relating to the reimbursement methodology for School Health and Related Services (SHARS).
32. Reimbursement Methodologies for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services (continued)

(5) Private duty nursing services, including, but not limited to, registered nurse (RN) services, and licensed vocational nurse/licensed practical nurse (LVN/LPN) services require prior authorization and are reimbursed based on the lesser of the provider’s billed charges or fees established by the Texas Health and Human Services Commission (HHSC).

a) Eligible providers include: independently enrolled RNs, independently enrolled LVNs/LPNs, RNs employed by or contracted with home health agencies, and LVNs/LPNs employed by or contracted with home health agencies.

b) The fees are access-based fees and are reviewed every two years. The fees are based on historical charges, a review of Medicaid fees paid by other states, a survey of costs for a representative sample of providers, an analysis of cost reports provided by home health agencies of similar nursing services, modeling using an analysis of other data available to HHSC, or a combination thereof. Payments based on a fee schedule are made for these services.

c) All fee schedules are available through the agency's website as outlined on Attachment 4.19-B, page 1.

d) The agency’s fee schedule was revised with new fees for EPSDT private duty nursing services effective September 1, 2019. The fee schedule was posted on the agency website on September 5, 2019.
32. Reimbursement Methodologies for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services - continued

6. Physical Therapy (PT)

(a) Services reimbursable only for Medicaid-eligible clients under age 21 include those delivered by the following provider types:

(1) Medicare-certified outpatient facilities known as comprehensive outpatient rehabilitation facilities (CORFs) and outpatient rehabilitation facilities (ORFs) in accordance with Item 1 of Attachment 4.19-B, relating to the reimbursement methodology for physicians and other practitioners. Payments based on a fee schedule are made for these services.

(2) School districts in accordance with Item 32(17) of Attachment 4.19-B, relating to the reimbursement methodology for School Health and Related Services (SHARS).

(3) Home health agencies’ reimbursement rates are determined by the Texas Health and Human Services Commission (HHSC). Payments based on a fee schedule are made for these services.

(b) All fee schedules are available through the agency’s website as outlined on Attachment 4.19-B, page 1.

The agency’s fee schedule was revised with new fees for EPSDT physical therapy services effective September 1, 2019. The fee schedule was posted on the agency website on September 5, 2019.
32. Reimbursement Methodologies for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services - continued

7. Occupational Therapy (OT)

(a) Services reimbursable only for Medicaid-eligible clients under age 21 include those delivered by the following provider types:

(1) Medicare-certified outpatient facilities known as comprehensive outpatient rehabilitation facilities (CORFs) and outpatient rehabilitation facilities (ORFs) in accordance with Item 1 of Attachment 4.19-B, relating to the reimbursement methodology for physicians and other practitioners. Payments based on a fee schedule are made for these services.

(2) School districts in accordance with Item 32(17) of Attachment 4.19-B, relating to the reimbursement methodology for School Health and Related Services (SHARS).

(3) Home health agencies' reimbursement rates are determined by the Texas Health and Human Services Commission (HHSC). Payments based on a fee schedule are made for these services.

(b) All fee schedules are available through the agency's website as outlined on Attachment 4.19-B, page 1.

The agency's fee schedule was revised with new fees for EPSDT occupational therapy services effective September 1, 2019. The fee schedule was posted on the agency website on September 5, 2019.

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32. Reimbursement Methodologies for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services - continued

8. Speech and Language

(a) Services reimbursable only for Medicaid-eligible clients under age 21 include those delivered by the following provider types:

(1) Medicare-certified outpatient facilities known as comprehensive outpatient rehabilitation facilities (CORFs) and outpatient rehabilitation facilities (ORFs) in accordance with Item 1 of Attachment 4.19-B, relating to the reimbursement methodology for physicians and other practitioners. Payments based on a fee schedule are made for these services.

(2) School districts in accordance with Item 32(17) of Attachment 4.19-B, relating to the reimbursement methodology for School Health and Related Services (SHARS).

(3) Home health agencies’ reimbursement rates are determined by the Texas Health and Human Services Commission (HHSC). Payments based on a fee schedule are made for these services.

(b) All fee schedules are available through the agency’s website as outlined on Attachment 4.19-B, page 1.

(c) The agency’s fee schedule was revised with new fees for EPSDT speech and language services effective September 1, 2019. The fee schedule was posted on the agency website on September 5, 2019.
32. **Reimbursement Methodologies for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services - continued**

9) Nutritional services provided by licensed dietitians to Medicaid-eligible clients under age 21 are reimbursed the lesser of the provider's billed charges or fees determined by the Texas Health and Human Services Commission (HHSC) in accordance with Item 1 of Attachment 4.19-B, relating to the reimbursement methodology for physicians and certain other practitioners.

a) All fee schedules are available through the agency's website as outlined on Attachment 4.19-B, page 1.

b) The agency's fee schedule was revised with new fees for EPSDT nutritional services effective September 1, 2011. The fee schedule will be posted on the agency website on September 9, 2011.

c) The reimbursement for services, effective September 1, 2011, will be equal to the reimbursement on August 31, 2010, less 12.5 percent.
32. Reimbursement Methodologies for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services - continued
(10) Physician services

(a) Services reimbursable only for Medicaid-eligible clients under age 21 include:

   (1) Vaccines not covered by the Texas Vaccines for Children Program (TVCP) for clients under age 21, which are reimbursed as access-based fees in accordance with Item 1 of Attachment 4.19-B, relating to the reimbursement methodology for physicians and certain other practitioners. Payments based on a fee schedule are made for these services.

   (2) Services delivered by school districts, in accordance with Item 32(17) of Attachment 4.19-B, relating to the reimbursement methodology for School Health and Related Services (SHARS).

(b) For dates of service on or after September 1, 2019, the reimbursement for services provided by a therapy assistant will be reimbursed at 80 percent of the rate paid to a licensed therapist for the same services.

(c) All fee schedules are available through the agency's website as outlined on Attachment 4.19-B, page 1.

(d) The agency's fee schedule was revised with new fees for EPSDT physician services effective March 1, 2023. The fee schedule was posted on the agency website on March 15, 2023.
32. Reimbursement Methodologies for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services – continued

11) Audiology and hearing services

a) Services reimbursable only for Medicaid-eligible clients under age 21 include those delivered by the following provider types:

1) Licensed audiologists in accordance with Item 1 of Attachment 4.19-B, relating to the reimbursement methodology for physicians and certain other practitioners. Payments based on a fee schedule are made for these services.

2) School districts, in accordance with Item 32(17) of Attachment 4.19-B, relating to the reimbursement methodology for School Health and Related Services (SHARS).

b) All fee schedules are available through the agency's website as outlined on Attachment 4.19-B, page 1.

c) The agency's fee schedule was revised with new fees for EPSDT audiology and hearing services effective September 1, 2011. The fee schedule will be posted on the agency website on September 9, 2011.

d) The reimbursement for services, effective September 1, 2011, will be equal to the reimbursement on August 31, 2010, less 12.5 percent.
32. Reimbursement Methodologies for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services - continued

12) Medical transportation services reimbursable only for Medicaid-eligible clients under age 21 include nonemergency specialized transportation provided for special education clients under age 21 by school districts, in accordance with Item 32(17) of Attachment 4.19-B, relating to the reimbursement methodology for School Health and Related Services (SHARS).
32. Reimbursement Methodologies for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services - continued

13) Dental services reimbursable only for Medicaid-eligible clients under age 21 include those provided by independently enrolled dentists who are reimbursed according to the lesser of the provider's billed charges or fees determined by the Texas Health and Human Services Commission (HHSC). These are access-based fees under Item 1 of Attachment 4.19-B, relating to the reimbursement methodology for physicians and other practitioners.

(a) All fee schedules are available through the agency's website as outlined in Attachment 4.19-B, page 1.

(b) The agency's fee schedule was revised with new fees for EPSDT dental services effective January 1, 2022. The fee schedule will be posted on the agency website by March 15, 2022.
32. Reimbursement Methodologies for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services - continued

(14) Personal care services (PCS)

a) Services reimbursable only for Medicaid-eligible clients under age 21 include those delivered by the following provider types:

1) School districts in accordance with Item 32(17) of Attachment 4.19-B, relating to the reimbursement methodology for School Health and Related Services (SHARS).

2) Home health agencies and other PCS providers delivering PCS in the client's home, excluding services delivered through the Consumer Directed Services service delivery model, are reimbursed the lesser of the provider's billed charges or fees established by the Texas Health and Human Services Commission (HHSC) based on an analysis of relevant cost or fee surveys. Payments based on a fee schedule are made for these services.

b) All fee schedules are available through the agency's website as outlined on Attachment 4.19-B, page 1.

c) The agency's fee schedule was revised with new fees for EPSDT Personal Care Services effective September 1, 2019. The fee schedule was posted on the agency website on September 5, 2019.
32. Reimbursement Methodologies for Early and Periodic Screening, Diagnosis and Treatment-Comprehensive Care Program (EPSDT-CCP) Services - continued

(17) School Health and Related Services (SHARS)
School-based services are known as School Health and Related Services (SHARS) in Texas, are delivered by school districts, and include the following Medicaid services as described in Appendix 1 to Attachment 3.1-A of the Texas Medicaid State Plan under Item 4.b. EPSDT Services:

1. Audiology and Hearing Services
2. Physician Services
3. Occupational Therapy
4. Physical Therapy
5. Psychological Services
6. Speech and Language Services
7. Nursing Services
8. Counseling Services
9. Transportation Services
10. Personal Care Services

A. Direct Medical Services Payment Methodology
Effective for dates of service on and after September 1, 2006, providers are reimbursed on an interim basis for SHARS direct medical services per unit of service at the lesser of the provider's billed charges or a provider-specific interim rate. Federal matching funds will be available for interim rates paid by the State only as long as all of the milestones contained in the CMS-approved "TEXAS SPA 06-005 MILESTONES DOCUMENT" are met. In this regard, meeting the milestones means the actions and/or items are accomplished by the dates indicated in the MILESTONES document. The units of service are 15-minute units for all covered services other than medication administration (a nursing service), which is based on a per-visit basis; assessment services, which are based on a per-hour basis; and trips. The provider-specific interim rate is the rate for a specific service for a period that is provisional in nature, pending the completion of a cost reconciliation and a cost settlement for that period.

To determine the Medicaid-allowable direct and indirect costs of providing SHARS direct medical services to Medicaid-eligible clients, the following steps are performed:

(1) Direct costs for direct medical services include unallocated payroll costs and other unallocated costs that can be directly charged to direct medical services. Direct payroll costs include total compensation (i.e., salaries and benefits and contract compensation) of direct services personnel.
32. Reimbursement Methodologies for Early and Periodic Screening, Diagnosis and Treatment-Comprehensive Care Program (EPSDT-CCP) Services - continued

listed in the descriptions of the covered Medicaid services delivered by school districts in Appendix 1 to Attachment 3.1-A of the Texas Medicaid State Plan under Item 4.b, excluding transportation personnel.

EPSDT Services. Other direct costs include costs directly related to the approved direct services personnel for the delivery of medical services, such as purchased services, capital outlay, travel, materials and supplies. These direct costs are accumulated on the annual cost report, resulting in total direct costs. The cost report contains the scope of cost and methods of cost allocation that have been approved by the Centers for Medicare & Medicaid Services (CMS).

(2) Total direct costs for direct medical services from Item 1 above are reduced by any federal payments for those costs, resulting in adjusted direct costs for direct medical services.

(3) Adjusted direct costs from Item 2 above are then allocated to direct medical services regardless of payer source by applying the direct medical services percentage from the CMS-approved time study, resulting in net direct costs.

A time study which incorporates a CMS-approved methodology is used to determine the percentage of time that medical service personnel spend on direct medical services, general and administrative time and all other activities to account for 100 percent of time to assure that there is no duplicate claiming. This time study methodology will utilize two mutually exclusive cost pools representing individuals performing predominantly administrative activities and direct services, respectively. A sufficient number of medical service personnel will be sampled to ensure time study results that will have a confidence level of at least 95 percent with a precision of plus or minus five percent overall. The same single direct medical services time study percentage is applied against costs for all medical disciplines.
32. Reimbursement Methodologies for Early and Periodic Screening, Diagnosis and Treatment-Comprehensive Care Program (EPSDT-CCP) Services - continued

(4) Indirect costs are determined by applying the school district’s specific unrestricted indirect cost rate to its net direct costs. Texas public school districts use predetermined fixed rates for indirect costs. TEA has, in cooperation with the United States Department of Education (USDE), developed an indirect cost plan to be used by school districts in Texas. Pursuant to the authorization in 34 CFR §75.561(b), TEA approves unrestricted indirect cost rates for school districts for the USDE, which is the cognizant agency for school districts. Providers are permitted only to certify Medicaid-allowable costs and are not permitted to certify any indirect costs that are outside their unrestricted indirect cost rate.

(5) Net direct costs and indirect costs are combined.

(6) Medicaid’s portion of total net costs is identified. The results of the previous step are multiplied by the ratio of the total number of students with Individualized Education Programs (IEPs) receiving medical services and eligible for Medicaid to the total number of students with IEPs receiving medical services.

B. Transportation Services Payment Methodology

Effective for dates of service on and after September 1, 2006, providers are reimbursed for covered SHARS transportation services per unit of service at the lesser of the provider’s billed charges or a provider-specific interim rate. The unit of service is based on a one-way trip. The provider-specific interim rate is the rate for a period that is provisional in nature, pending the completion of a cost reconciliation and a cost settlement for that period.

To determine the Medicaid-allowable direct and indirect costs of providing SHARS covered transportation services to Medicaid-eligible clients, the following steps are performed:

(1) Direct costs for covered transportation services include unallocated payroll costs and other unallocated costs that can be directly charged to covered transportation services. Direct payroll costs include total compensation (i.e., salaries and benefits and contract compensation) of bus
32. Reimbursement Methodologies for Early and Periodic Screening, Diagnosis and Treatment-Comprehensive Care Program (EPSDT-CCP) Services - continued

drivers and mechanics. Other direct costs include costs directly related to the delivery of covered transportation services, such as professional and contracted services, contracted transportation costs, gasoline and other fuels, other maintenance and repair costs, vehicle insurance, interest, rentals, and vehicle depreciation. Depreciation must be documented by completing the Depreciation Schedule in the SHARS Cost Report. Allowable depreciation expense includes only pure straight-line depreciation. No accelerated or additional first-year depreciation expense is allowable. Required detail must be provided for each depreciable asset and each depreciable asset must be assigned a correct estimated useful life. Minimum usual lives must be consistent with "Estimated Useful Lives of Depreciable Hospital Assets," published by the American Hospital Association (AHA). These direct costs are accumulated on the annual cost report, resulting in total direct costs.

(2) Total direct costs for covered transportation services from Item 1 above are reduced by any federal payments for those costs, resulting in adjusted direct costs for covered transportation services.

(3) Adjusted direct costs from Item 2 above are then allocated to Medicaid by applying the ratio of one-way trips provided pursuant to an IEP to Medicaid beneficiaries over total one-way specialized transportation trips. Trip logs will be maintained daily to record one-way specialized transportation trips.

(4) Indirect costs are determined by applying the school district's specific unrestricted indirect cost rate to its net direct costs. Texas public school districts use predetermined fixed rates for indirect costs. TEA has, in cooperation with the United States Department of Education (USDE), developed an indirect cost plan to be used by school districts in Texas. Pursuant to the authorization in 34 CFR §75.561(b), TEA approves unrestricted indirect cost rates for school districts for the USDE, which is the cognizant agency for school districts. Providers are permitted only to certify Medicaid-allowable
32. **Reimbursement Methodologies for Early and Periodic Screening, Diagnosis and Treatment-Comprehensive Care Program (EPSDT-CCP) Services - continued**

   costs and are not permitted to certify any indirect costs that are outside their unrestricted indirect cost rate.

   (5) Net direct costs and indirect costs are combined.

C. **Certification of Funds Process**

   Each provider certifies on a quarterly basis an amount equal to each interim rate times the units of service reimbursed during the previous federal fiscal quarter. In addition, each provider certifies on an annual basis through its cost report its total actual, incurred allowable costs/expenditures, including the federal share and the nonfederal share.

   Providers are permitted only to certify Medicaid-allowable costs and are not permitted to certify any indirect costs that are outside their unrestricted indirect cost rate.

D. **Annual Cost Report Process**

   For the 2008 SHARS Cost Report, the cost reporting period is September 1, 2007, through September 30, 2008. For the 2009 and subsequent SHARS Cost Reports, the cost-reporting period is the federal fiscal year (October 1 through September 30). The cost report is due on or before April 1 of the year following the reporting period. The primary purposes of the cost report are to:

   (1) document the provider's total CMS-approved, Medicaid-allowable scope of costs for delivering SHARS, including direct costs and indirect costs, based on CMS-approved cost allocation methodology procedures; and

   (2) reconcile its interim payments to its total CMS-approved, Medicaid-allowable scope of costs based on CMS-approved cost allocation methodology procedures.

   The annual SHARS Cost Report includes a certification of funds statement to be completed, certifying the provider's actual, incurred costs/expenditures. All filed annual SHARS Cost Reports are subject to desk review by HHSC or its designee.

E. **The Cost Reconciliation Process**

   The cost reconciliation process must be completed within twenty-four months of the end of the reporting period covered by the annual SHARS Cost Report. The total CMS-approved, Medicaid-
allowable scope of costs based on CMS-approved cost allocation methodology procedures are compared to the provider's Medicaid interim payments for SHARS delivered during the reporting period as documented in the Medicaid Management Information System (MMIS), resulting in a cost reconciliation.

For the purposes of cost reconciliation, the state may not modify the CMS-approved scope of costs, the CMS-approved cost allocation methodology procedures, or its CMS-approved test study for cost-reporting purposes. Any modification to the scope of cost, cost allocation methodology procedures, or test study for cost-reporting purposes requires approval from CMS prior to implementation; however, such approval does not necessarily require the submission of a new state plan amendment.

F. The Cost Settlement Process

EXAMPLE: For services delivered for the period covering September 1, 2006, through August 31, 2007, the annual SHARS Cost Report is due on or before March 1, 2008, with the cost reconciliation and settlement processes completed no later than August 31, 2009.

EXAMPLE: For services delivered for the period covering September 1, 2007, through September 30, 2008, the annual SHARS Cost Report is due on or before April 1, 2009, with the cost reconciliation and settlement processes completed no later than September 30, 2010. The cost reconciliation and settlement completion date of September 30 applies to all subsequent cost-reporting periods.

If a provider's interim payments exceed the actual, certified costs of the provider for SHARS to Medicaid clients, HHSC will recoup the federal share of the overpayment using one of these two methods:

1. Offset all future claims payments from the provider until the amount of the federal share of the overpayment is recovered;
2. The provider will return an amount equal to the overpayment.

If the actual, certified costs of a provider for SHARS exceed the interim Medicaid payments, HHSC will pay the federal share of the difference to the provider in accordance with the final actual certification agreement and submit claims to the CMS for reimbursement of that payment in the federal fiscal quarter following payment to the provider.

HHSC shall issue a notice of settlement that denotes the amount due to or from the provider.
32. Reimbursement Methodologies for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services - continued

18) EPSDT Case Management

(a) Providers of EPSDT Case Management Services are reimbursed the lesser of the provider's billed charges or fees determined by the Texas Health and Human Services Commission (HHSC) for three types of encounters, including comprehensive assessment visits, follow-up face-to-face visits, and follow-up telephone consultations. The fees are market-based rates determined using an analysis of relevant cost or fee surveys for similar services available to HHSC.

(b) All fee schedules are available through the agency's website as outlined on Attachment 4.19-B, page 1.

(c) The agency's fee schedule was revised with new fees for EPSDT case management effective January 1, 2013.
32. Reimbursement Methodologies for Early and Periodic Screening, Diagnosis and Treatment- Comprehensive Care Program (EPSDT-CCP) Services - continued

(19) Environmental Lead Investigations. The rate for on-site environmental lead investigations is reimbursable only for Medicaid-eligible clients under age 21. The initial rate is based on the estimated costs to perform an inspection of the child’s primary dwelling. The estimated costs used to develop this rate include salary and fringe costs. Indirect costs are included based on the estimated lifespan of the equipment and the number of anticipated investigations completed annually.

(a) Payment is limited to providers that are Certified Lead Risk Assessors accredited by the Texas Department of State Health Services.

(b) The rate for environmental lead investigations will be reviewed and updated periodically by projecting the initial rate from the historical cost period used to develop the initial rate to the perspective rate period using the Personal Consumption Expenditures (PCE) Chain - Type Price Index.

(c) All fee schedules are available through the agency’s website, as outlined on Attachment 4.19-B, page 1.

(d) The agency’s fee schedule was revised with the new fee for environmental lead investigations effective September 1, 2022 and is effective for services provided on or after that date. This fee schedule will be posted on the agency website by September 15, 2022.
32. **Reimbursement Methodologies for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services - continued**

(19) **Prescribed Pediatric Extended Care Center (PPECC) Services**

(a) Payment rates are developed based on payment rates determined for other programs that provide similar services. If there are no similar services or no prior provider experience in the state that can inform the development of payment rates, payment rates are determined using a pro forma analysis.

(b) A pro forma analysis is defined as an item-by-item, or classes-of-items, calculation of the reasonable and necessary expenses for a provider to operate a PPECC while meeting all regulatory requirements. This analysis may involve assumptions about the salary of an administrator or program director, staff salaries, employee benefits and payroll taxes, building depreciation, mortgage interest, contracted client care expenses, and other building or administration expenses using inflated historical costs of delivering similar services, where appropriate data are available, and estimating the basic types and costs of products and services necessary to deliver services meeting federal and state requirements.

(c) To determine the cost per unit of service, all the pro forma expenses are totaled, and the total is divided by the estimated units of service.

(d) Providers of a bundled service payment will maintain data to include information showing the provision, by the practitioner, of the individual covered Medicaid service in the bundled payment, the extent of services the provider furnishes to beneficiaries, and the cost, by practitioner and type of service, of services delivered under the bundled rate.

(e) PPECCs are limited to 12 hours a day and are further restricted by state licensure requirements to daytime hours; therefore, the rates will not include room and board.

(f) The per diem PPECC transportation rate is a once per day round trip encounter rate. The rate is payable only on days the client utilizes PPECC transportation.

(g) HHSC reviews and, if necessary, updates all rates on a biennial basis.

(h) If HHSC requires the provider to submit a cost report, the provider must follow the prescribed cost reporting guidelines.

(i) All fee schedules are available through the agency's website as outlined in Attachment 4.19-B, page 1.

(j) The agency's fee schedule will be revised with new fees for PPECC services effective June 1, 2023. The fee schedule will be posted on the agency website by September 1, 2023.
33. Case Management for Children Who are Blind or Visually Impaired was deleted in SPA 17-0001:

Page 26 (TN 12-030)
35. **Services by Certified Pediatric Nurse Practitioners and Certified Family Nurse Practitioners**

(a) Certified pediatric nurse practitioners (CPNP) and certified family nurse practitioners (CFNP) are known in Texas as advance practice nurses (APN). APNs include nurse practitioners (NP) and clinical nurse specialists (CNS). NPs and CNSs deliver the services that can be provided by CPNPs and CFNPs. Payment for covered professional services provided by NPs and CNSs is limited to the lesser of the provider’s billed charges or 92 percent of the rate reimbursed to a physician for the same professional service made in accordance with Item 1 of this attachment, relating to the reimbursement methodology for physicians and certain other practitioners. Payment to NPs and CNSs is at the same level as physicians for drugs and supplies.

(b) All fee schedules are available through the agency’s website as outlined on Attachment 4.19-B, page 1.

(c) The agency’s fee schedule was revised with new fees for CPNPs and CFNPs effective February 1, 2011 and this fee schedule will be posted on the agency’s website on April 8, 2011.

(d) The reimbursement for services effective September 1, 2010 through January 31, 2011 will be equal to the reimbursement on August 31, 2010, less one percent. For new reimbursement rates or reimbursement rates that were revised after August 31, 2010, for services effective September 1, 2010 through January 31, 2011, the reimbursement will be reduced by one percent.

(e) The reimbursement for services effective February 1, 2011 will be equal to the reimbursement on August 31, 2010, less two percent. For new reimbursement rates or reimbursement rates revised after August 31, 2010, for services effective February 1, 2011, the reimbursement will be reduced by two percent.
38. Case Management for Pregnant Women Age 21 and Older

(a) Providers of Case Management Services for Pregnant Women age 21 and older are reimbursed the lesser of the provider's billed charges or fees determined by the Texas Health and Human Services Commission (HHSC) for three types of encounters, including comprehensive assessment visits, follow-up face-to-face visits, and follow-up telephone consultations. The fees are market-based rates determined using an analysis of relevant cost or fee surveys for similar services available to HHSC.

(b) All fee schedules are available through the agency's website as outlined on Attachment 4.19-B, Page 1.

(c) The agency's fee schedule was revised with new fees for case management for pregnant women effective January 1, 2013.
39. Case Management Services for Infants and Toddlers with Developmental Disabilities

(a) Effective for services provided on or after October 1, 2011, two statewide prospective rates are established for case management services for infants and toddlers with developmental disabilities. A 15 minute unit of service is established. Case management must be delivered as follows:

(1) Face to face contact. Interaction directly with the child and the child’s parent or routine caregiver billed in 15 minute increments.

(2) Telephone contact. Interaction directly with the child’s parent or routine caregiver billed in 15 minute increments.

(b) Provider costs will be collected for use as a basis for updating reimbursement rates.

(1) Reported expenses. Providers must ensure that all requested costs are included in the cost reporting system.

(2) Data collected. The data collected includes the number of units of service provided. The cost data includes direct services costs, programmatic indirect costs, and general and administrative costs including salaries, benefits, and non-labor costs. Programmatic indirect costs include salaries, benefits and other costs of this case management program that are indirectly related to the delivery of case management services to clients. General and administrative overhead costs include the salaries, benefits and other costs that, while not directly part of the case management services program, constitute costs that support the operations of the case management services program.

(3) Unallowable expenses. Unallowable expenses included in the cost report are omitted from the cost report database and appropriate adjustments are made to expenses and other information reported by providers. The purpose is to ensure that the database reflects costs and other information which are consistent with efficiency, economy, and quality of care; are necessary for the provision of covered case management services, and are consistent with federal and state Medicaid regulations. If there is doubt as to the accuracy or allowability of a significant part of the information reported, individual cost reports may be eliminated from the database.

(4) Total costs are projected from the historical reporting period to the prospective rate period. Cost projections adjust the allowable historical costs for significant changes in cost related conditions anticipated to occur between the historical cost period and the prospective rate period. Significant conditions include, but are not necessarily limited to, wage and price inflation or deflation, changes in program utilization and efficiency, and modification of federal or state regulations and statutes. The personal consumption expenditures (PCE) chain-type index, which is based on data from the U.S. Department of Commerce, is the most general measure of inflation is used to project costs.
40. EPSDT - School Health and Related Services (SHARS) provided to children with disabilities under age 21

The following reimbursement methodology will expire effective September 1, 2006.

(a) The Health and Human Services Commission (HHSC) or its designee reimburses enrolled providers for providing school health and related services to Medicaid-eligible students with disabilities. HHSC or its designee calculates reimbursement rates at least once every five years for school health and related services (SHARS), with adjustments made for inflation annually for those years when reimbursement rates are not calculated. These rates are:

(1) prospective; and
(2) cost related.

(b) Basis for rate analysis.

(1) Because the services named in Title 1 of the Texas Administrative Code (TAC) §354.1341(d)(1)-(9) (relating to Benefits and Limitations) were comparable to those included in 25 TAC §621.23(5)(C)-(E) (relating to Service Delivery Requirements for Comprehensive Services) for the Early Childhood Intervention (ECI) program, initial rates were derived from data collected as a part of the ECI program ratesetting process prior to October 1, 1994.

(2) For subsequent periods, HHSC or its designee collect cost data from a representative sample of providers as reported to the Texas Education Agency (TEA) through the Public Education Information Management System (PEIMS), the Foundation School Program (FSP), the Medicaid Administration Claims (MAC) program, and/or other auditable sources. These data contain the direct costs associated with delivery of SHARS, the indirect program costs associated with service delivery, and general and administrative costs associated with the management of the facility and program.

(3) The costs from the historical cost-reporting period are adjusted to the prospective rate period using reasonable and appropriate methods for projecting costs as determined by HHSC or its designee. HHSC or its designee may utilize a general cost inflation index obtained from a reputable independent professional source and, where HHSC or its designee deems appropriate and pertinent data are available, develop and/or utilize several cost-specific and program-specific inflation indices, as follows.

A. HHSC or its designee utilizes the Implicit Price Deflator (IPD) for Government Consumption Expenditures and Gross Investment for State and Local Governments as the general cost inflation index.
B. HHSC or its designee may use specific indices in place of the general cost inflation index specified in subparagraph (A) of this paragraph when appropriate cost-specific or program-specific cost indices are available. The specific indices that HHSC or its designee may use include, but are not limited to, the following:

(i) Federal Insurance Contributions Act (FICA) or Social Security taxes, including Old Age, Survivors, and Disability Insurance (OASDI) and Medicare taxes, are set by federal statute. The inflation rate for these taxes is the average tax rate, or average tax per payroll dollar, during the prospective reimbursement period divided by the average tax rate, or average tax per payroll dollar, during each provider's reporting period.

(ii) The unemployment tax inflation index is based on unemployment insurance payroll taxes in accordance with the Federal Unemployment Tax Act (FUTA) and the Texas Unemployment Compensation Act (TUCA) rates and is the average tax rate during the prospective reimbursement period divided by the average tax rate during each provider's reporting period.

(iii) Inflation factors for salaries of clinicians, certified/licensed assistants, school health aides, and personal care attendants are based on wage survey data pertaining to specific types of staff in Texas when HHSC or its designee has determined that reliable data of this kind are available for specific services.

(4) Providers participating in the MAC program are required to provide quarterly time study information. The information includes time information for clinicians, certified/licensed assistants, and school health aides delivering the following SHARS: audiology, counseling, occupational therapy, physical therapy, psychological services, speech therapy, assessment and school health services. Costs for these services are properly allocated to each unit of service based upon the results of the MAC program quarterly time study information, resulting in a cost per unit of service for each district for each of the listed services. Other personnel delivering SHARS who are not required to provide quarterly time study information for the MAC program (e.g., personal care attendants) will be required to provide time study information for one quarter for the calculation of reimbursement rates for services provided by them.
A. For services provided in an individual setting by the licensed or certified clinician, the cost per unit of service for each type of clinician is arrayed from low to high, with the mean cost per unit of service selected as the recommended rate for that service. For services provided in an individual setting by a licensed or certified assistant, the cost per unit of service for each type of licensed or certified assistant is arrayed from low to high, with the mean cost per unit of service selected as the recommended rate for that service.

B. For services provided in a group setting by the licensed or certified clinician, the recommended rate for the service provided by the licensed or certified clinician in an individual setting is divided by the average number of clients in a group, based on a study of a representative sample of the services provided in group settings. For services provided in a group setting by a licensed or certified assistant, the recommended rate for the service provided by the licensed or certified assistant in an individual setting is divided by the average number of clients in a group, based on a study of a representative sample of the services provided in group settings.

C. For school health services, recommended rates are calculated for services provided in an individual or group setting by a Registered Nurse (RN), a Licensed Vocational Nurse (LVN) or a Licensed Practical Nurse (LPN), and by an unlicensed person to whom the task has been properly delegated by an RN in accordance with Subparagraphs A and B of this paragraph.

D. Medication administration will be reimbursed either under school health services as a service provided by an RN, LVN or LPN, or unlicensed person to whom the task has been properly delegated by an RN or under a separate reimbursement rate calculated per dose as a percentage of the recommended rate for services provided by an RN, LVN or LPN, or unlicensed person to whom the task has been properly delegated by an RN, depending on the service requirements of the student. The initial percentage effective September 1, 2004, is 20%, based on a time study of the length of time required by RNs to administer medication by dose.

(5) Since time for medical services staff is not covered by the MAC program quarterly time study information and since most of these services are delivered by contracted staff, the recommended rate per unit of service is based on a survey of the average cost per provider per unit of service for these services. The average cost per provider per unit of service is arrayed from low to high, with the mean cost per unit of service selected as the recommended rate for medical services.
(6) Reimbursement for special transportation services is based on a rate per student one-way trip, with student one-way trip being defined as one Medicaid-eligible student requiring special transportation services picked up from home or school and delivered to a location where an approved Medicaid service is provided or picked up from a location where an approved Medicaid service is provided and delivered to home or school. The recommended rate for special transportation services is primarily based upon costs and statistics reported by districts in the FSP report. The costs per district per student round trip is calculated and arrayed from low to high, with the mean cost per unit of service selected as the recommended rate per student one-way trip for special transportation services.

(c) Unallowable costs are defined as those expenses incurred by a provider that are neither directly or indirectly related to the provision of contracted services according to applicable laws, rules, and standards. Unallowable costs are not used in calculating recommended rates. Providers have the right to notice of exclusions and disallowances made during the conduct of desk reviews or on-site audits of the costs, statistics, time study information and any other information used in the calculation of reimbursement rates for school health and related services. Providers may request an informal review and, if necessary, an administrative hearing of any exclusion or disallowance taken by HHSC or its designee during the conduct of desk reviews or on-site audits.

(d) HHSC or its designee may adjust reimbursement rates for SHARS when federal or state laws, rules, regulations, policies, or guidelines are adopted, promulgated, judicially interpreted, or otherwise changed in ways that can reasonably be expected to effect allowable costs. HHSC or its designee may also adjust reimbursement rates when changes in economic factors significantly affect allowable costs. Any of these adjustments may result in increases or decreases in the reimbursement rates.
41. Services Provided by Certified Registered Nurse Anesthetists and Anesthesiologist Assistants

(a) Payment for covered anesthesia services provided by a certified registered nurse anesthetist (CRNA) or Anesthesiologist Assistant (AA) is limited to the lesser of the provider’s billed charges or 92 percent of the rate reimbursed to a physician anesthesiologist for the same services made in accordance with item 1 of this attachment.

(b) All fee schedules are available through the agency’s website as outlined on Attachment 4.19-B, Page 1.

(c) The agency’s fee schedule was revised with the new fees for CRNAs and AAs effective June 1, 2013, and this fee schedule will be posted on the agency’s website on June 4, 2013.
42. Reimbursement Methodology for Primary Home Care Services - Home and Community Care for Functionally Disabled Elderly Individuals §1905 (a) (23)

(1) Personal Care Services. Payment for covered services will be determined by the reimbursement methodology for Primary Home Care (personal care) in Attachment 4.19-B Pages 6 - 6 (f). Costs will be aggregated into one data base and the same rate will be used for personal care services under the §1115 waiver referenced in §1929 (b) (2) (B) and will ensure equal treatment of all recipients receiving personal care.
43. **Licensed Clinical Social Worker Services**

Payment to licensed clinical social workers for mental health counseling for emotional disorders or conditions is limited to the lesser of the actual charge or 70 percent of the existing fee for similar services provided by psychiatrists and psychologists made in accordance with Item 1 of this attachment, relating to the reimbursement methodology for physicians and certain other practitioners.

(a) All fee schedules are available through the agency’s website as outlined on Attachment 4.19-B, page 1.

(b) The agency’s fee schedule was revised with new fees for licensed clinical social workers effective July 1, 2013, and this fee schedule will be posted on the agency’s website on July 15, 2013.

44. **Licensed Professional Counselor Services**

Payment to licensed professional counselors for mental health counseling for emotional disorders or conditions is limited to the lesser of the actual charge or 70 percent of the existing fee for similar services provided by psychiatrists and psychologists made in accordance with Item 1 of this attachment, relating to the reimbursement methodology for physicians and certain other practitioners.

a) All fee schedules are available through the agency’s website as outlined on Attachment 4.19-B, page 1.

(b) The agency’s fee schedule was revised with new fees for licensed professional counselors effective July 1, 2013, and this fee schedule will be posted on the agency’s website on July 15, 2013.
43. Licensed Clinical Social Worker Services

Payment to licensed clinical social workers for mental health counseling for emotional disorders or conditions is limited to the lesser of the actual charge or 70 percent of the existing fee for similar services provided by psychiatrists and psychologists made in accordance with Item 1 of this attachment, relating to the reimbursement methodology for physicians and certain other practitioners.

(a) All fee schedules are available through the agency’s website as outlined on Attachment 4.19-B, page 1.

(b) The agency’s fee schedule was revised with new fees for Licensed Clinical Social Workers effective September 1, 2013, and this fee schedule will be posted on the agency’s website on September 15, 2013.

44. Licensed Professional Counselor Services

Payment to licensed professional counselors for mental health counseling for emotional disorders or conditions is limited to the lesser of the actual charge or 70 percent of the existing fee for similar services provided by psychiatrists and psychologists made in accordance with Item 1 of this attachment, relating to the reimbursement methodology for physicians and certain other practitioners.

a) All fee schedules are available through the agency’s website as outlined on Attachment 4.19-B, page 1.

(b) The agency’s fee schedule was revised with new fees for licensed professional counselors effective September 1, 2013, and this fee schedule will be posted on the agency’s website on September 15, 2013.

State: Texas
Date Received: 30 September, 2013
Date Approved: 27 May, 2014
Date Effective: 1 September, 2013
Transmittal Number: 13-39
45. Licensed Marriage and Family Therapist Services

Payment to licensed marriage and family therapists for mental health counseling for emotional disorders or conditions is limited to the lesser of actual charge or 70 percent of the existing fee for similar services provided by psychiatrists and psychologists made in accordance with Item 1 of this attachment, relating to the reimbursement methodology for physicians and certain other practitioners.

(a) All fee schedules are available through the agency's website as outlined on Attachment 4.19-B, page 1.

(b) The agency's fee schedule was revised with new fees for licensed marriage and family therapist services effective September 1, 2013, and this fee schedule will be posted on the agency's website on September 15, 2013.
46. Renal Dialysis Facility Services

(a) Payment for in-facility renal dialysis treatment services and home renal dialysis treatment services is based upon the composite rate reimbursement methodology used by Medicare. The composite rates reflect all changes enacted by the Balanced Budget Refinement Act of 1999 (BBRA).

(b) All required items and services included under the composite rate must be made available by the facility, either directly or under arrangements, for each dialysis patient. If the facility fails to make available (either directly or under arrangements) any item or service listed in this subsection, or any part of an item or service listed in this subsection (b), then the facility cannot be reimbursed any amount for items and services that the facility provides. Required items and services include:

1. medically necessary dialysis equipment and dialysis support equipment;
2. home dialysis support services including the delivery, installation, maintenance, repair, and testing of home dialysis equipment, and home support equipment;
3. purchase and delivery of all necessary dialysis supplies, except blood which is separately reimbursable under this state plan;
4. routine end-stage renal dialysis (ESRD) related laboratory tests; and
5. all dialysis services furnished by the facility's staff.

(c) The following items and services also are included in the composite rate and are not billed separately when provided by a dialysis facility:

1. cardiac monitoring;
2. catheter changes;
3. crash cart usage for cardiac arrest;
4. declotting of shunts by facility staff and any supplies used to declot shunts;
5. dialysate used during treatment;

SUPERSEDES: TN- _09-23_

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Supersedes TN No. _09-23_
46. Renal Dialysis Facility Services (continued)

(6) oxygen and administration of oxygen;

(7) staff time used to administer blood, inject separately billable drugs, blood
collection, and non-routine peritoneal items;

(8) suture removal and dressing changes; and

(9) other items and services related to dialysis treatment, as determined by
HHSC.

(d) All fee schedules are available through the agency’s website, as outlined on

(e) The reimbursement rate for services effective September 1, 2011 will be equal to
the reimbursement rate on August 31, 2010, less seven percent.

(f) The agency’s fee schedule contains the current fees in effect as of the date of
this plan amendment, which is effective September 1, 2011 and is effective for
services provided on or after that date. This fee schedule was posted on the
agency’s website on September 9, 2011.
47. Specialized Skills Training

(a) The Commission determines a prospective uniform reimbursement rate for the Texas Early Childhood Intervention Program (ECI) Medicaid programs. Early Childhood Intervention program providers are reimbursed according to the reimbursement methodology. The Commission determines the rate based on costs contained in the ECI providers' cost reports, which are reported on a quarterly basis. The recommended rate is determined in the following manner:

1. Salaries and benefits for staff delivering services are added to allocated costs for ECI overhead and host agency administration costs.

2. These total costs for services are divided by the total direct service hours to calculate a cost per hour.

3. The resulting total cost per hour for services is projected from the historical reporting period to the perspective rate period using the Personal Consumption Expenditures (PCE) Chain-Type Index.

4. The projected total cost per hour for services is the proposed reimbursement rate. The reimbursement rate will be paid on an hourly basis, and will be pro-rated for 15-minute intervals.

5. The provider's reported costs will be examined annually to determine if it is necessary to re-base the rate.

(b) The Commission establishes the reimbursement rate following a public meeting after consideration of financial and statistical information and public testimony.

(c) Effective October 1, 2011, a reimbursement rate is added to allow for the provision of specialized skills training in a group setting.

(d) The rate of $119.69 per hour, which has been in effect since October 1, 2006, is adjusted by applying inflation from federal fiscal year 2007 to federal fiscal year 2010 of 5.71 percent to calculate the individual rate of $126.52 to be effective on or after March 15, 2010.

(e) All fee schedules are available through the agency's website as outlined on Attachment 4.19-8, Page 1.
48. Reimbursement methodology for outpatient services provided in Indian Health Services facilities operating under the authority of P. L. 93-638.

For outpatient services provided to Native Americans by a qualified facility operated by the Indian Health Service or tribe, the applicable rate will be paid as published and specified by the Office of Management and Budget (OMB) in the Federal Register.
49. Physician Assistants

(a) Payment for covered professional services provided by a physician assistant (PA) and billed under the PA’s own provider number is limited to the lesser of the provider’s billed charges or 92 percent of the rate reimbursed to a physician for the same professional service made in accordance with Item 1 of this attachment, relating to the reimbursement methodology for physicians and certain other practitioners. Payment to PAs is the same level as physicians for laboratory services, x-ray services, injections, family planning services, drugs and supplies.

(b) All fee schedules are available through the agency’s website, as outlined on Attachment 4.19-B, page 1.

(c) The agency’s fee schedule was revised with new fees for physician assistants effective February 1, 2011, and is effective for services provided on or after that date. This fee schedule will be posted on the agency’s website on April 8, 2011.

(d) The reimbursement for services effective September 1, 2010 through January 31, 2011 will be equal to the reimbursement on August 31, 2010, less one percent. For new reimbursement rates or reimbursement rates that were revised after August 31, 2010, for services effective September 1, 2010 through January 31, 2011, the reimbursement will be reduced by one percent.

(e) The reimbursement for services effective February 1, 2011 will be equal to the reimbursement on August 31, 2010, less two percent. For new reimbursement rates or reimbursement rates revised after August 31, 2010, for services effective February 1, 2011, the reimbursement will be reduced by two percent.
Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), and 1903 of the Social Security Act with respect to non-payment for provider-preventable conditions.

In compliance with 42 CFR 447.26(c), the Medicaid Agency provides:

a) That no reduction in payment for a provider preventable condition (PPC) will be imposed on a provider when the condition identified existed prior to the initiation of treatment by that provider. Reductions are only applied to claims if the present on admission (POA) indicates that the condition occurred during the hospital stay. Claims indicating that conditions are present at the time of admission are not subject to reductions.

b) That reductions in provider payment may be limited to the extent that the following apply:

1. The identified provider preventable conditions would otherwise result in an increase in payment. The claim payment is only reduced if the disallowance of the diagnosis results in a downgrade to the APR-DRG.

2. The State can reasonably isolate, for non-payment, the portion of the payment directly related to the treatment of a PPC. The State reduces the payment only if the treatment of the PPC would increase the APR-DRG payment. The payment is based on the disallowance of the diagnosis codes that are considered to be acquired while the patient is in the hospital.

c) Assurance that non-payment for PPC does not prevent access to services for Medicaid beneficiaries. Claims with PPCs are still reimbursed by the Medicaid program. The only impact to the claim is to lower the payment to eliminate payment for the acquired condition.
Payment Adjustment for Provider Preventable Conditions (continued)

Other Provider-Preventable Conditions

The State identifies the following other provider preventable conditions for non-payment under Section(s) 4.19-B.

- Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

☐ Additional other provider preventable conditions identified below:

Payment Adjustment Methodology

The Texas Medicaid Management Information system requires POA indicators to be submitted with each diagnosis code on inpatient hospital claims. Those POA indicators will guide the payment of the claim. The claim is initially sent to the APR-DRG grouper with all diagnosis codes and a "Non-POA" APR-DRG is assigned to the claim. If the claim is found to have a diagnosis that was not present at the time of admission based on the POA indicator, that diagnosis is disallowed and the claim is re-grouped. The process will downgrade the assigned APR-DRG to a lesser APR-DRG, which will result in a smaller payment. Where DRGs are not applicable, claims with any Other Provider Preventable Conditions identified will not be paid.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: Texas

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

Except for a nominal recipient copayment (as specified in Attachment 4.18 of this state plan), if applicable, the Medicaid agency uses the following general method for payment:

1. Payments are limited to state plan rates and payment methodologies for the groups and payments listed below and designated with the letters "SP".

   For specific Medicare services which are not otherwise covered by this state plan, the Medicaid agency uses Medicare rates unless a special rate or method is set out on Page 3 in items 1, 2, & 3 of this attachment.

2. Payments are up to the full amount of the Medicare rate for the groups and payments listed below, and designated with the letters "MR."

3. Payments are up to the amount of a special rate, or according to a special method, described on Page 3 in item ______ of this attachment, for those groups and payments listed below and designated with the letters "NR".

4. Any exceptions to the general methods used for a particular group or payment are specified on Page 4 in items 5 & 6 of this attachment.

STATE: Texas
DATE REC'D: 3-29-13
DATE APVD: 6-12-13
DATE EFF: 1-1-13
HOFA 179: 13-01

TN: 13-01 Approval Date: 6-12-13 Effective Date: 1-1-13

Supersedes TN: 13-22

SUPERSEDES: TN- 12-2-2
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
State/Territory: Texas

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES  
OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

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<td>*Part B MR Deductibles</td>
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<td>*Part B MR Deductibles</td>
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* The payment of the Medicare Part B deductible and coinsurance for services listed in Supplement 1 to Attachment 4.19-B, Page4, item 6 is based on the Medicare rate.

TN: 13-01  
Approval Date: 6-12-13  
Effective Date: 1-1-13

Supersedes TN: 12-22

SUPERSEDES: TN- 12-22
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinurance

* The payment of the Medicare Part A deductible and coinsurance for inpatient hospital services and the payment of the Medicare Part B deductible and coinsurance for outpatient and professional services are based on the following. The payment of all other Part A deductible and coinsurance is based on the Medicare rate.

1. If the Medicare payment amount equals or exceeds the Medicaid payment rate, the State is not required to pay the Medicare deductible/coinsurance on a crossover claim. However, for Part B services, the state will pay the Part B deductible for dual eligibles up to the annual maximum deductible amount set by Medicare each year.

2. If the Medicare payment amount is less than the Medicaid payment rate, the State is required to pay the Medicare deductible/coinsurance on a crossover claim, but the amount of payment is limited to the lesser of the deductible/coinsurance (resulting in a combined Medicare/State payment amount equal to the Medicare rate) or the amount remaining after the Medicare payment amount is subtracted from the Medicaid payment rate (resulting in a combined Medicare/State payment amount equal to the Medicaid payment rate). However, for Part B services, the state will pay the Part B deductible for dual eligibles up to the annual maximum deductible amount set by Medicare each year.

3. If a claim for Part B services includes both deductible and coinsurance owed, the State will pay the Part B deductible for dual eligibles up to the annual maximum deductible amount set by Medicare each year. To determine how much coinsurance to pay, the State will consider the total of the Medicare payment and the deductible payment. If the total of these two payments is more than the Medicaid payment rate, then the State will not pay any coinsurance on the claim. If the total of these two payments is less than the Medicaid payment rate, then the State will pay the amount remaining after the total payment amount (Medicare payment plus deductible payment) is subtracted from the Medicaid payment rate (resulting in a combined Medicare/State payment equal to the Medicaid payment rate).

TN: 13-01 Approval Date: 6-10-13 Effective Date: 1-1-13

Supersedes TN: 12-35
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: Texas

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

4. Coverage of a recipient's deductible and/or coinsurance liabilities as specified in this section satisfies the State's obligation to provide Medicaid coverage for services that would have been paid in the absence of Medicare coverage.

5. On crossover claims from renal dialysis facility providers, the payment will be equal to the Medicare coinsurance minus five percent. For renal dialysis claims, the state will pay the Part B deductible for dual eligibles up to the annual maximum deductible amount set by Medicare each year.

6. The payment of the Medicare Part B deductible and coinsurance for the following types of crossover claims is based on the Medicare rate:
   • services provided by psychiatrists, psychologists, and licensed clinical social workers;
   • codes R0070 and R0075, related to the transport of portable x-ray equipment; and
   • ambulance services, including ground and air ambulance services.
METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES – OTHER TYPES OF CARE

COORDINATION OF TITLE XIX WITH PART A AND PART B OF TITLE XVIII FOR INDIVIDUALS WHO ENROLL WITH MEDICARE ADVANTAGE HEALTH PLANS THAT ENTER INTO A MEDICARE ADVANTAGE PLAN AGREEMENT WITH THE CENTERS FOR MEDICARE AND MEDICAID SERVICES.

I. Definitions

For purposes of this provision, the following terms mean:

- **Cost Sharing Obligations** mean those financial payment obligations incurred by the State in satisfaction of the deductibles, coinsurance, and co-payments for the Medicare Part A and Part B programs with respect to Dual Eligible Members. Cost Sharing Obligations do not include: (1) Medicare premiums that the State is required to pay under the Texas State Plan on behalf of Dual Eligible Members; (2) wrap-around services that are covered by Medicaid; or (3) effective March 1, 2015, coinsurance for Part A-like services provided during a Dual Eligible Member's Medicare-covered stay in a nursing facility.

- **Dual Eligible** means a Medicare Managed Care recipient who is also eligible for Medicaid, and for whom the State has a responsibility for payment of Cost Sharing Obligations under the Texas State Plan. The categories of Dual Eligibles covered by this State Plan Amendment are limited to: QMB Only, QMB Plus, and SLMB Plus.

- **Dual Eligible Member** means a Dual Eligible who is eligible to participate in, and voluntarily enrolled in, the Medicare Advantage Health Plan’s MA Product.

- **MA Agreement** means the Medicare Advantage Health Plan agreement between a health plan and the Centers for Medicare and Medicaid Services (CMS) to provide the MA Product.

- **MA Product** means the Medicare Part C and other health plan services provided to MA Health Plan members pursuant to an MA Agreement.
I. Definitions (continued)

- **MA Health Plan** means a health plan that has entered into a MA Agreement with the CMS.

- **Nonparticipating Plan** means a MA Health Plan that has not entered into a State Agreement.

- **Participating Plan** means a MA health plan that has entered into a state agreement.

- **State** means the State of Texas.

- **State Agreement** means the agreement between the State of Texas and an MA health plan whereby the MA health plan receives a monthly capitated payment.

II. Scope

The State will enter into state agreements with MA health plans whereby the State will pay the MA health plans a monthly capitated payment. In exchange, the MA health plan will pay health care providers the cost sharing obligations attributable to dual eligible members. The capitated payment will represent payment in full for the cost sharing obligations attributable to a dual eligible member under sections 3.2 and 4.19-B of the Texas State Plan, plus all costs associated with the administration of the state agreement. Nothing herein precludes an MA health plan from entering into agreements with network providers that vary the amount or method of payment for the cost sharing obligations or from utilizing the MA health plan's coordination of benefits procedures.

For participating plans, the state agreement will be the only vehicle for recovery of the cost sharing obligations attributable to dual eligible members. A participating plan may not seek additional payments from the State or dual eligible members for such cost sharing obligations.

A health care provider who provides services to a participating plan's dual eligible member must seek payment for the member's cost sharing obligations from the participating plan. Such health care provider may not seek payment for the member's cost sharing obligations from the State or the dual eligible member.

A non-participating plan is not entitled to recover cost sharing obligations attributable to a dual eligible member from the State or the dual eligible member.
II. Scope (continued)

A health care provider who provides services to a non-participating plan’s dual eligible member may submit a claim for cost sharing obligations to the State’s claims administrator. The cost sharing obligations are limited to state plan rates and payment methodologies. The claim must comply with the State’s requirements for electronic or manual claims adjudication. Such health care provider may not seek payment for the member’s cost sharing obligations from the dual eligible member.

III. Methodology

The State has set the capitation for participating plans at $10 per member per month. This capitation is intended to provide for cost sharing obligations for dual eligible members in Texas. The capitation rate was established based on an analysis of the following: (a) the managed care experience for a large sample of dual eligible members, (b) information regarding current market cost-sharing arrangements for comparable MA health plans, (c) information from other states regarding how they reimburse MA health plans for member cost sharing, and (d) comments from MA health plans that currently participate in Texas.
Explanation of Supplement 2 "Missing":

When the State submitted TX 08-001, the State added Supplement 2 to Attachment 4.19 B, Pages 1, 2, and 3 (all new pages). These pages should be a part of Supplement 1 to Attachment 4.19 B and not a new Supplement 2 to Attachment 4.19 B. CMS requested that the State change the pages to reflect the correct CMS template page identification for pages related to Supplement 1 to Attachment 4.19B.

Changes have been made under SPA 14-046:

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<td>Page 5</td>
<td>Page 1 (TN 08-01)</td>
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<td>Page 6</td>
<td>Page 2 (TN 11-45)</td>
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<td>Page 7</td>
<td>Page 3 (TN 11-45)</td>
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Consumer Directed Personal Assistance Services

(1) The participant’s budget is calculated by multiplying the payment rate(s) for the consumer-directed service(s) identified in the service plan by the units of service identified in the plan. The participant’s budget accounts for hourly payments made for Support Consultation services.

(2) The payment rate for Consumer Directed Services is calculated as follows:

(a) The payment rate for consumer directed services is calculated based on the expected reimbursement for such services under the state plan for adults or 1915(c) waivers for children in EPSDT, adjusted by $1.00 per unit to account for the self-directed service delivery model.

(b) The hourly payment rate for Support Consultation services is determined by modeling the cost of providing this service using staff costs and other statistics from cost report data for staff whose required qualifications are similar to the qualifications required for individuals delivering Support Consultation services.
Community First Choice (CFC) Reimbursement Methodology

(a) Except as otherwise noted in the plan, State-developed fee schedule rates are the same for both government and private providers of services provided under the CFC option. The agency’s fee schedule is effective for services provided on or after June 1, 2023. All rates are published at: https://pfd.hhs.texas.gov/ and http://public.tmhp.com/FeeSchedules/StaticFeeSchedule/FeeSchedules.aspx.

(b) State Plan CFC Services: Rates are established using pre-existing rates from other programs.

(1) STAR+PLUS Personal Assistance Services (PAS) CFC, STAR+PLUS Habilitation CFC, and STAR Kids Habilitation and Attendant Care CFC: Rates will be equal to a weighted average of rates established for Community Living Assistance and Support Services (CLASS) waiver habilitation services according to the reimbursement methodology for the CLASS waiver program and proxy rates for attendant services used in the calculation of the STAR+PLUS managed care capitation rates for the Home and Community-based Services (HCBS) risk group. The weighted average will include applicable attendant compensation rate enhancements. The fee schedule for STAR+PLUS PAS, STAR+PLUS Habilitation, and STAR Kids Habilitation and Attendant Care was revised and posted on the agency website on September 1, 2019.

(A) Proxy rates are equal to rates established for attendant services under the Community Based Alternatives (CBA) waiver prior to its termination, updated for changes in allowable reported expenses and units of service.

(B) Weighting factors assume that 30 percent of personal attendant services historically provided to existing recipients in the STAR+PLUS HCBS risk group and 100 percent of personal attendant services provided to newly eligible recipients under CFC will be for habilitation.

(C) CLASS waiver habilitation rates and proxy rates for CBA waiver attendant services are current as of September 1, 2019.

(2) CLASS Habilitation CFC: Rates will be equal to rates established for CLASS waiver habilitation services, including applicable attendant compensation rate enhancements, according to the reimbursement methodology for the CLASS waiver program. The fee schedule for CLASS waiver habilitation rates was revised and posted on the agency website on September 1, 2015.
Community First Choice (CFC) Reimbursement Methodology (continued)

(3) Deaf-Blind with Multiple Disabilities (DBMD) Residential Habilitation
CFC: Rates will be equal to rates established for DBMD waiver residential habilitation services, including applicable attendant compensation rate enhancements, according to the reimbursement methodology for the DBMD waiver program. The fee schedule for DBMD waiver residential habilitation rates was revised and posted on the agency website on September 1, 2019.

(4) Home and Community-Based Services (HCS) Supported Home Living (SHL) CFC: Rates will be equal to rates established for HCS waiver SHL transportation services, including applicable attendant compensation rate enhancements, according to the reimbursement methodology for the HCS waiver program. The HCS waiver SHL transportation rate fee schedule was revised and posted on the agency website on September 1, 2015.

(5) Texas Home Living (TxHmL) Community Support Services (CSS)
CFC: Rates will be equal to rates established for TxHmL waiver CSS transportation, including applicable attendant compensation rate enhancements, according to the reimbursement methodology for the TxHmL waiver program. The TxHmL waiver CSS transportation rates fee schedule was revised and posted on the agency website on September 1, 2015.

(6) Personal Care Services (PCS) Attendant Care CFC: Rates will be equal to rates established for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) PCS attendant services according to Item 32 of Attachment 4.19-B of this State plan. The PCS attendant services fee schedule was revised and posted on the agency website on September 1, 2019.

(7) PCS Habilitation CFC: Rates will be equal to rates established for EPSDT PCS services for recipients with a behavioral health condition according to Item 32 of Attachment 4.19-B of this State plan. The PCS behavioral services rates fee schedule was revised and posted on the agency website on September 1, 2019.

(8) CFC Consumer Directed Services (CDS): The rates for CFC services included in the CDS option provide the funds available to the consumers participating in CDS. These rates are modeled and based on the rates paid to contracted agencies for providing services through the agency option. The fee schedules for CDS rates for all CFC services were revised and posted on the agency website on September 1, 2019. The STAR Kids CFC Habilitation and Attendant Care CDS rate, effective June 1, 2023, was revised further and will be posted on the agency website by September 1, 2023.
Community First Choice (CFC) Reimbursement Methodology (continued)

(9) CFC Support Consultation Services: Rates are determined by modeling the cost of providing this service using staff costs and other statistics from the most recently audited cost reports from providers for staff whose required qualifications are similar to the qualifications required for individuals delivering this service. CFC support consultation services are only available to consumers participating in CDS and who receive CFC services that are included in the CDS option. The fee schedules for CFC support consultation services were revised and posted on the agency website on September 1, 2019.

(10) Emergency Response Services (ERS) CFC: The Health and Human Services Commission (HHSC) determines the payment rate through the analysis of financial and statistical data submitted by provider agencies on cost reports and, as deemed appropriate, a market survey analysis of emergency response equipment suppliers.

(A) Allowable expenses are projected from the provider agency's reporting period to the rate period using the Personal Consumption Expenditures (PCE) chain-type price index. Depreciation and mortgage interest are not adjusted for inflationary increases.

(B) Allowable reported expenses are combined into three cost areas: responder, program operations, and facility. To determine the projected cost per unit of service, a contracted provider's projected expenses in each cost area are divided by its total units of service for the reporting period.

(C) The contracted providers' projected costs per unit of service are ranked from low to high in each cost area, with corresponding units of service.

(D) The 80th percentile cost, weighted by units of service, is determined for each cost area. The payment rate is the sum of the 80th percentile costs of the three cost areas.

(E) ERS rates are current as of June 1, 2015.

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TN: 22-0028 Approval Date: March 1, 2023
Supersedes TN: 19-0034 Effective Date: 09-01-2022
Community First Choice (CFC) Reimbursement Methodology (continued)

(c) Changes to Reimbursement Methodologies: Whenever a change is made to any of the reimbursement methodologies described in subsections (1) through (12) above which is anticipated to cause a change in the rate payable to a provider, a state plan amendment will be submitted.
1905(a)(29) Medication-Assisted Treatment (MAT)

Medicaid providers of MAT are reimbursed based on fee schedules as follows:

a) Payment for covered Medication Assisted Treatment Services provided by eligible providers is limited to the lesser of the customary charge or the allowable rates per established fee schedule by the single state agency.

b) The reimbursement for unbundled prescribed drugs and biologicals used to treat opioid use disorder will be reimbursed using the same methodology as described for prescribed drugs located in Attachment 4.19-B, pages 2b, 2c, 2c.1, 2c.2, 2c.3, and 2c for drugs that are dispensed or administered.

c) The fee schedule established by HHSC is based on (1) the published Medicare reimbursement rate; (2) the average wholesale price (AWP) or provider invoice cost; (3) a medically comparable code; and/or some combination or percentage thereof.

d) Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Medication-Assisted Treatment Services.

e) All fee schedules are available through the agency’s website as outlined on Attachment 4.19-B, Page 1.

f) The agency’s fee schedule for MAT services is revised with updates in alignment with Attachment 4.19-B Page 1a.3 of the Texas Medicaid State Plan.

TN: 22-0035 Approval Date: March 22, 2023
Supersedes TN: 21-0004 Effective Date: 09-01-2022
Financial Services Management Agency (FMSA) Reimbursement Methodology

(a) The monthly payment to the FMSA is determined using provider cost data, collected on a biennial basis. The FMSA monthly rate equals a weighted average of allowable FMSA costs, adjusted from the cost reporting year to the perspective rate year. FMSA services are authorized only for consumers participating in Consumer Directed Services (CDS) and who receive CDS services. The fee schedule for FMSA payments was revised, effective September 1, 2022.
Hospital Augmented Reimbursement Program (HARP) Methodology for Non-state government-owned and operated hospitals (Outpatient Payments)

(a) Introduction. Non-state government-owned and operated hospitals participating in the Texas Medicaid program that meet the conditions of participation and serve fee-for-service patients are eligible for reimbursement. The non-federal share of the payments is funded through intergovernmental transfer (IGT). The Health and Human Services Commission (HHSC) will establish each hospital's eligibility for an amount of reimbursement using the methodology described in this appendix.

(b) Definitions

(1) Fee-for-Service (FFS)--A system of health insurance payment in which a health care provider is paid a fee by HHSC through the contracted Medicaid claims administrator directly for each service rendered. For Texas Medicaid purposes, fee-for-service excludes any service rendered under a managed care program through a managed care organization.

(2) Intergovernmental transfer (IGT)--A transfer of public funds from another state agency or a non-state governmental entity to HHSC.

(3) Medicare payment gap--The difference between what Medicare is estimated to pay for the services and what Medicaid actually paid for the same services from the most recent FFS upper payment limit (UPL) demonstration.

(4) Non-state government-owned and operated hospital--A hospital that is owned and operated by a local government entity, including but not limited to a city, county, or hospital district.

(5) Outpatient hospital services--Preventive, diagnostic, therapeutic, rehabilitative, palliative services or a subset of these services identified by HHSC that are furnished to outpatients of a hospital under the direction of a physician or dentist.

(6) Program period--Each program period is equal to a federal fiscal year beginning October 1 and ending September 30 of the following year.
(7) Prospective Payment System--A method of reimbursement in which payment is made based on a predetermined, fixed amount.

(8) Sponsoring governmental entity--A state or non-state governmental entity that agrees to transfer to HHSC some or all of the non-federal share of program expenditures.

(9) State government-owned hospital--Any hospital owned by the state of Texas that is not considered an IMD.

(c) Participation requirements. As a condition of participation, all hospitals participating in the program must allow for the following.

(1) The hospital must submit a properly completed enrollment application by the due date determined by HHSC. The enrollment period must be no less than 15 business days, and the final date of the enrollment period will be at least nine days prior to the intergovernmental transfer (IGT) notification.

(2) If a provider has changed ownership in the past five years in a way that impacts eligibility for this program, the provider must submit to HHSC, upon demand, copies of contracts it has with third parties with respect to the transfer of ownership or the management of the provider and which reference the administration of, or payment from, this program.

(d) Payments for non-state government-owned and operated hospitals.

(1) Eligible hospitals. Payments under this subsection will be limited to hospitals defined as a "non-state government-owned and operated hospital" that are enrolled in Medicare and participate in Texas Medicaid fee-for-service.

(2) Non-federal share of program payments. The non-federal share of the payments is funded through IGTs from sponsoring governmental entities. No state general revenue is available to support the program.

(A) HHSC will communicate suggested IGT responsibilities. Suggested IGT responsibilities will be based on the maximum dollars to be available under the program for the program period as determined by HHSC. HHSC will also communicate estimated revenues each enrolled hospital could earn under the program for the program period with those estimates based on HHSC's suggested IGT responsibilities.

(B) HHSC will issue an IGT notification to specify the date that IGT is requested to be transferred not fewer than 14 business days before IGT transfers are due. HHSC may post the IGT deadlines and other associated information on HHSC's website, send
the information through the established Medicaid notification procedures used by HHSC's fiscal intermediary, send through other direct mailings, send through GovDelivery, or provide the information to the hospital associations to disseminate to their member hospitals.

(3) Payment Methodology. To determine each participating non-state government-owned and operated hospital’s outpatient HARP payment, HHSC will use the outpatient FFS Medicare payment gap.

(e) Changes in operation. If an enrolled hospital closes voluntarily or ceases to provide hospital services in its facility, the hospital must notify the HHSC Provider Finance Department by hand delivery, United States (U.S.) mail, or special mail delivery within 10 business days of closing or ceasing to provide hospital services. Notification is considered to have occurred when the HHSC Provider Finance Department receives the notice.

(f) Reconciliation. HHSC will reconcile the amount of the non-federal funds expended under this section during the program period with the amount of funds transferred to HHSC by the sponsoring governmental entities for that same period. If the amount of non-federal funds expended under this section is less than the amount transferred to HHSC, HHSC will refund the balance proportionally to how it was received.

(g) Payments under this section will be made on a semi-annual basis.

For fiscal year 2022, the following providers are eligible for a HARP payment:

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<tr>
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State Assurances with Respect to Limits on payment for Drugs

In accordance with 42 CFR §447.333, the Single State Agency finds and assures the following:

Payments for Drugs

a. In the aggregate, the Agency's Medical expenditures for multiple source drugs identified and listed in accordance with 42 CFR §447.332(a) are in accordance with the upper limits specified in 42 CFR §447.332(b) for the annual finding.

b. The upper limits referenced in a. may be exceeded only with physician certification as specified in 42 CFR §447.331(c).

c. The agency will make the annual findings as specified in accordance with 42 CFR §447.333 and make the findings and supplementary data available to HCFA upon request.

STATE ~ DATE REC'D ~ DATE APP'V'D ~ HCFA 179

Supersedes 87-21
State Assurances with Respect to

Limits on Payment for Drugs

In accordance with 42 CFR §447.333, the Single State Agency finds and assures the following:

Payments for Drugs

a. In the aggregate, the Agency's Medicaid expenditures for all other drugs are in accordance with 42 CFR §447.331.

b. The Agency will make the triennial findings as specified in accordance with 42 CFR §447.333 and make these findings and supplementary data available to HCFA upon request.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State of ___________________ Texas ___________________

PAYMENTS FOR RESERVED BEDS DURING RECIPIENTS ABSENCE FROM AN INSTITUTION

Subject to the qualifications, limitations and exclusions covering payments for medical and remedial care and services and elsewhere as provided in the State Plan, payment will only be made to eligible providers for reserving beds in Intermediate Care Facilities and Skilled Nursing Facilities for eligible recipients during temporary leaves of absence for therapeutic purposes not to exceed three days per leave of absence. Leaves must be authorized and documented by the recipients’s attending physician as part of the recipients’ total plan of care.

Subject to the qualifications, limitations and exclusions covering payments for medical and remedial care and services and elsewhere as provided in the State Plan, payment will only be made to eligible providers for reserving beds in Intermediate Care Facilities for the Mentally Retarded for eligible recipients during temporary leaves of absence for: (1) therapeutic purposes not to exceed three days per leave of absence and for (2) extended therapeutic purposes taken in increments of four or more days per absence not to exceed a total of ten days per resident per calendar year. One extended therapeutic leave may be combined with one therapeutic leave per calendar year. Leaves of absence must be authorized and documented by the recipient’s Qualified Mental Retardation Professional (QMRP), if not contraindicated by the attending physician.
Reimbursement Methodology for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)*

1. Authority. The Texas Health and Human Services Commission (HHSC), the Single State Medicaid Agency, has final approval authority of Medicaid payment rates. HHSC determines ICF/IID Medicaid payment rates after consideration of analysis of financial and statistical information, and the effect of the payment rates on the achievement of program objectives, including economic conditions and budgetary considerations.

2. General. Payment rates are uniform statewide for the same class of service and provider type. Payment rates are determined prospectively with retrospective adjustments as outline in this plan. The unit of service is a day of care provided to a Medicaid client. Payment rates will be determined for a period of two years for non-state operated facilities and for a period of one year to coincide with the state fiscal year for state-operated facilities.

3. Pro Forma Costing. When historical costs are unavailable, such as in the case of changes in program requirements, payment rates may be based on a pro forma approach. This approach involves using historical costs of delivering similar services, where appropriate data are available, and determining the types and costs of products and services necessary to deliver services meeting federal and state requirements.

4. Adjusting Payment Rates. HHSC may adjust payment rates to compensate for anticipated changes in laws, rules, regulations, policies, guidance, economic factors, or implementation of federal or state court orders or settlement agreements. Should HHSC adjust payment rates for these purposes, a state plan amendment will be submitted.

5. Cost Reports. In order to ensure adequate financial and statistical information upon which to base payment rates, each contracted provider is required to submit a cost report every other year and, if necessary, (a) supplemental report(s). It is the responsibility of the provider to submit accurate and complete information in accordance with all pertinent cost report rules and cost report instructions.

* "Intellectual disability" has the same meaning as "mental retardation" as used in other sections of the Texas Medicaid State Plan
Reimbursement Methodology for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), continued

6. Allowable and Unallowable Costs. Allowable and unallowable costs are defined to identify expenses that are reasonable and necessary to provide client contracted care and are consistent with federal and state laws and regulations.

(a) Allowable Costs. Allowable costs are expenses, both direct and indirect, that are reasonable and necessary in the normal conduct of operations to provide contracted client services meeting all pertinent state and federal requirements. Only allowable costs are included in the reimbursement determination process.

(b) Unallowable Costs. Unallowable costs are expenses that are not reasonable or necessary. Providers must not report as an allowable cost on a cost report a cost that has been determined to be unallowable.

(c) Detailed Definitions. Detailed definitions of allowable and unallowable cost are prescribed in Title 1 of the Texas Administrative Code, Chapter 355, Subchapter A, relating to Cost Determination Process.

(d) Changes to Allowable and Unallowable Costs. Whenever a change is made to the definitions of allowable and unallowable costs as described in subsection (C) of this section that is anticipated to cause a change in the rate payable to a provider, a state plan amendment will be submitted.

7. Desk Reviews and Field Audits. Desk reviews and field audits are performed on provider cost reports in order to ensure that financial and statistical information reported in the cost report conforms to all applicable rules and instructions.

8. Informal Reviews and Appeals. A contracted provider may request an informal review and, subsequently, an appeal of a desk review or field audit disallowance.
Reimbursement Methodology for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), continued

9. Projected Costs. HHSC projects ICF/IID providers’ costs by accounting for changes in cost-related conditions anticipated to occur between the base period and the prospective rate period. Such changes include, but are not limited to, wage-and-price inflation or deflation, changes in program utilization, modifications of federal or state regulations and statutes, and implementation of federal court orders and settlement agreements. The base period is a single state fiscal year spanning from September 1 through August 31, and the prospective rate period is two state fiscal years beginning with the first day of a state fiscal year which is at least one fiscal year after the base period year. Inflation factors and multipliers that HHSC uses to project costs from the base period to the prospective rate period are determined per 9(a) through 9(d).

(a) General Inflation Index. For general inflation adjustments, HHSC uses the Personal Consumption Expenditures (PCE) chain-type price index published by the Bureau of Economic Analysis of the U.S. Department of Commerce. HHSC uses a PCE forecast published by IHS Markit or its successor.

(b) Item-specific and Program-specific Inflation Indices. HHSC uses specific indices in place of the general inflation index when appropriate item- or program-specific inflation indices are available from cost reports or other surveys, other Texas state agencies, nationally recognized public agencies, or independent private firms or sources, and HHSC has determined that these specific inflation indices are derived from information that adequately represents the program(s) or cost(s) to which the specific index is to be applied. The item-specific index that HHSC uses for ICF/IID providers’ costs is specified in (9)(c).

(c) For inflation adjustments of costs pertaining to wages and salaries of licensed vocational nurses and nurse aides, HHSC uses an employment cost index of wages and salaries for private industry workers in nursing and residential care facilities published by the U.S. Bureau of Labor Statistics. HHSC uses a forecast of this inflation index published by IHS Markit or its successor. Periodic reviews of the chosen inflation index will be performed based on cumulative cost report data on nursing wages and salaries.

(d) Adjustment of Tax Rates. HHSC includes Federal Insurance Contributions Act (FICA) payroll tax rates, such as for Social Security taxes and Medicare taxes, and federal and state unemployment tax rates in its projected costs of non-contracted staff salaries and wages. When a FICA tax rate or unemployment tax rate is amended per federal or state statute, HHSC adjusts its cost projections in accordance with the amended tax rate.

(e) State-operated facility costs used in the interim payment rate determination are adjusted in accordance with 10(a)(2)(A).
Reimbursement Methodology for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), continued

10. Payment Rate Determination. Payment rates are determined for services provided to eligible consumers in ICF/IID facilities. HHSC determines payment rates for two types of facilities: state-operated and non-state operated.

(a) State-Operated Facilities. HHSC determines interim payment rates at least once annually. Interim rates are uniform statewide by class and do not vary by level of need. Interim rates are set prospectively with one or more settlements per fiscal year.

(1) Rate classes. The state-operated facilities are divided into two classes that are determined by the size of the facility.

(A) Large facility — A facility with a Medicaid certified capacity of 17 or more as of the first day of the full month immediately preceding a rate’s effective date or, if certified for the first time after a rate’s effective date, as of the date of the initial certification.

(B) Small facility — A facility with a Medicaid certified capacity of 16 or fewer as of the first day of the full month immediately preceding a rate’s effective date or, if certified for the first time after a rate’s effective date, as of the date of initial certification.

(2) Determination of State-Operated Facility Rates. Eligible state-operated facilities are reimbursed an interim rate with a settlement. HHSC will determine payment rates for state-operated facilities in the following manner:

(A) An interim payment rate is determined by unit of service for each class of state-operated facility based on the most recent cost reports accepted by HHSC adjusted to reflect changes in projected expenditures resulting from changes in economic conditions, occupancy levels, and projected operating budgets. Costs reported on the state-operated cost reports include all Medicaid allowable costs expended at the state-operated facilities including medical expenses and drug costs not paid through the consumer’s Medicaid card or Medicare Part D.

(B) A settlement is determined for each state-operated facility on a facility-by-facility basis based on cost reports for the rate period as audited by HHSC. If there is a difference between the allowable costs from the audited cost reports and the reimbursement due under the interim payment rate, including adjustments for applied income for the state fiscal year.
Reimbursement Methodology for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), continued

(C) Since provision is made to ensure that reasonable and necessary costs are covered, state-operated facilities do not qualify for additional supplemental reimbursement for individuals whose needs require a significantly greater than normal amount of care.

(D) Cost reports from facilities in this class will not be included in the cost arrays that are used to determine reimbursement rates for other classes of providers.

(E) During any fiscal year, if HHSC determines that actual costs merit a partial settlement related to that fiscal year to ensure the uninterrupted delivery of Medicaid services to individuals with intellectual disabilities, HHSC will initiate such a partial settlement. Following each fiscal year, HHSC will initiate an annual settlement to adjust Medicaid reimbursements to recover actual costs for that fiscal year.
Reimbursement Methodology for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), continued

(b) Non-state-operated Facilities. This facility type includes both private and non-state governmental owned facilities. HHSC determines payment rates. Payment rates are uniform statewide by class and by level of need. Payment rates are determined prospectively.

(1) Rate classes. The non-state-operated facilities are divided into three classes that are determined by the size of the facility:

(A) Large facility — a facility with Medicaid certified capacity of 14 or more beds as of the first day of the full month preceding the rate’s effective date or, if certified for the first time after a rate’s effective date, as of the date of the initial certification;

(B) Medium facility — a facility with Medicaid certified capacity of nine through 13 beds as of the first day of the full month preceding the rate’s effective date or, if certified for the first time after a rate’s effective date, as of the date of the initial certification; and

(C) Small facility — a facility with Medicaid certified capacity of eight or fewer beds as of the first day of the full month preceding the rate’s effective date or, if certified for the first time after a rate’s effective date, as of the date of the initial certification.

(2) Cost components. The modeled rates described in section 10(b)(3) are based on cost components shown below. The determination of these cost components is based on historical costs and financial, statistical, and operational information collected from ICF/IID providers. Included in the costs are:

(A) Direct services costs, included compensation costs for direct care personnel and direct care supervisors.

(B) Other resident care costs, including compensation costs for laundry and housekeeping personnel, social workers, medical records personnel, resident care training personnel, therapists, psychologists and other direct care consultants, as well as costs for medical equipment and supplies, and laundry/housekeeping equipment and supplies.
Reimbursement Methodology for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), continued

(C) Dietary costs, including compensation costs for dietary personnel as well as costs for food and dietary supplements.

(D) Transportation, facilities and operations costs, including compensation costs for maintenance personnel and drivers, maintenance supplies, contract maintenance and repairs, building and building equipment, departmental equipment and transportation equipment rental/lease and depreciation, land and leasehold improvement, depreciation/amortization, mortgage interest, property taxes, property and vehicle insurance, and utilities and telecommunications.

(E) Administration expenses, compensation costs for administration personnel such as facility administrator, clerical support and central office staff, management contract fees, professional service fees, contracted administrative staff, general liability insurance, interest expense on working capital, allowable advertising, travel and seminars, dues and subscriptions, office supplies, central office costs, and other office expenses.

(3) Determination of modeled rates. The modeled rates are determined using the most recent audited cost reports available at the time the proposed rates are calculated and projected to the rate period. HHSC adjusts reported expenses using a cost finding methodology to determine daily allowed costs. Providers are responsible for eliminating all unallowable expenses from the cost report. HHSC will exclude unallowable costs from the cost report and will exclude entire cost reports from rate determination if it believes that the cost reports do not reflect economic and efficient use of resources.
Reimbursement Methodology for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), continued

(4) Levels of need. Non-state operated daily reimbursement rates will be differentiated based on consumer level of need and the facility class. The level of need system is a classification system that differentiates rates based on the needs of the individuals served.

(A) The level of need classification is based upon the Inventory for Client and Agency Planning (ICAP) service levels. Individuals are classified in the intermittent category if they have an ICAP service level of 7, 8, or 9; individuals are classified at a limited level if they have an ICAP service level of 4, 5, or 6; individuals are classified at an extensive level if they have an ICAP service level of 2 or 3; individuals are classified as pervasive if they have an ICAP service level of 1; and individuals are identified as pervasive plus if they exhibit dangerous behaviors that require 1:1 supervision at least 16 hours per day.

(B) For individuals who have extraordinary medical needs or behavioral challenges, there is an opportunity to adjust the level of need to more appropriately reflect level of service needed. Individuals who receive three or more hours of nursing service a week are eligible to be moved to the next higher level of need (LON) category. An individual cannot move to the next higher LON category for both a medical and a behavior reason.

(5) Add-on reimbursement rate. There is an available add-on reimbursement rate, in addition to the daily reimbursement rate, for certain individuals.

(A) The add-on is based on the Resource Utilization Group (RUG-III) 34 group classification system, Version 5.20, index maximizing, as established by the State and the Centers for Medicare & Medicaid Services.

(B) There are three add-on groupings based on certain RUG-III 34 classification groups:

(i) Group 1 is comprised of Extensive Services 3 (SE3), Extensive Services 2 (SE2), and Rehabilitation D (RAD).

(ii) Group 2 is comprised of Rehabilitation C (RAC), Rehabilitation B (RAB), Extensive Services 1 (SE1), Special Care C (SSC), Special Care B (SSB), and Special Care A (SSA).

(iii) Group 3 is comprised of Rehabilitation A (RAA), and Clinically Complex groups CA1, CA2, CB1, CB2, CC1, and CC2.
Reimbursement Methodology for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), continued

(C) An individual must meet the following criteria to be eligible to receive the add-on rate:

(i) be assigned a RUG-III 34 classification in Group 1, Group 2, or Group 3;

(ii) be a resident of a large state-operated facility for at least six months immediately prior to referral; and

(iii) have a level of need which includes a medical level of need increase as described in (4)(B) above, but not be assessed a level of need of pervasive plus.

(D) The add-on for each Group is determined based on date and costs from the most recent nursing facility cost reports accepted by HHSC.

(i) For each Group, compute the median direct care staff per diem base rate component for all facilities as specified in the Nursing Facility State Plan Attachment 4.19-D(IV)(B)(3); and

(ii) Subtract the average nursing portion of the current recommended modeled rates as specified in 10(b)(3) of this attachment.

(E) Until such time as HHSC has received, verified and evaluated adequate cost data from participating ICF/IID providers, the add-on rate for each Group will be adjusted each time that HHSC adjusts the Nursing Facility RUG-III rate upon which it is based.

(F) The add-on rates can be found at httpsad.hhs.texas.gov/
Reimbursement Methodology for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), continued

11. Medical Service and Durable Medical Equipment Covered as ICF/IID Services. Individuals who reside in non-state operated ICF/IID facilities receive medical and dental service through the Medicaid identification card. With the exception of the durable medical equipment described in subparagraphs (A)-(D) below and augmentative communication devices (ACDs), any medical expenses other than services covered elsewhere in the State Plan are the responsibility of the ICF/IID provider. For durable medical equipment other than ACD, ICF/IID providers will be paid for the actual cost of a consumer's durable medical equipment costs up to $5,000 per consumer per year through a voucher system if:

(a) the cost of the equipment exceeds $1,000;

(b) the ICF/IID provider receives prior approval to purchase the equipment;

(c) the ICF/IID provider submits a voucher for the cost of the equipment; and

(d) if the consumer is eligible for Medicare benefits, the ICF/IID provider as submitted a Medicare claim prior to requesting payment.

Costs reimbursed through the voucher system are not used in setting the reimbursement rates for ICF/IID services.

12. Payment for Dental Services Available to Consumers in ICF/IID. Payments for dental services as described in item 15b of Appendix 1 to Attachment 3.1-A and Item 15b of Appendix 3.1-B for persons 21 years of age and older who reside in an ICF/IID will be based on Texas Health Steps policies, procedures, limitations, and rates, and will be obtained through the consumer's Medicaid card.

13. Medicare Part D. For individuals eligible for Medicare Part D, the cost of any drug that is in a category that is covered by Medicare Part D is unallowable for cost reporting purposes.


(a) HHSC or its designee reimburses ICF/IID providers for costs necessarily incurred to provide augmentative communication devices (ACDs) to residents of ICF/IID facilities that demonstrate a verifiable medical need. This payment is not part of the facility reimbursement rate and is a separate payment amount reimbursed to the ICF/IID through a voucher.

(b) The ICF/IID is required to request two bids for an ACD of a type that meets the recipient's need and the reimbursement of the devise will be the lesser of the two
Reimbursement Methodology for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), continued

bids. In the event that only one bid can be obtained due to a lack of ACD providers, a request for an exception will be considered by HHSC or its designee. Prior authorization is still required if an exception is granted by HHSC or its designee.
15. Reimbursement Methodology for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), continued

(A) Effective September 1, 2015, payment rates for non-state operated facilities, including both private and non-state government owned facilities, will be equal to the rates in effect on August 31, 2015, plus 2.02 percent. This payment rate increase uses the allowable/unallowable costs that are currently defined in the approved plan pages at Attachment 4.19-D, ICF/IID. These rates were posted on the agency's website at https://rad.hhs.texas.gov/ on September 1, 2015.

(B) The agency's fee schedule was revised with new rates for ICF/IID effective September 1, 2019, and the fee schedule was posted on the agency's website on September 1, 2019 at https://rad.hhs.texas.gov/. No payment under this section is dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.
Reimbursement Methodology for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), continued

16. Attendant Compensation Rate Enhancement

(a) Attendant compensation cost center. This cost center will include attendant employee salaries and/or wages (including payroll taxes, worker's compensation, or employee benefits), contract labor costs, and personal vehicle mileage reimbursement for attendants.

(b) Rate year. The rate year begins on the first day of September and ends on the last day of August of the following year.

(c) Open enrollment. Each contracted provider must notify HHSC in a manner specified by HHSC of its desire to participate or its desire not to participate in the Attendant Compensation Rate Enhancement and its desired level of participation in an enrollment period prior to the rate year.

(d) Determination of attendant compensation rate component for nonparticipating contracted providers. An attendant compensation cost center rate component will be calculated separately for day habilitation and residential services based on the percentage of the direct service cost component from (X)(B)(2)(a) accruing from day habilitation attendant compensation costs and residential attendant compensation costs, respectively.

(e) Determination of attendant compensation rate enhancements. Attendant compensation rate enhancement payment increments of $0.05 are associated with each attendant compensation rate enhancement level. The maximum number of rate enhancement payment levels is 25 for a maximum rate enhancement payment per unit of service of $1.25.
Reimbursement Methodology for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), continued

(f) Spending requirements for participating contracted providers. Participating contracts are subject to a spending requirement with recoupment calculated separately for their day habilitation and residential services as follows: Accrued attendant compensation revenue per unit of service is multiplied by 0.90 to determine the spending requirement per unit of service. The accrued attendant compensation spending per unit of service will be subtracted from the spending requirement per unit of service to determine the amount to be recouped. If the accrued attendant compensation spending per unit of service is greater than or equal to the spending requirement per unit of service, there is no recoupment. The amount paid for attendant compensation per unit of service after adjustments for recoupment must not be less than the amount determined for nonparticipating contracted providers.
Reimbursement Methodology for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), continued

17. Supplemental payments to qualifying non-state government-owned intermediate care facilities for individuals with intellectual disabilities (ICF/IID).

(a) The supplemental payments described in this section will be made in accordance with the applicable regulations regarding Medicaid upper payment limit provisions codified at Title 42 Code of Federal Regulations (CFR) § 447.272.

(b) Definitions. When used in this section, the following definitions apply:

(1) Aggregate upper payment limit — A reasonable estimate of the amount that would be paid for the services furnished by non-state government-owned ICFs/IID under Medicare payment principles.

(2) HHSC — The Texas Health and Human Services Commission or its designee.

(3) Intergovernmental transfer (IGT) — A transfer of public funds from a government entity to HHSC.

(4) Medicaid supplemental payment limit — The maximum supplemental payment available to a participating non-state government-owned ICF/IID for a specific Medicaid supplemental payment limit calculation period.

(5) Medicaid supplemental payment limit calculation period — The federal fiscal quarter determined by HHSC for which supplemental payment amounts are calculated.

(6) Non-state government-owned ICF/IID — An ICF/IID where a non-state governmental entity is party to the facility’s Medicaid contract.

(7) Non-state government-entity — A community center established under Chapter 534, Subchapter A of the Texas Health and Safety Code or a hospital authority, hospital district, health care district, city, or county.
Reimbursement Methodology for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), continued

(8) Public funds — Funds derived from taxes, assessments, levies, investments, and other public revenues within the sole and unrestricted control of the governmental entity that is party to the Medicaid contract of the ICF/IID. Public funds do not include gifts, grants, trusts, or donations, the use of which is conditioned on supplying a benefit solely to the donor or grantor of the funds.

(c) Medicaid supplemental payment limits.

(1) The aggregate supplemental payment amount for non-state government-owned ICFs/IID is calculated for each Medicaid supplemental payment limit calculation period by taking the difference between the aggregate upper payment limit from subparagraph (A) of this paragraph and the aggregate Medicaid payment from subparagraph (B) of this paragraph:

(A) The aggregate upper payment limit for non-state government-owned ICFs/IID will be calculated based on Medicare payment principles and in accordance with the Medicaid upper payment limit provisions codified at Title 42 CFR § 447.272. The aggregate upper payment limit is equal to the sum of the Medicare-equivalent payments for all non-state government-owned ICFs/IID. The Medicare-equivalent payment for each non-state government-owned ICF/IID is calculated as follows based on date from the most recent reliable Medicaid cost report.

(i) Determine the Medicare adjusted cost by subtracting ancillary and capital costs from total Medicaid allowable costs and multiplying the costs by 1.12.
Reimbursement Methodology for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), continued

(ii) Determine the Medicare adjusted cost per day of service by dividing
the value from clause (i) of this subparagraph by the total days of
service.

(iii) Determine the Medicare-equivalent payment by multiplying the result
from clause (ii) of this subparagraph by the total Medicaid days of
service.

(B) The aggregate Medicaid payment for non-state government-owned
ICFs/IID prior to the supplemental payment will be the sum of Medicaid
level of need (LON) payments for all non-state government-owned
ICFs/IID as captured on the most recent reliable Medicaid cost report.

(2) The Medicaid supplemental payment limit for each participating non-state
government-owned ICF/IID for each Medicaid supplemental payment limit
calculation period will be determined by dividing that facility’s Medicaid
days of service during the Medicaid supplemental payment limit calculation period
for all non-state government-owned ICFs/IID, multiplying the resulting
percentage by the aggregate supplemental payment amount from paragraph
(1) of this subsection, and dividing the resulting product by four.

(d) Payment frequency. HHSC will distribute Medicaid supplemental payments to
participating non-state government-owned ICFs/IID on a quarterly basis
subsequent to the Medicaid supplemental payment limit calculation period.

(e) Required application. Before a non-state government-owned ICF/IID may receive
supplemental payments under this section, the non-state governmental entity
that is party to the ICF/IID’s Medicaid provider agreement must submit a properly
completed “Medicaid Supplemental Payment Program Certification of ICF/IID
Participation.” The non-state governmental entity will use this form to certify that
it is a party to the ICF/IID’s Medicaid provider agreement.
Reimbursement Methodology for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)

“RESERVED”
State Assurances for Intermediate Care Facilities for the Mentally Retarded (ICF-MR)

As required by 42 CFR 447.253 (b) - (g):

- The department assures that the Title XIX ICF-MR payment rates are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

- The department assures that its proposed payment rates are reasonably expected to pay no more in the aggregate for ICF-MR care services than the amount that the department reasonably estimates would be paid under the Medicare principles of reimbursement.

- The department assures that it provides an appeals procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with respect to such issues that the department determines appropriate, of payment rates.

- The department assures that it requires in its state plan that each participating provider submit financial and statistical information at least annually in a uniform cost report prescribed by the department.

- The department assures that it provides for desk audit verification of each cost report, and for the on-site audit of a sufficient number of cost reports each year to ensure the fiscal integrity of the Texas Medicaid ICF-MR program.

- The department assures that it has provided public notice when proposing significant changes to the reimbursement methodology for ICF-MRs.

- The department assures that it has found the payment rate to be determined in accordance with methods and standards specified in the approved state plan.

- The department assures that for ICF-MRs, the payment methodology used by the state can reasonably be expected not to increase payments solely as a result of changes in ownership in excess of the increase which would result from applying the Social Security Act §1861 (v)(1)(O).
In the most recently approved assurance for ICF-MR, Transmittal Number 89-8, the department estimated that the average rate to private providers generated as a result of the amendments would not increase relative to the average rate in effect in the immediately preceding period. The assurance is still valid for this Transmittal Number 90-10.

In approved assurance Transmittal Number 89-8, the department estimated that there will be no effect on the availability of services on a statewide or geographic basis, there will be no effect on the type of care furnished, and there will be no effect on the extent of provider participation. The assurance is still valid for this Transmittal Number 90-10.

In approved Transmittal Number 89-8, as required in 42 CFR 447.253(b)(2) and 447.272(b), the department made a finding that its proposed payment rates are reasonably expected to pay no more in the aggregate for State School facility care services than the amount that the agency reasonably estimates would be paid for the services under the Medicare principles of reimbursement. The assurance is still valid for this Transmittal Number 90-10.
July 7, 1988

Mr. Don Hearn, Chief
State Operations Branch
Health Care Financing Administration
1200 Main Tower Building
Dallas, Texas 75202

Dear Mr. Hearn:

We have reviewed your letter of June 7, 1988, reference DPO-TX-88-03, and offer the following additional and clarifying information.

1. The assurances and related information required for a significant Plan amendment and are given in Attachment 1.

2.a. A sample of clients will be selected which insures an adequate representation of a variety of client characteristics found in the Intermediate Care Facility for the Mentally Retarded (ICF-MR) client population. A random sample of ICF-MR facilities will be made and a study of the client characteristics such as age, functional ability, behavior, and medical condition will be conducted to determine if adequate representation exists in the sample. If any of these characteristics are under-represented in the random sample, the sample will be expanded or modified to enhance the sample and insure adequate representation for statistical analysis.

b. Attachment 2 is a copy of the Client Assessment Profile (CAP) and Attachment 3 is a copy of the Texas Index for Level of Effort for the Mentally Retarded (TILE-MR) classification system that you requested. Please append these to 4.19-D.

c. The weighting factors used to determine the weighted average rates are detailed in Attachment 4. The weighting factors are called effort index in the TILE-MR classification system. The effort index is derived from the mean care minutes determined for each category from a time study done in conjunction with client assessments in the project research effort.

d. The blending percentages for the twelve month rate phase-in for each phase of the pilot project are as follows:
1. First quarter. Payments to facilities are based 75% on the current individual facility rates and 25% on the case mix rates.

2. Second quarter. Payments to facilities are based 50% on the current individual facility rates and 50% on the case mix rates.

3. Third quarter. Payments to facilities are based 25% on the current individual facility rates and 75% on the case mix rates.

4. Fourth quarter. Payments to facilities are based 100% on the current individual facility rates.

The Historical Expenditure Provision (HEP) and Stop Loss Insolvency Provision (SLIP) adjustments are applied to the total blended portion of the rate during the twelve month phase-in.

2.e. An example of the rate calculations can be found on Attachment 5.

If you have any questions concerning this response, please do not hesitate to call.

Sincerely,

Marlin W. Johnston
This is in response to the requirements in Chapter 42 Code of Federal Regulations (CFR) 447.250 and following. The Department's best estimates at present are that costs associated with this phase of the project will be budget neutral. The Department is providing the following assurances in regard to the aforementioned proposed change in the reimbursement methodology for those ICFs-MR selected for participation. The Department assures that:

- The Department has made a finding that the Title XIX Intermediate Care Facility for the Mentally Retarded, Intermediate Care Facility, and Skilled Nursing Facility payment rates are reasonable and adequate to meet the costs that are incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

- The Department has made a finding that its proposed payment rates are reasonably expected to pay no more than in the aggregate for long term facility services than the amount that the agency reasonably estimates would be paid for the services under the Medicare principles of reimbursement.

- The Department assures that it provides an appeals procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with issues that the Department determines appropriate, of payment rates.

- The Department assures that it requires in its state plan that each participating provider submit financial and statistical information at least annually in a uniform cost report prescribed by the Department.

- The Department assures that it provides for desk audit verification of each cost report, and for the on-site audit of a sufficient number of cost reports each year to insure the fiscal integrity of the Texas Medical Long Term Care Program.

- The Department assures that it has provided public notice when proposing significant changes to the Reimbursement Methodology for Intermediate Care Facilities for the Mentally Retarded, Skilled Nursing Facilities, and Intermediate Care Facilities.

- The department assures that it has found the payment rate to be determined in accordance with methods and standards specified in the approved state plan.
The Medicaid revision to the Deficit Reduction Act Section 1902(a)(13)(A) and (B), requires state assurances in regards to reimbursement for capital related cost for Inpatient Hospitals, Intermediate Care Facilities for the Mentally Retarded, Intermediate Care Facilities, and Skilled Nursing Facilities. The Department is providing the following assurances in regard to the Act:

- The Department assures that for inpatient hospital services, the Texas Title XIX State Plan reimbursement methodology (Attachment 4.19-A) cites applicable Medicare principles for determining allowable capital related costs, thus in accordance with Section 1902(a)(13)(B), payments can reasonably be expected to not exceed the Medicare statute at 1861(v)(1)(O).

- The Department assures that for Intermediate Care Facilities for the Mentally Retarded, Intermediate Care Facilities, and Skilled Nursing Facilities, the payment methodology used by the State can reasonably be expected not to increase payments solely as a result of changes of ownership which occur on or after July 18, 1984, in excess of the increase which would result from applying the Medicaid statute 1861(v)(1)(O).

As required under 447.255(a) & (b), the Department provides the following assurances:

- The Department assures that the estimated average proposed payment rate for the restricted group of ICFs/MR is estimated to be budget neutral with regard to the average total payments made to the affected facilities in the immediately preceding rate period;

- The Department assures that the proposed payment methodology will have no short term effect on (l) the availability of services on a statewide or geographical area basis; (2) the type of care furnished; (3) the extent of provider participation in the ICF/MR program.
Mr. James R. Merryman  
Associate Regional Administrator  
Health Care Financing Administration  
Department of Health and Human Services  
1200 Main Tower Building, Suite 2435  
Dallas, Texas  75202

Dear Mr. Merryman:

This is in response to the requirements in Chapter 42 Code of Federal Regulations 447.253 (a)-(g) and 447.255, regarding State Assurances. This is also to submit Transmittal Number 86-2, Amendment Number 148 to the Texas Title XIX Medical Assistance Plan which adds a supplemental reimbursement rate (SNL1) for skilled recipients whose needs require a greater than normal amount of care as indicated by six related criteria on the Level-of-Care Assessment Form (3652). The department is providing the following assurances in regard to the aforementioned proposed change in the methodology for SNF's. The department assures that:

- The department has made a finding that the Title XIX ICF-MR, ICF, and SNF payment rates are reasonable and adequate to meet the costs that are incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

- The department has made a finding that its proposed payment rates are reasonably expected to pay no more in the aggregate for long term care facility services than the amount that the agency reasonably estimates would be paid for the services under the Medicare principles of reimbursement.

- The department assures that it provides an appeals procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with issues that the Department determines appropriate, of payment rates.

- The department assures that it requires in its state plan that each participating provider submit financial and statistical information at least annually in a uniform cost report prescribed by the department.
The department assures that it provides for desk audit verification of each cost report, and for the on-site audit of a sufficient number of cost reports each year to insure the fiscal integrity of the Texas Medical Long Term Care program.

The department assures that it has provided public notice when proposing significant changes to the Reimbursement Methodology for Intermediate Care Facilities for the Mentally Retarded, Skilled Nursing Facilities and Intermediate Care Facilities.

The department assures that it has found the payment rate to be determined in accordance with methods and standards specified in the approved state plan.

The proposed reimbursement rate for services need level 1 (SNL1) will be $7.42 effective January 1, 1986 to December 31, 1986. This is a new supplemental rate.

The consensus of long-term institutional care givers in Texas is that the Medicare diagnosis-related group (DRG) reimbursement methodology has resulted in earlier discharge from acute care hospitals for many patients. This in turn has generated pressure on the long-term institutional care system to accept recipient/patients whose care needs are significantly greater and more expensive than was previously the case. As a result, the Texas Department of Human Services (TDHS) is implementing a supplementation to the skilled rate for patients whose care needs greatly exceed that amount of care normally given in a SNF facility. It is expected that this supplemental reimbursement rate (SNL1) will be provided for the care of between 10% and 20% of patients with a SNF level-of-care. It is expected that this SNL1 will, and should, significantly improve access to care and quality-of-care for this patient group.

The Medicaid revision to the Deficit Reduction Act section 1902(a)(13)(A) and (B), requires State assurances in regards to reimbursement for capital related cost for Inpatient Hospital, Intermediate Care Facilities for the Mentally Retarded, Intermediate Care Facilities, and Skilled Nursing Facilities. The department is providing the following assurances in regard to the Act:

- The department assures that for inpatient hospital services, the Texas Title XIX State Plan reimbursement methodology (Attachment 4.19-A) cites applicable Medicare principles for determining allowable capital related costs, thus in accordance with Section 1902(a)(13)(B), payments can reasonably be expected to not exceed the Medicare statute at 1861(v)(1)(O).
the department assures that for Intermediate Care Facilities for the Mentally Retarded, Intermediate Care Facilities, and Skilled Nursing Facilities, the payment methodology used by the State can reasonably be expected not to increase payments solely as a result of changes of ownership which occur on or after July 18, 1984, in excess of the increase which would result from applying the Medicaid statute 1861(v)(1)(D).

Your approval of the State Assurances and of the change to the SNF rate setting methodology will be appreciated.

Sincerely,

Marlin W. Johnston

Attachments
Mr. James R. Merryman  
Associate Regional Administrator  
Health Care Financing Administration  
Department of Health and Human Services  
1200 Main Tower Building  
Suite 2435  
Dallas, Texas 75202

Dear Mr. Merryman:

The Texas Department of Human Services is responding to Mr. Don Hearn's formal request (under 42 CFR 447.256), which was received on April 30, 1986, for additional information in regard to this department's Medicaid Plan transmittal 86-2 amending the State's methods and standards of payment for long-term care facility services. This letter only responds to the questions posed by Mr. Hearn.

a. Premise of the Plan Amendment. "...the State is requested to clarify, first, why the Medicare prospective payment system has raised the cost of skilled care for Medicaid patients. Second, the State is asked to provide the basis for its estimate that up to 20 percent of its Medicaid patients would require this supplement."

TDHS Response: TDHS' research into the issue of DRG-related increases in the costs for Skilled care for Medicaid patients is still in progress, and, as a result, the department will not support this argument for the present. The department wishes to state that, for the purposes of this amendment, it has used the reimbursement model developed for the state of Maryland by Robert T. Deane, Ph.D., as the basis for both the criteria identifying clients with appropriately severe care needs and the direct care staff costs necessary to support these needs. This model, approved by HCFA, identifies "heavy care" SNF patients as those having dependencies in five activities of daily living (ADLS): bathing, dressing, mobility, feeding, and continence. Direct care staff wage scales and related expenses derived from Texas nursing facility cost reports were used in order to make the model appropriate for Texas' use. This model enables TDHS to identify and calculate the costs of those areas of patient care which require additional effort or expense above that amount calculated to support the standard flat rate SNF reimbursement level.
Additionally, the department regrets that the original Transmittal 86-2 indicated that approximately 20% of current or future SNF patients would fall under this "heavy care" sub-category of the SNF level of care. In fact, departmental projections indicate that the actual percentage of heavy care patients eligible for TDHS additional reimbursement may be closer to 34% of SNF totals. Use of the Maryland reimbursement model, referred to above, in analyzing the Level-of-Care Assessment forms (3652) indicates that 71.68% of the SNF population falls within the "Heavy Care" category. Furthermore, nearly one-half of these heavy care patients, or 33.65% of total SNF clients, qualify as "Heavy Special Care", in that they have the additional requirement of non-oral nourishment such as tube feeding.

b. Cost Findings/Rate-Setting Methodology And Payment Levels: "...the State is requested to provide additional information explaining: (1) how the $7.42 amount was computed, (2) how the State determined this to be an adequate and reasonable level of payment, and (3) whether the supplement would be updated during the rate year to take into account changes in the general economy or local health care market."

TDHS Response: Service Needs Level 1 (SNL1) Supplementary reimbursement estimates were arrived at through two sets of calculations. First, time-motion estimates for appropriate classes of personnel required to deliver heavy special care were taken from the Maryland model and "costed out" using average wages and benefits as reported by Texas providers. This calculation yielded a wage and benefit delivery cost for SNL1 of $27.93 per diem. Secondly, the wage and benefits portion (for direct patient care personnel only) of the projected 1986 SNF patient care cost area was calculated at $20.51. The difference between these two figures, or $7.42, is the amount appropriate for SNL1 supplementary reimbursement.

The department believes that, because the model upon which its calculations are based is an acceptable model in use elsewhere (i.e. Maryland), and because the amounts and figures used in the calculations are specific to Texas Nursing Home Costs as reported in annual cost reports, the level of payment proposed is both adequate and reasonable.

Finally, the department does not intend to update the amount of the SNL1 reimbursement during the rate year to respond to changes in the general economy or the local health care market. Any changes proposed in the SNL1 reimbursement amount will be presented when the department submits its assurances to HCFA (i.e., annually) and will be based upon methodology in the approved State Plan.

c. Upper Limit: "We ask that the State clarify its assurance and indicate how this additional payment would not jeopardize the State's compliance with the upper limit requirement."
TDHS Response: Find attached calculations entitled "HCFA Reimbursement Ceilings for Freestanding Texas SNFs" which indicate that the lowest ceiling ($49.60) applicable in Texas at any time during the period in question (calendar year 1986) is well above the highest adjusted Texas SNF rate plus SNL1 ($47.81).

d. Effective Date: "...we first ask whether the State intends to provide a supplemental payment after December 31, 1986. If so, we assume that the State realizes that another plan amendment must be submitted. Submission of a new amendment must occur timely to allow continuation of payment under the federally approved plan."

TDHS Response: The Department intends that this proposed amendment to the methodology shall become a permanent part of the Department's rate-setting methodology. The dollar amounts calculated for calendar year 1986 and quoted in our March 20, 1986 request for approval are subject to annual review under the approved methodology.

Thank you for the opportunity to clarify the assurances previously submitted. If further information is necessary please inform me.

Sincerely,

Marlin W. Johnston

Marlin W. Johnston
HCFA Reimbursement Ceilings for Freestanding Texas SNFs
(Effective January 1-December 31, 1986)

Federal notice (50FR48304) established a revised schedule of
limits on SNF inpatient routine service expenses to be effective
January 1, 1986, and applicable to cost reporting periods begin­
ing on or after that date. Federal notice (51FR-BERC-333-FN)
establishes a revised schedule of limits on SNF inpatient routine
service expenses to be effective May 1, 1986, and applicable to
cost reporting periods beginning on or after that date. As
demonstrated below, if these HCFA ceilings were to be applied
to the Texas Medicaid Long Term Care Program, the 1986 uniform SNF
rate would not be affected. Even for those heavy-care clients
receiving supplemental payments of $7.42 per day (SNL1), total
reimbursement is well below the HCFA limits.

A.) Lowest HCFA Reimbursement Ceiling for a Texas SNF located in
an MSA:

\[
\begin{array}{lcc}
\text{1/1-4/30/86} & \text{5/1-12/31/86} \\
\text{Labor Component} & \$46.85 & \$47.64 \\
\text{Wage Index} & 0.8107 & 0.8105 \\
\text{Adjusted Labor Component} & \$37.98 & \$38.61 \\
\text{Non-Labor Component} & \$11.62 & \$11.74 \\
\text{Adjusted HCFA Limit} & \$49.60 & \$50.35 \\
\end{array}
\]

B.) Lowest HCFA Reimbursement Ceiling for a Texas SNF not located
in an MSA:

\[
\begin{array}{lcc}
\text{1/1-4/30/86} & \text{5/1-12/31/86} \\
\text{Labor Component} & \$48.95 & \$50.19 \\
\text{Wage Index} & 0.8423 & 0.8180 \\
\text{Adjusted Labor Component} & \$41.23 & \$41.06 \\
\text{Non-Labor Component} & \$ 9.79 & \$ 9.92 \\
\text{Adjusted HCFA Limit} & \$51.02 & \$50.98 \\
\end{array}
\]

C.) Texas SNF reimbursement rate:

\[
\begin{array}{lcc}
\text{SNF Class-rate} & \$44.05 \\
\text{Fixed Asset Component} & \$ 3.66 \\
\text{Adjusted Texas SNF rate} & \$40.39 \\
\text{Heavy Care Supplement (SNL1)} & \$ 7.42 \\
\text{Highest Adjusted Total SNF Reimbursement} & \$47.81 \\
\end{array}
\]
Texas Medicaid SNF/ICF Program
Projected Expenses and Reimbursement Rates

<table>
<thead>
<tr>
<th>Patient Care Cost Area</th>
<th>Rates Effective 1-1-85 to 12-31-85</th>
<th>Rates Proposed Effective 1-1-86 to 12-31-86</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>o SNF</td>
<td>$26.439</td>
<td>$27.993</td>
<td>5.88%</td>
</tr>
<tr>
<td>o ICF</td>
<td>15.739</td>
<td>16.515</td>
<td>4.93%</td>
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<tr>
<td>o ICF II</td>
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<td>12.528</td>
<td>5.17%</td>
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<tr>
<td>Dietary Care Cost Area</td>
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<tr>
<td>Facility Cost Area</td>
<td>6.586</td>
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</tr>
<tr>
<td>Administration Cost Area</td>
<td>3.407</td>
<td>3.612</td>
<td>6.02%</td>
</tr>
</tbody>
</table>

Reimbursement Rates

| o SNF                  | $41.65                           | $44.05                          | 5.76%    |
| o Service Need Level 1 (SNL1) |                        | 7.42                           | ----     |
| o ICF                  | 31.12*                           | 32.73*                          | 5.17%    |
| o ICF II               | 27.29*                           | 28.75*                          | 5.35%    |

*Rates include $0.16 for Durable Medical Equipment and 1861(j)(1) staffing requirements.
Texas Medicaid ICF-MR Program
State Schools
Projected Expenses and Reimbursement Rates

<table>
<thead>
<tr>
<th>Projected Expenses</th>
<th>Rates Effective 1-1-85 to 12-31-85</th>
<th>Rates Proposed Effective 1-1-86 to 12-31-86</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care Cost Area</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ICF MR I</td>
<td>$23.182</td>
<td>$22.980</td>
<td>-0.87%</td>
</tr>
<tr>
<td>ICF MR V</td>
<td>38.893</td>
<td>37.818</td>
<td>-2.76%</td>
</tr>
<tr>
<td>ICF MR VI</td>
<td>46.342</td>
<td>45.746</td>
<td>-1.29%</td>
</tr>
<tr>
<td>Dietary Care Cost Area</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ICF MR I</td>
<td>6.877</td>
<td>7.721</td>
<td>12.27%</td>
</tr>
<tr>
<td>ICF MR V</td>
<td>6.763</td>
<td>7.721</td>
<td>14.17%</td>
</tr>
<tr>
<td>ICF MR VI</td>
<td>6.877</td>
<td>7.573</td>
<td>10.12%</td>
</tr>
<tr>
<td>Facility Cost Area</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ICF MR I</td>
<td>8.495</td>
<td>6.278</td>
<td>-26.10%</td>
</tr>
<tr>
<td>ICF MR V</td>
<td>8.495</td>
<td>6.278</td>
<td>-26.10%</td>
</tr>
<tr>
<td>ICF MR VI</td>
<td>8.495</td>
<td>6.234</td>
<td>-26.62%</td>
</tr>
<tr>
<td>Administrative Cost Area</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ICF MR I</td>
<td>15.346</td>
<td>18.740</td>
<td>22.12%</td>
</tr>
<tr>
<td>ICF MR V</td>
<td>15.346</td>
<td>17.606</td>
<td>14.73%</td>
</tr>
<tr>
<td>ICF MR VI</td>
<td>16.669</td>
<td>17.789</td>
<td>13.53%</td>
</tr>
<tr>
<td>Comprehensive Medical</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ICF MR I</td>
<td>6.997</td>
<td>7.791</td>
<td>11.35%</td>
</tr>
<tr>
<td>ICF MR V</td>
<td>6.997</td>
<td>7.791</td>
<td>11.35%</td>
</tr>
<tr>
<td>ICF MR VI</td>
<td>7.601</td>
<td>7.791</td>
<td>2.50%</td>
</tr>
<tr>
<td>Reimbursement Rates</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ICF MR I</td>
<td>$60.90</td>
<td>$63.51</td>
<td>4.29%</td>
</tr>
<tr>
<td>ICF MR V</td>
<td>76.49</td>
<td>77.21</td>
<td>0.94%</td>
</tr>
<tr>
<td>ICF MR VI</td>
<td>84.98</td>
<td>85.13</td>
<td>0.18%</td>
</tr>
</tbody>
</table>
Texas Medicaid ICF-MR Program
Community Based
Projected Expenses and Reimbursement Rates

<table>
<thead>
<tr>
<th>Projected Expenses</th>
<th>Rates Effective 1-1-85 to 12-31-85</th>
<th>Rates Proposed Effective 1-1-86 to 12-31-86</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care Cost Area</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ICF MR I</td>
<td>$28.980</td>
<td>$29.393</td>
<td>1.43%</td>
</tr>
<tr>
<td>ICF MR V</td>
<td>24.516</td>
<td>25.654</td>
<td>4.64%</td>
</tr>
<tr>
<td>ICF MR VI</td>
<td>27.307</td>
<td>31.721</td>
<td>16.16%</td>
</tr>
<tr>
<td>Dietary Care Cost Area</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ICF MR I</td>
<td>4.422</td>
<td>5.112</td>
<td>15.60%</td>
</tr>
<tr>
<td>ICF MR V</td>
<td>5.074</td>
<td>5.490</td>
<td>8.20%</td>
</tr>
<tr>
<td>ICF MR VI</td>
<td>5.141</td>
<td>5.294</td>
<td>2.98%</td>
</tr>
<tr>
<td>Facility Cost Area</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ICF MR I</td>
<td>10.213</td>
<td>9.493</td>
<td>-7.05%</td>
</tr>
<tr>
<td>ICF MR V</td>
<td>8.907</td>
<td>8.119</td>
<td>-8.85%</td>
</tr>
<tr>
<td>ICF MR VI</td>
<td>10.318</td>
<td>10.033</td>
<td>-2.76%</td>
</tr>
<tr>
<td>Administrative Cost Area</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ICF MR I</td>
<td>10.281</td>
<td>12.192</td>
<td>18.59%</td>
</tr>
<tr>
<td>ICF MR V</td>
<td>5.247</td>
<td>6.193</td>
<td>18.03%</td>
</tr>
<tr>
<td>ICF MR VI</td>
<td>7.464</td>
<td>6.909</td>
<td>-7.44%</td>
</tr>
<tr>
<td>Reimbursement Rates</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ICF MR I</td>
<td>$53.90</td>
<td>$56.19</td>
<td>7.43%</td>
</tr>
<tr>
<td>ICF MR V</td>
<td>43.74</td>
<td>45.46</td>
<td>3.93%</td>
</tr>
<tr>
<td>ICF MR VI</td>
<td>50.23</td>
<td>53.96</td>
<td>7.43%</td>
</tr>
</tbody>
</table>
Texas Department of Human Services

September 18, 1986

Mr. James R. Merryman
Associate Regional Administrator
Health Care Financing Administration
Department of Health and Human Services
1200 Main Tower Building, Suite 2435
Dallas, Texas 75202

Dear Mr. Merryman:

This is in response to the Health Care Financing Administration's (HCFA) letter dated September 2, 1986, regarding the Texas Department of Human Services' (TDHS) Medicaid Plan Transmittal 86-6. That transmittal proposed to amend Texas' method and standards of payment to community-based Intermediate Care Facilities for the Mentally Retarded (ICF/MR) by providing an additional amount for the care of those Level VI individuals whose care needs are exceptionally heavy.

Find attached information responding to the HCFA concern that the additional $9.68 which TDHS proposes to add to the per diem rate for those community-based ICF/MR VI facilities might jeopardize the state's compliance with HCFA's upper limit requirement.

Thank you for your prompt consideration of this matter.

Sincerely,

Marlin W. Johnston

Attachment
It is the position of the Texas Department of Human Services (TDHS) that the primary variant between calculations regarding the acceptable upper limit amounts for Skilled Nursing Facilities (SNF) and Intermediate Care Facilities for the Mentally Retarded (ICF/MR) Level VI is direct care staffing ratios and the resulting cost differential to the two types of care. The following calculations establish an equivalence between the two types of care as regards staffing ratios.

The ICF/SNF Standards for Participation at 40 TAC 16.3004 require a licensed nurse/patient ratio of 1 to 15; the requirement for aides and orderlies (40 TAC 16.3005) is more general, requiring only that there be adequate staff "to meet the needs of the recipient/patients." Sample surveys by TDHS in 1982, 1984, and 1985 of skilled facilities in Texas have indicated average ratios of non-licensed staff to patients ranging from 1 to 3.8 to 1 to 4.3. Selecting the ratio which produces the lowest HCFA ceiling, the total direct care staff (i.e., licensed nurses plus aides and orderlies) to patient ratio may be calculated as follows:

\[
\begin{align*}
\text{Nurse/Patient Ratio} & \quad \text{Aides/Patient Ratio} \\
(1) & \quad 1/15 \\n(2) & \quad 1/3.8 \\
& \quad + \\
& \quad 1/15 + 3.95/15 \\
& \quad 4.95/15; \text{ by reduction} \\
(3) \quad \text{Total Direct Care Staff/Patient Ratio} & \quad 1/3.030
\end{align*}
\]

According to the Code of Federal Regulations (42 CFR 442.445) the staff/patient requirement (including all direct care staff) for an ICF/MR VI is 1 to 2. We can thus compute an equivalence ratio between SNF and ICF/MR VI total staffing requirements by inversion and division:

\[
\begin{align*}
(4) & \quad (1/3.030) / (1/2) = (1/3.030) \times (2/1); \text{ thus} \\
(5) \quad \text{MR/SNF Direct Care Staffing Equivalence Ratio} & \quad 1.515
\end{align*}
\]

The 1984 Cost Report data base indicated that direct patient care wages constituted 62.262% and 63.519% of total wages in SNF and ICF/MR Level VI facilities, respectively. Given this near equality, in conjunction with the reasonable assumption that the distribution between professional and non-professional direct care staff in SNFs is similarly equivalent to that in ICFs/MR, the total labor equivalence factor may be computed as follows:

\[
\text{APPROVED BY DHHS/HCFA/DPO} \\
\text{DATE: 10/17/86} \\
\text{TRANSMITTED NO.: 86-6}
\]
Having calculated an equivalence factor for staffing in ICFs/MR vs. SNFs, the HCFA reimbursement ceilings for Texas ICFs/MR may be calculated as follows:

A. Lowest HCFA Reimbursement Ceiling for a Texas ICF/MR located in an MSA:

<table>
<thead>
<tr>
<th>Component</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labor Component</td>
<td>$47.64</td>
</tr>
<tr>
<td>Wage Index</td>
<td>.8105</td>
</tr>
<tr>
<td>Adjusted Labor Component</td>
<td>$38.61</td>
</tr>
<tr>
<td>Labor Equivalence Factor</td>
<td>1.321</td>
</tr>
<tr>
<td>MR Adjusted Labor Component</td>
<td>$51.00</td>
</tr>
<tr>
<td>Non-Labor Component</td>
<td>$11.74</td>
</tr>
<tr>
<td>Adjusted HCFA Limit</td>
<td>$62.74</td>
</tr>
</tbody>
</table>

B. Lowest HCFA Reimbursement Ceiling for a Texas ICF/MR not located in an MSA:

<table>
<thead>
<tr>
<th>Component</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labor Component</td>
<td>$50.19</td>
</tr>
<tr>
<td>Wage Index</td>
<td>.8180</td>
</tr>
<tr>
<td>Adjusted Labor Component</td>
<td>$41.06</td>
</tr>
<tr>
<td>Labor Equivalence Factor</td>
<td>1.321</td>
</tr>
<tr>
<td>MR Adjusted Labor Component</td>
<td>$54.24</td>
</tr>
<tr>
<td>Non-Labor Component</td>
<td>$9.92</td>
</tr>
<tr>
<td>Adjusted HCFA Limit</td>
<td>$64.16</td>
</tr>
</tbody>
</table>

**APPROVED BY DHHS/HCFA/DPO**

**DATE:** 10-17-86

**TRANSMITIAL NO:** 86-6
C. Texas Medicaid ICF/MR VI Reimbursement:

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICF/MR VI Class Rate</td>
<td>$53.96</td>
</tr>
<tr>
<td>Less Fixed Capital Asset Component</td>
<td>- 5.20</td>
</tr>
<tr>
<td>Adjusted ICF/MR VI Rate</td>
<td>$48.76</td>
</tr>
<tr>
<td>Heavy Case Supplement (SNL1-MR VI)</td>
<td>$1.25</td>
</tr>
<tr>
<td>Average Pharmacy Expense</td>
<td>-</td>
</tr>
<tr>
<td>Adjusted Maximum Total ICF/MR VI Reimbursement</td>
<td>$59.69</td>
</tr>
</tbody>
</table>

The Texas Medicaid adjusted maximum total ICF/MR VI reimbursement of $59.69 (including the SNL1 supplement of $9.68) clearly falls below the lowest HCFA ceilings of $62.71 and $64.12 for MSAs and non-MSAs, respectively.

APPROVED BY DHHS/HCFA/CCO
DATE: 10-17-86
TRANS. TOTAL NO: 86-1
Dear Mr. Merryman:

This is in response to the requirements in Chapter 42 Code of Federal Regulations 447.253 (a)-(g) and 447.255, regarding State Assurances. This is also to submit Transmittal Number 86-6, Amendment Number 152, to the Texas Title XIX Medical Assistance Plan, which adds a supplemental reimbursement rate for community based ICF-MR VI recipients whose needs require a greater than normal amount of care, as indicated by six related criteria on the Level-of-Care Assessment Form (3652). The Department is providing the following assurances in regard to the aforementioned proposed change in the methodology for ICF-MR community-based facilities. The Department assures that:

1. The Department has made a finding that the Title XIX ICF-MR rates are reasonable and adequate to meet the costs that are incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

2. The Department has made a finding that its proposed payment rates are reasonably expected to pay no more in the aggregate for long term care facility services than the amount that the agency reasonably estimates would be paid for the services under the Medicare principles of reimbursement.

3. The Department assures that it provides an appeals procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with issues that the Department determines appropriate, of payment rates.

4. The Department assures that it requires in its State Plan that each participating provider submit financial and statistical information at least annually in a uniform cost report prescribed by the Department.

5. The Department assures that it provides for desk audit verification of each cost report, and for the on-site audit of a sufficient number of cost reports each year to insure the fiscal integrity of the Texas Medical Long Term Care Program.
The Department assures that it has provided public notice when proposing significant changes to the Reimbursement Methodology for Intermediate Care Facilities for the Mentally Retarded.

The Department assures that it has found the payment rate to be determined in accordance with methods and standards specified in the approved State Plan.

The proposed supplemental reimbursement rate for service need level 1 (SNL1) will be $9.68 effective May 1, 1986 to December 31, 1986. Changes to this rate may be made at least annually as provided for in the State Plan.

The Department has based its supplemental rate upon analysis of cost reports submitted by ICF-MR facilities and upon the results of time/motion studies conducted by the State of Ohio (attachment). These studies have nationwide validity and are appropriate for use by the State of Texas. It has been determined that the supplemental per diem reimbursement is necessary to prevent fiscal distress to certain ICF-MR VI facilities which provide care to recipients who exhibit significantly greater than normal care requirements. It is projected that this supplemental reimbursement will be provided for the care of between 20% and 30% of recipients with an ICF-MR VI level of care. It is expected that this supplemental rate will, and should, ensure continued access to care for the high-care section of the ICF-MR VI recipient group.

The Medicaid revision to the Deficit Reduction Act section 1902 (a)(13)(A) and (B), requires State assurances in regards to reimbursement for capital related cost for Inpatient Hospital, Intermediate Care Facilities for the Mentally Retarded, Intermediate Care Facilities, and Skilled Nursing Facilities. The Department is providing the following assurances in regard to the Act:

The Department assures that for Intermediate Care Facilities for the Mentally Retarded the payment methodology used by the State can reasonably be expected not to increase payments solely as a result of changes of ownership which occur on or after July 18, 1984, in excess of the increase which would result from applying Section (v)(1)(O) of the Social Security Act.

Your acceptance of the State's Assurances and of the change to the State Plan as it relates to the ICF-MR community based facility rate setting methodology will be appreciated.

Sincerely,

Marlin W. Johnston
The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.
REIMBURSEMENT METHODOLOGY FOR NURSING FACILITIES

The Texas Health and Human Services Commission (HHSC), the Single State Medicaid Agency has final approval authority of Medicaid rates. HHSC determines nursing facility (NF) Medicaid payment rates after consideration of analysis of financial and statistical information, and the affect of the reimbursement on achievement of program objectives, including economic conditions and budgetary considerations.

(I) General

(A) Uniform Rates. Reimbursement rates are uniform statewide for the same class of service.

(B) Prospective Rates with a Retrospective Adjustment. Reimbursement rates are determined prospectively with a retrospective adjustment for failure to meet staffing and/or spending requirements.

(C) Unit of Service. The unit of service reimbursed is a day of care provided to a Medicaid client by a Medicaid contracted NF. A day is defined as a 24-hour period extending from midnight to midnight.

(D) Frequency of Rate Determination. Rates are determined for a period of two years based upon odd-year cost reports.

(E) References in the text to the Texas Department of Human Services (DHS) should be considered to be references to HHSC or its designee.
II. Cost Reporting.

A. Cost Reports. In order to ensure adequate financial and statistical information upon which to base reimbursement, TDHS requires that each contracted provider submit an annual cost report and, if necessary, a supplemental report(s). It is the responsibility of the provider to submit accurate and complete information, in accordance with all pertinent TDHS cost reporting rules and cost report instructions, on the cost report and/or any supplemental reports required by TDHS.

B. Pro Forma Costing. When historical costs are unavailable, such as in the case of changes in program requirements, reimbursement will be based on a pro forma approach. This approach involves using historical costs of delivering similar services and determining the types and costs of products and services necessary to deliver services meeting federal and state requirements.

C. Desk Reviews and Field Audits. TDHS conducts desk reviews and field audits of provider cost reports in order to ensure that all financial and statistical information reported in the cost reports conforms to all applicable rules and instructions.

D. Informal Reviews and Appeals. A contracted provider may request an informal review, and subsequently an appeal, of a desk review or field audit disallowance.
Ill. Cost Finding Methodology. HHSC adjusts reported expense data using a cost finding methodology to determine per diem allowed costs. HHSC makes certain adjustments to ensure that costs used for rate projections are required for long term care, derived from the marketplace, and incurred from economic and efficient use of resources.

A. Cost determination by cost area. HHSC combines adjusted expenses (A.1. through A.4. below) and other pertinent data (A.5. below) from the rate base to determine five cost-related components.

1. Direct Care Staff cost component. The direct care staff cost component includes compensation for employee and contract labor Registered Nurses, Licensed Vocational Nurses, Medication Aides and Certified Nurse Aides performing nursing-related duties for Medicaid-contracted beds.

2. Other Recipient Care cost component. The other recipient care cost component includes compensation costs for social workers, activities staff, direct care staff trainers, therapists, pharmacists, medical directors and other direct care consultants, as well as costs for medical equipment and supplies, and laundry/housekeeping equipment and supplies.

3. Dietary cost component. The dietary cost component includes compensation costs for dietary staff as well as costs for food, ancillary nutritional therapy supplements, dietary equipment, and dietary supplies.

4. General and Administration cost component. The general and administration cost component includes compensation costs for administrative and maintenance staff as well as costs for management, legal and other consulting fees, property and equipment repair and maintenance, office supplies and equipment, insurance (excluding liability insurance), property taxes, transportation, and working capital interest.

5. Fixed Capital Asset component. Fixed capital charges are based on the most recent appraised value of facilities, including land and improvements, as determined by the most recent assessment of the local taxing authority and reported on the cost report. Tax exempt facilities not provided an appraisal from their local taxing authority because of an exempt status must contract with an independent appraiser to appraise the facility land and improvements.

B. Exclusion of Certain Reported Expenses. Providers are responsible for eliminating all unallowable expenses from the cost report. HHSC reserves the right to exclude any unallowable expenses from the cost report and to exclude entire cost reports from the data base if it is believed that the cost reports do not reflect economic and efficient use of resources.

1. Fixed Capital Asset Charges. Effective September 1, 1990, fixed capital asset costs are reimbursed in the form of a Use Fee calculated as described under section (IV)(B)(1). Consequently, the following fixed capital asset charges are excluded from the rate base for purposes of calculating the General and Administration cost component: building and building equipment depreciation and lease expense; mortgage interest; land improvement depreciation; and leasehold improvement amortization.
(C) Adjustments to certain reported expenses. HHSC makes adjustments to the expenses reported by providers to ensure that expenses used in rate determination are required for long term care, derived from the market place and incurred from economic and efficient use of resources.

1. Limits on certain administration costs. To ensure that the results of cost analyses accurately reflect the costs that an economic and efficient provider must incur, related-party facility administrator and owner salaries, wages, and/or benefits are limited to the 90th percentile of nonrelated-party administrator salaries, wages and/or benefits adjusted for inflation using the Personal Consumption Expenditures (PCE) chain-type price index. Related-party assistant administrator salaries, wages, and/or benefits are limited to the 90th percentile of nonrelated-party assistant administrator salaries, wages, and/or benefits adjusted for inflation using the PCE chain-type price index.

2. Occupancy adjustments. HHSC adjusts the facility and administration costs of providers with occupancy rates below a target occupancy rate. The target occupancy rate is the lower of (a) 85 percent or (b) the overall average occupancy rate for contracted beds in facilities included in the rate base during the cost-reporting periods included in the rate base. For each provider whose occupancy falls below the target occupancy rate, an adjustment factor is calculated as follows: adjustment factor = 1.00 – (provider’s occupancy rate/ appropriate target occupancy rate). This adjustment factor is then multiplied by each cost line item in the facility and administration cost areas of the cost reports, and the result of this calculation is subtracted from the line item amount.

(D) Projected Costs. HHSC projects NF providers’ costs by accounting for changes in cost-related conditions anticipated to occur between the base period and the prospective rate period. Such changes include, but are not limited to, wage and price inflation or deflation, changes in program utilization, modifications of federal or state regulations and statutes, and implementation of federal court orders and settlement agreements. The base period is a single state fiscal year spanning from September 1 through August 31, and the prospective rate period is two state fiscal years beginning with the first day of a state fiscal year which is at least one fiscal year after the base period year. Inflation factors and multipliers that HHSC uses to project costs from the base period to the prospective rate period are determined per (D)(1) through (D)(4).

1. General Inflation Index. For general inflation adjustments, HHSC uses the Personal Consumption Expenditures (PCE) chain-type price index published by the Bureau of Economic Analysis of the U.S. Department of Commerce. HHSC uses a PCE forecast published by IHS Markit or its successor.
(2) **Item-specific and Program-specific Inflation Indices.** HHSC uses specific indices in place of the general inflation index when appropriate item- or program-specific inflation indices are available from cost reports or other surveys, other Texas state agencies, nationally recognized public agencies, or independent private firms or sources, and HHSC has determined that these specific inflation indices are derived from information that adequately represents the program(s) or cost(s) to which the specific index is to be applied.

(3) For inflation adjustments of costs pertaining to wages and salaries of licensed vocational nurses and nurse aides, HHSC uses an employment cost index of wages and salaries for private industry workers in nursing and residential care facilities published by the U.S. Bureau of Labor Statistics. HHSC uses a forecast of this inflation index published by IHS Markit or its successor. Periodic reviews of the chosen inflation index will be performed on cumulative cost report data on nursing wages and salaries.

(4) **Adjustment of Tax Rates.** HHSC includes Federal Insurance Contributions Act (FICA) payroll tax rates, such as Social Security taxes and Medicare taxes, and federal and state unemployment tax rates in its projected costs of non-contracted staff salaries and wages. When a FICA tax rate or unemployment tax rate is amended per federal or state statute, HHSC adjusts its cost projections in accordance with the amended tax rate.
(IV) Rate Setting Methodology.

(A) Case-mix classes. The Texas Health and Human Services Commission (HHSC) reimbursement rates for nursing facilities vary according to the assessed characteristics of the recipient. Rates are determined for 34 case-mix classes of service, plus a 35th, temporary classification assigned by default when assessment data are incomplete or in error and a 36th classification assigned by default when an assessment is missing.

(B) Reimbursement determination.

(1) Rate components. Under the case mix methodology, rates are comprised of five cost-related components: the dietary component; the general/administration component; the fixed capital asset use fee component; the other recipient care component; and the direct care staff component. The direct care staff component is calculated as specified in (VI).

(a) The dietary component is constant across all case-mix classes and is calculated at the median cost (weighted by Medicaid days of service in the database) in the array of projected allowable per diem costs for all contracted nursing facilities included in the applicable database, multiplied by 1.07.
(b) The general/administration component is constant across all case-mix classes and is calculated at the median cost (weighted by Medicaid days of service in the database) in the array of projected allowable per diem costs for all contracted nursing facilities included in the applicable database, multiplied by 1.07.
(c) The fixed capital asset use fee component is calculated as follows:

(i) Determine the eightieth percentile in the array of allowable appraised property values per licensed bed, including land and improvements. Appraised values for this purpose are determined by the most recent appraisal available from the local taxing authority and reported on the Texas Medicaid cost report. Tax-exempt facilities not provided an appraisal from their local taxing authority because of an exempt status must contract with an independent appraiser to appraise the facility land and improvements. Facilities not reporting an appraised property value are not included in the array for purposes of calculating the use fee.

(ii) Project the eightieth percentile of appraised property values per bed by one-half the forecasted increase in the Personal Consumption Expenditures (PCE) chain-type price index from the cost-reporting year to the rate year.

(iii) Calculate an annual use fee per bed as the projected eightieth percentile of appraised property values per bed times an annual use rate of fourteen percent.

(iv) Calculate a per diem use fee per bed by dividing the annual use fee per bed by annual days of service per bed at the higher of 85 percent occupancy, or the statewide average occupancy rate during the cost-reporting period.

(v) The use fee is limited to the lesser of (a) the fee as calculated in (IV)(B)(1)(c)(i)-(iv) above, or (b) the fee as calculated by inflating the fee from the previous rate period by the forecasted change in the PCE chain-type price index.
(d) The other recipient care rate component varies according to case-mix class of service and is calculated as follows. Adjust the raw sum of other recipient care costs in all nursing facilities included in the applicable database in order to account for disallowed costs and inflation, as specified under (III). Then divide the adjusted total by the sum of recipient days of service in all facilities in the database. Multiply the resulting weighted, average per diem cost of other recipient care by 1.07. The result is the average other recipient care rate component. To calculate the other recipient care per diem rate component for each of the Resource Utilization Group (RUG-III) case-mix groups and for the default groups, multiply each of the standardized statewide case-mix indexes from (IV)(B)(3)(c) below by the average other recipient care rate component.
(2) Case-mix classification system. All Medicaid recipients are classified according to the Resource Utilization Group (RUG-III) 34 group classification system, Version 5.20, index maximizing, as established by the state and the Centers for Medicare and Medicaid Services (CMS). Each of the case-mix groups, including the default groups, is assigned CMS standard nursing time measurements for Registered Nurses (RNs), Licensed Vocational Nurses (LVNs) and aides (Medication Aides and Certified Nurse Aides). These measurements indicate the amount of staff time required on average to deliver care to residents in that group.

(3) Per diem rate methodology. Staff determine per diem rate recommendations for each of the RUG-III groups and for the default groups according to the following procedures:

(a) For each RUG-III group, calculate a total LVN-equivalent minute statistic by converting the CMS standard nursing time measurements for RNs, LVNs and aides into Texas-specific LVN-equivalent minutes as per (VI)(D) below and summing the converted figures.

(b) Weight the total LVN-equivalent minute statistics from (IV)(B)(3) above for each RUG-III group except the default groups as follows and determine the statewide average total adjusted minutes:

(i) For rates effective September 1, 2008, the total LVN-equivalent minute statistics for each RUG-III group will be weighted by the estimated statewide recipient days of service by case mix group during the period beginning the first day of December, 2007 and ending the last day of February, 2008.

(ii) For rates effective September 1, 2009, the total LVN-equivalent minute statistics for each RUG-III group will be weighted by the estimated statewide recipient days of service by case mix group during the period beginning the first day of September, 2008 and ending the last day of February, 2009.

(iii) For rates effective September 1, 2011 and thereafter, for the other recipient care rate component, the total LVN-equivalent minute statistics for each RUG-III group will be weighted by the estimated statewide recipient days of service by case mix group during the period beginning the first day of September, 2008 and ending the last day of February, 2009.

(c) Calculate standardized statewide case-mix indexes. Determine the standardized statewide case-mix index for each of the RUG-III groups by dividing each of the total LVN-equivalent minute statistics described under (IV)(B)(3)(a) above by the statewide average total adjusted minutes described under (IV)(B)(3)(b).
(4) Total case mix per diem rates. Total case mix per diem rates vary according to case mix class of service and according to participant status in the Enhanced Direct Care Staff Rate described in (VI).

(a) For each participating facility, for each of the RUG-III case mix groups and for the default groups, the recommended total per diem rate is the sum of the following five rate components:

(i) the dietary rate component from (IV)(B)(1)(a);

(ii) the general and administration rate component from (IV)(B)(1)(b);

(iii) the fixed capital asset use fee component from (IV)(B)(1)(c);

(iv) the case mix group's other recipient care per diem rate component by case mix group from (IV)(B)(1)(d); and

(v) the case mix group's total direct care staff rate component for that participating facility as determined in (VI)(F).

(b) For nonparticipating facilities, for each of the RUG-III case mix groups and for the default groups, the recommended total per diem rate is the sum of the following five rate components:

(i) the dietary rate component from (IV)(B)(1)(a);

(ii) the general and administration rate component from (IV)(B)(1)(b);

(iii) the fixed capital asset use fee component from (IV)(B)(1)(c);

(iv) the case mix group's other recipient care per diem rate component by case mix group from (IV)(B)(1)(d); and

(v) the case mix group's direct care staff base rate component as determined in (VI)(E).
(5) Supplemental reimbursement.

(a) Supplemental reimbursement for ventilator-dependent residents. Qualifying residents receive a supplement to the per diem rate specified in (IV)(B)(4).

(i) To qualify for supplemental reimbursement, a resident must require artificial ventilation for at least 6 consecutive hours daily and the use must be prescribed by a licensed physician.

(ii) A ventilator-dependent resource differential case-mix index for the other recipient care rate component is calculated by subtracting the standardized statewide case mix index for the SE1 RUG-III case mix group from 3.61. A ventilator-dependent resource differential case mix index for the direct care staff base rate component is calculated by dividing the resource differential case mix index for the other recipient care rate component by 0.9908.

(iii) The per diem rate supplement is calculated by multiplying the resource differential case mix index for the other recipient care rate component times the per diem average other recipient care rate component, as described in (IV)(B)(1)(d) and multiplying the resource differential case mix index for the direct care staff base rate component by the average direct care staff base rate component as described in (VI)(E) and summing the products.

(iv) The supplemental reimbursement for residents requiring continuous artificial ventilation is 100% of the per diem ventilator rate supplement.

(v) The supplemental reimbursement for residents not requiring continuous artificial ventilation daily but requiring artificial ventilation for at least 6 consecutive hours daily is 40% of the per diem ventilator rate.
IV. Rate Setting Methodology (continued)

(C) Special reimbursement class. HHSC may define special reimbursement classes, including experimental reimbursement classes of service, to be used in research and demonstration projects on new reimbursement methods and reimbursement classes of service to address the cost differences of a select group of recipients. Special classes may be implemented on a statewide basis, may be limited to a specific region of the state, or may be limited to a selected group of providers. Reimbursement for the Pediatric Care Facility class is calculated as specified in VII.
IV. Rate Setting Methodology (continued)

Reserved
(D) Compliance with Omnibus Budget Reconciliation Acts.

(1) Costs of Compliance with Omnibus Budget Reconciliation Act of 1987 (OBRA 1987). All the costs of compliance with OBRA 1987 are being reported on the cost reports used to set payment rates. It is no longer necessary to provide an add-on to meet these costs. Hence, the payment rates will not require enhancement.

(2) Compliance with Section 4801 of the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990). As explained in (IV)(D)(1), the payment rates will not require enhancement to cover costs of compliance with OBRA 1987. The actual costs of OBRA 1987 appear in provider cost reports used to develop payment rates.

(E) Effective October 1, 1990, any reference in any section of the state plan material to Intermediate Care Facility/Skilled Nursing Facility (ICF/SNF) should be read as Nursing Facility (NF).
(F) Texas Index for Level of Effort (TILE) to RUG-III hold harmless transition. For rates effective September 1, 2008, through August 31, 2009, payment rates for the direct care staff and other recipient care components will be equal to the rates in effect on August 31, 2008 times 1.085, payment rates for the dietary, general/administration and fixed capital asset rate components will be equal to the rates in effect on August 31, 2008 times 1.025, payment rates for the professional and general liability insurance add-on and the professional-only liability insurance add-on will be equal to the rates in effect on August 31, 2008 times 1.024, and the payment rate for the general-only liability insurance add-on will be equal to the rate in effect on August 31, 2008 times 1.018.

(1) To calculate the updated direct care staff per diem rate component for each of the RUG-III case mix groups and for the default groups, divide each of the standardized statewide case mix indexes from (IV)(B)(3)(c) by 0.9908, multiply each quotient by the statewide average TILE case mix index for the period beginning the first day of December, 2007 and ending the last day of February, 2008 and multiply each product by the average updated direct care staff rate component.

(2) To calculate the updated other recipient care per diem rate component for each of the RUG-III case mix groups and for the default groups, divide each of the standardized statewide case mix indexes from (IV)(B)(3)(c) by 1.0267, multiply each quotient by the statewide average TILE case mix index for the period beginning the first day of December, 2007 and ending the last day of February, 2008 and multiply each product by the average updated other recipient care rate component.

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TN No. 09-16 Approval Date SEP 11 2009 Effective Date 9-1-09
Supersedes TN No. 08-23
(3) For state fiscal year 2009 only, for each Medicaid-contracted nursing facility, HHSC will:

(i) Calculate the sum of the weighted average TILE direct care staff base rate (with no enhanced direct care staff rate) and other recipient care rate based on the TILE rates for these cost areas in effect on August 31, 2008 and the facility's approved to be paid days of service by TILE from January 1, 2008 through June 30, 2008.

(ii) Calculate the sum of the weighted average RUG-III direct care staff base rate (with no enhanced direct care staff rate) and other recipient care rate based on the RUG rates for these cost areas in effect on September 1, 2008 and the facility's approved to be paid days of service by RUG-III for those recipients paid under RUG-III from September 1, 2008 through February 28, 2009.

(iii) Compare the sum from (IV)(F)(3)(i) to the sum from (IV)(F)(3)(ii). If the sum from (IV)(F)(3)(i) is greater than the sum from (IV)(F)(3)(ii), the facility will be paid 80 percent of the difference between the sum from (IV)(F)(3)(i) and the sum from (IV)(F)(3)(ii) times the facility's approved to be paid days of service for those recipients paid under RUG-III from September 1, 2008 through February 28, 2009.

(iv) Calculate the sum of the weighted average RUG-III direct care staff base rate (with no enhancements) and other recipient care rate based on the RUG rates for these cost areas in effect on September 1, 2008 and the facility's approved to be paid days of service by RUG-III for those recipients paid under RUG-III from March 1, 2009 through August 31, 2009.

(v) Compare the sum from (IV)(F)(3)(i) to the sum from (IV)(F)(3)(iv). If the sum from (IV)(F)(3)(i) is greater than the sum from (IV)(F)(3)(iv), the facility will be paid 80 percent of the difference between the sum from (IV)(F)(3)(i) and the sum from (IV)(F)(3)(iv) times the facility's approved to be paid days of service for those recipients paid under RUG-III from March 1, 2009 through August 31, 2009.
(vi) Calculate the sum of the weighted average RUG-III direct care staff base rate (with no enhancements) and other recipient care rate based on the RUG rates for these cost areas in effect on September 1, 2008, and the facility's approved to be paid days of service by RUG-III for those recipients paid under RUG-III from September 1, 2008, through August 31, 2009.


(-a-) If the sum from (IV)(F)(3)(i) is greater than the sum from (IV)(F)(3)(vi), determine the difference between the sum from (IV)(F)(3)(i) and the sum from (IV)(F)(3)(vi) times the facility's approved to be paid days of service for those recipients paid under RUG-III from September 1, 2008, through August 31, 2009 and subtract the hold harmless payments made under (IV)(F)(3)(iii) and (v) from this product.

(-1-) If the result is a positive number, DADS will pay the facility the difference.

(-2-) If the result is a negative number, DADS will recoup the difference from the facility.

(-b-) If the sum from (IV)(F)(3)(i) is less than the sum from (IV)(F)(3)(vi) and the facility received a hold harmless payment under (IV)(F)(3)(iii) and / or (v), DADS will recoup from the facility the hold harmless payments made under these subparagraphs.
Reimbursement Methodology for Nursing Facilities (continued)

(G) Effective September 1, 2013, for each RUG-III and supplemental reimbursement group, each rate component will be equal to the rate component in effect on August 31, 2013, plus 2.00 percent. Rate components include the direct-care staff base-rate component, direct-care staff enhancement add-on rate component, other recipient care rate component, dietary rate component, general/administration rate component, fixed capital asset use fee component, and liability insurance rate component. These rates were posted on the agency’s website at https://pfd.hhs.texas.gov/long-term-services-supports/nursing-facility-nf on September 1, 2013.

(H) Effective September 1, 2014, for each RUG-III and supplemental reimbursement group, each rate component will be equal to the rate component in effect on August 31, 2013, plus 6.00 percent. Rate components include the direct-care staff base-rate component, direct-care staff enhancement add-on rate component, other recipient care rate component, dietary rate component, general/administration rate component, fixed capital asset use fee component, and liability insurance rate component. These rates were posted on the agency’s website at https://pfd.hhs.texas.gov/long-term-services-supports/nursing-facility-nf on September 1, 2014.

(I) Effective June 10, 2023, through August 31, 2023, for each RUG-III group, each rate component will be equal to the rate component in effect on June 9, 2023, plus a temporary add-on of $19.63 for miscellaneous costs will be included in addition to the rate components. The temporary add-on will be effective through August 31, 2023. These rates were posted on the agency’s website at https://pfd.hhs.texas.gov/long-term-services-supports/nursing-facility-nf on June 10, 2023.
Liability Insurance Costs. Effective September 1, 2001, the portion of the rate accruing from reported general liability insurance costs will only be disbursed to providers certifying that they have purchased general liability insurance acceptable to HHSC and the portion of the rate accruing from reported professional liability insurance costs will only be disbursed to providers certifying that they have purchased professional liability insurance acceptable to HHSC. Providers who cancel or fail to renew their liability coverage during a rate year must notify HHSC within two weeks of the effective date of their cancellation or failure to renew.

* Pen & ink change made per State's 10-10-01 request.
Allowable and unallowable costs. Allowable and unallowable costs are defined to identify expenses which are reasonable and necessary to provide client contracted care and are consistent with federal and state laws and regulations.

(1) Allowable costs. Allowable costs are expenses, both direct and indirect, that are reasonable and necessary in the normal conduct of operations to provide contracted client services meeting all pertinent state and federal requirements. Only allowable costs are included in the reimbursement determination process.

(2) Unallowable costs. Unallowable costs are expenses that are not reasonable or necessary. Providers must not report as an allowable cost on a cost report a cost which has been determined to be unallowable.

(3) Detailed definitions. Detailed definitions of allowable and unallowable costs are prescribed in Title 1 of the Texas Administrative Code, Chapter 355, relating to Cost Determination Process.

(4) Changes to allowable and unallowable costs. Whenever a change is made to the definitions of allowable and unallowable costs as described in subsection (3) above which is anticipated to cause a change in the rate payable to a provider, a state plan amendment will be submitted.
(VI) Direct Care Staff Rate Component.

(A) Direct care staff cost center. This cost center will include compensation for employee and contract labor Registered Nurses (RNs), Licensed Vocational Nurses (LVNs), medication aides, and nurse aides performing nursing-related duties for Medicaid-contracted beds. For facilities receiving supplemental reimbursement for ventilator-dependent residents or children with tracheostomies, this cost center also includes compensation for employee and contract labor registered Respiratory Therapists and certified Respiratory Therapy Technicians. Staff members performing more than one function in a facility without a differential in pay between functions are categorized at the highest level of licensure or certification they possess.

(B) Rate year. The standard rate year begins on the first day of September and ends on the last day of August of the following year.

(C) Enrollment. An initial enrollment contract amendment is required from each facility choosing to participate in the enhanced direct care staff rate.

(1) Participating and nonparticipating facilities may request to modify their enrollment status during any open enrollment period. Nonparticipants and participants requesting to increase their enrollment levels will be limited to requesting increases of three or fewer enhancement levels during any single open enrollment period unless such limits are waived by HHSC. Enrollment will begin on the first day of July and end on the last day of that same July preceding the rate year for which payments are being determined, unless HHSC notified facilities prior to the first day of July that the open enrollment has been postponed or canceled. Should conditions warrant, additional enrollment periods may be conducted during a rate year. Facilities which do not submit an enrollment contract amendment by the last day of the open enrollment period will continue at the level of participation of the previous year within available funds until the facility notifies HHSC that it no longer wishes to participate or until the facility’s enrollment is limited in accordance with (VI)(C)(2).

(2) A facility will not be enrolled in the enhanced direct care staff rate at a level higher than the level it achieved on its most recently available, audited Staffing and Compensation Report. A facility may request a revision of its enrollment limitation if the facility’s most recently available, audited Staffing and Compensation Report does not represent its current staffing levels.

(3) At no time will a facility be allowed to enroll in the enhancement program at a level higher than its current level of enrollment plus three additional levels unless otherwise instructed by HHSC.
(D) Determination of staffing requirements for participants. Facilities choosing to participate in the Enhanced Direct Care Staff Rate agree to maintain certain direct care staffing levels above the minimum staffing levels described in (VI)(D)(1). In order to permit facilities the flexibility to substitute RN, LVN and aide (medication aide and nurse aide) staff resources and, at the same time, comply with an overall nursing staff requirement, total nursing staff requirements are expressed in terms of LVN-equivalent minutes. The most recent available, reliable relative compensation levels for RNs, LVNs, and aides in Texas NFs, including salaries, wages, payroll taxes and benefits, are used to convert RN and aide minutes into LVN-equivalent minutes. For example, if the most recent available, reliable relative compensation levels for RNs, LVNs, and aides were $0.42, $0.28, and $0.14 per minute respectively, one minute of LVN time would be equivalent to 0.67 minutes of RN time ($0.28 / $0.42 = 0.67), and to two minutes of aide time ($0.28 / $0.14 = 2.00). Conversely, one minute of RN time would be equivalent to 1.5 minutes of LVN time ($0.42 / $0.28 = 1.5), and one minute of aide time would be equivalent to 0.5 minutes of LVN time ($0.14 / $0.28 = 0.5).

(1) Minimum staffing levels. For each participating facility, determine a minimum LVN-equivalent staffing level as follows:

(a) Determine minimum required LVN-equivalent minutes per resident day of service for various types of residents using time study data, cost report information, and other appropriate data sources.

(i) Determine LVN-equivalent minutes associated with Medicare residents based on the data sources from (VI)(D)(1)(a) adjusted for estimated acuity differences between Medicare and Medicaid residents.

(ii) Determine minimum required LVN-equivalent minutes per resident day of service associated with each Resource Utilization Group (RUG-III) case mix group and additional minimum required minutes for Medicaid residents reimbursed under the RUG-III system who also qualify for supplemental reimbursement for ventilator care or pediatric tracheostomy care. These minimum required minutes are determined using the data sources from (VI)(D)(1)(a) adjusted for acuity differences between Medicare and Medicaid residents and other factors.

(b) Based on most recently available, reliable utilization data, determine for each facility the total days of service by RUG-III group, days of service provided to Medicaid residents qualifying for Medicaid supplemental reimbursement for ventilator or tracheostomy care, total days of service for Medicare Part A residents in Medicaid contracted beds, and total days of service for all other residents in Medicaid contracted beds.

(c) Multiply the minimum required LVN-equivalent minutes for each RUG-III group and supplemental reimbursement group from (VI)(D)(1)(a) by the facility's Medicaid days of service in each RUG-III group and supplemental reimbursement group from (VI)(D)(1)(b) and sum the products.

(d) Multiply the minimum required LVN-equivalent minutes for Medicare residents by the facility's Medicare Part A days of service in Medicaid contracted beds.
(e) Divide the sum from (VI)(D)(1)(c) by the facility's total Medicaid days of service, with a day of service for a Medicaid RUG-III recipient who also qualifies for a supplemental reimbursement counted as one day of service, compare this result to the minimum required LVN-equivalent minutes for a RUG-III PD1 and multiply the lower of these two figures by the facility's other resident days of service in Medicaid contracted beds.

(f) Sum the results of (VI)(D)(1)(c), (d), and (e), divide the sum by the facility's total days of service in Medicaid contracted beds, with a day of service for a Medicaid recipient who also qualifies for a supplemental reimbursement counted as one day of service. The result of these calculations is the minimum LVN-equivalent minutes per resident day the participating facility must provide.

(2) Enhanced staffing levels. Facilities desiring to participate in the enhanced direct care staff rate are required to staff above the minimum requirements from (VI)(D)(1). These facilities may request LVN-equivalent staffing enhancements from an array of LVN-equivalent enhanced staffing options and associated add-on payments during enrollment. Enhanced staffing options offered are based upon multiples of one LVN-equivalent minute.

(3) Granting of staffing enhancements. All requested enhancements are divided into two groups after applying any enrollment limitations from (VI)(C): pre-existing enhancements that facilities request to carry over from the prior year and newly requested enhancements. Newly requested enhancements may be enhancements requested by facilities that were nonparticipants in the prior year or by facilities that were participants in the prior year desiring to be granted additional enhancements. Using the process described herein, the distribution of pre-existing enhancements is determined. If funds are available after the distribution of pre-existing enhancements, the distribution of newly requested enhancements is determined.

(a) For each enhancement option, projected Medicaid units of service for facilities requesting that option are determined and multiplied by the rate add-on associated with the option as determined in (VI)(F)(2).

(b) The sum of the products from subparagraph (VI)(D)(3)(a) is compared to available funds.

(c) If the product is less than or equal to available funds, all requested enhancements are granted.

(d) If the product is greater than available funds, enhancements are granted beginning with the lowest level of enhancement and granting each successive level of enhancement until requested enhancements are granted within available funds.
Determination of direct care staff base rate.

1. Determine the total recipient care costs from the direct care staff cost center in all nursing facilities included in the Texas Nursing Facility Cost Report database used to determine the nursing facility rates in effect on January 1, 2000 (hereinafter referred to as the initial database).

2. Adjust the total from (VI)(E)(1) to inflate the costs to the prospective rate year as per (III)(D).

3. Divide the result from (VI)(E)(2) by the total recipient days of service in all facilities in the initial database and multiply the result by 1.07. The result is the average direct care staff rate component for all facilities.

4. For rates effective September 1, 2009 and thereafter, to calculate the direct care staff per diem rate component for all facilities for each of the RUG-III case mix groups and for the default groups, divide each RUG-III index from (IV)(B)(3)(c) by 0.9908 and then multiply each of the resulting quotients by the average direct care staff base rate component from (VI)(E)(3).

5. The direct care staff per diem rates will remain constant except for adjustments for inflation from (VI)(E)(2).

STATE: TX
DATE REC'D: DEC 1 2 2008
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DATE EFF: SEP 1 2008
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(F) Determination of each participating facility's total direct care staff rate. Each participating facility's total direct care staff rate will be equal to the direct care staff base rate from (IV)(E) plus any add-on payments associated with enhanced staffing levels selected by and awarded to the facility during open enrollment. HHSC will determine a per diem add-on payment for each enhanced staffing level taking into consideration the most recently available, reliable data relating to LVN equivalent compensation levels. For add-on payments effective September 1, 2003 through December 31, 2005, the add-on payment for each enhanced staffing level will be equal to the add-on payment in effect on August 31, 2003 less 1.75%. For add-on payments effective January 1, 2006 through August 31, 2007, the add-on payment for each enhanced staffing level will be equal to the add-on payment in effect on December 31, 2005 plus 12.2%. For add-on payments effective September 1, 2007 through August 31, 2008, the add-on payment for each enhanced staffing level will be equal to the add-on payments effective August 31, 2007, plus 3.0%.
(G) Staffing requirements for participating facilities. Each participating facility will be required to maintain adjusted LVN equivalent minutes equal to those determined in (VI)(D). Each participating facility's adjusted LVN equivalent minutes maintained during the reporting period will be determined as follows:

1. Determine unadjusted LVN equivalent minutes maintained. Using facility-specific staffing and spending information, HHSC will determine the unadjusted LVN equivalent minutes maintained by each facility during the reporting period.

2. Determine adjusted LVN equivalent minutes maintained. Compare the unadjusted LVN equivalent minutes maintained by the facility during the reporting period from (VI)(G)(1) to the LVN equivalent minutes required of the facility as determined in (VI)(D). The adjusted LVN equivalent minutes are determined as follows:

   (a) If the number of unadjusted LVN equivalent minutes maintained by the facility during the reporting period is greater than or equal to the number of LVN equivalent minutes required of the facility or less than the minimum LVN equivalent minutes required for participation as determined in (VI)(D)(1), the facility's adjusted LVN equivalent minutes maintained is equal to its unadjusted LVN equivalent minutes; or

   (b) If the number of unadjusted LVN equivalent minutes maintained by the facility during the reporting period is less than the number of LVN equivalent minutes required of the facility, but greater than or equal to the minimum LVN equivalent minutes required for participation as determined in (VI)(D)(1); the following steps are performed.

      (i) Determine what the facility's accrued Medicaid fee-for-service revenue for the reporting period would have been if their staffing requirement had been set at a level consistent with the highest LVN equivalent minutes that the facility actually maintained.

      (ii) Determine the facility's adjusted accrued revenue by multiplying the accrued revenue from (VI)(G)(2)(b)(i) by .85.

      (iii) Determine the facility's accrued allowable Medicaid fee-for-service direct care staff expenses for the rate year.

      (iv) Determine the facility's direct care spending surplus for the reporting period by subtracting the facility's adjusted accrued direct care revenue from (VI)(G)(2)(b)(ii) from the facility's accrued allowable direct care expenses from (VI)(G)(2)(b)(iii).

      (v) If the facility's direct care spending surplus from (VI)(G)(2)(b)(iv) is less than or equal to zero, the facility's adjusted LVN equivalent minutes maintained is equal to the unadjusted LVN equivalent minutes maintained as calculated in (VI)(G)(1).

      (vi) If the facility's direct Care spending surplus from (VI)(G)(2)(b)(iv) is greater than zero, the adjusted LVN-equivalent minutes maintained by the facility during the reporting period is set equal to the facility's direct care spending surplus from (VI)(G)(2)(b)(iv) divided by the per diem enhancement add-on for one LVN equivalent minute as determined in (VI)(F) plus the unadjusted LVN equivalent minutes maintained by the facility during the reporting period from (VI)(G)(1) according to the following formula:

         \[
         \text{(Direct Care Spending Surplus / Per Diem Enhancement Add-on for One LVN Equivalent Minute)} + \text{Unadjusted LVN Equivalent Minutes.}
         \]

   (c) For adjusted LVN equivalent minutes calculated on or after March 1, 2004, requirements relating to the minimum LVN equivalent minutes required for participation in (VI)(G)(2)(a) and (b) do not apply.
(H) Staffing accountability. Participating facilities will be responsible for maintaining the staffing levels determined in (VI)(D). HHSC will determine the adjusted LVN equivalent minutes maintained by each facility during the reporting period by the method described in (VI)(G). Participating facilities that fail to maintain staffing at their required level will have their direct care staff rates and staffing requirements adjusted to a level consistent with the highest staffing level that they actually attained and all direct care staff revenues associated with unmet staffing goals will be recouped by HHSC or its designee.

(I) Spending requirements for participants. Participating facilities are subject to a direct care staff spending requirement with recoupment calculated as follows:

1. At the end of the rate year, a spending floor will be calculated by multiplying accrued Medicaid fee-for-service direct care staff revenues by 0.85.

2. Accrued allowable Medicaid direct care staff fee-for-service expenses for the rate year will be compared to the spending floor from (VI)(I)(1). HHSC or its designee will recoup the difference between the spending floor and accrued allowable Medicaid direct care staff fee-for-service expenses from facilities whose Medicaid direct care staff spending is less than their spending floor.

3. Upon request from a parent company, sole member or governmental body that controls more than one nursing facility contract, HHSC will evaluate the contract's compliance with the spending requirements in the aggregate for all contracts that the parent company, sole member or governmental body it controlled at the end of the rate year or at the effective date of the change of ownership or termination of its last nursing facility contract.

4. At no time will a participating facility’s direct care rates after spending recoupment be less than the direct care base rates.
Dietary and Fixed Capital Mitigation. Recoupment of funds described in (VI)(1) may be mitigated by high dietary and/or fixed capital expenses as follows.

(1) Calculate dietary cost deficit. At the end of the facility's rate year, accrued Medicaid dietary per diem revenues will be compared to accrued, allowable Medicaid dietary per diem costs. If costs are greater than revenues, the dietary per diem cost deficit will be equal to the difference between accrued, allowable Medicaid dietary per diem costs and accrued Medicaid dietary per diem revenues. If costs are less than revenues, the dietary cost deficit will be equal to zero.

(2) Calculate dietary revenue surplus. At the end of the facility's rate year, accrued Medicaid dietary per diem revenues will be compared to accrued, allowable Medicaid dietary per diem costs. If revenues are greater than costs, the dietary per diem revenue surplus will be equal to the difference between accrued Medicaid dietary per diem revenues and accrued, allowable Medicaid dietary per diem costs. If revenues are less than costs, the dietary revenue surplus will be equal to zero.

(3) Calculate fixed capital cost deficit. At the end of the facility's rate year, accrued Medicaid fixed capital per diem revenues will be compared to accrued, allowable Medicaid fixed capital per diem costs (i.e., building and building equipment depreciation or lease expense, mortgage interest, land improvements depreciation and leasehold improvements amortization). If costs are greater than revenues, the fixed capital cost per diem deficit will be equal to the difference between accrued allowable Medicaid fixed capital per diem costs and accrued Medicaid fixed capital per diem revenues. If costs are less than revenues, the fixed capital cost deficit will be equal to zero. For purposes of this paragraph, fixed capital per diem costs of facilities with occupancy rates below 85% are adjusted to the cost per diem the facility would have accrued had it maintained an 85% occupancy rate throughout the rate year. For each facility whose occupancy falls below 85%, an adjustment factor is calculated as follows: adjustment factor = 1.00 - (facility's occupancy rate / .85). This adjustment factor is then multiplied by accrued, allowable Medicaid fixed capital per diem costs, and the result of this calculation is subtracted from accrued, allowable Medicaid fixed capital per diem costs.
(4) Calculated fixed capital revenue surplus. At the end of the facility's rate year, accrued Medicaid fixed capital per diem revenues will be compared to accrued, allowable Medicaid fixed capital per diem costs as defined in (VI)(J)(c). If revenues are greater than costs, the fixed capital revenue per diem surplus will be equal to the difference between accrued Medicaid fixed capital per diem revenues and accrued, allowable Medicaid fixed capital per diem costs. If revenues are less than costs, the fixed capital revenue surplus will be equal to zero. For purposes of this paragraph, fixed capital per diem costs of facilities with occupancy rates below 85% are adjusted to the cost per diem the facility would have accrued had it maintained an 85% occupancy rate throughout the rate year. For each facility whose occupancy falls below 85%, an adjustment factor is calculated as follows: adjustment factor = 1.00 - (facility's occupancy rate / .85). This adjustment factor is then multiplied by accrued, allowable Medicaid fixed capital per diem costs, and the result of this calculation is subtracted from accrued, allowable Medicaid fixed capital per diem costs.

(5) Facilities with a dietary per diem cost deficit will have their dietary per diem cost deficit reduced by their fixed capital per diem revenue surplus, if any. Any remaining dietary per diem cost deficit will be capped at $2.00 per diem.

(6) Facilities with a fixed capital cost per diem deficit will have their fixed capital cost per diem deficit reduced by their dietary revenue per diem surplus, if any. Any remaining fixed capital per diem cost deficit will be capped at $2.00 per diem.

(7) Each facility's recoupment, as calculated in (VI)(I), will be reduced by the sum of that facility's dietary per diem cost deficit as calculated in (VI)(J)(5) and its fixed capital per diem cost deficit as calculated in (VI)(J)(6).
(K) Medicaid Swing Bed Program for Rural Hospitals. When a rural hospital participating in the Medicaid swing bed program furnishes NF nursing care to a Medicaid recipient, HHSC or its designee makes payment to the hospital using the same procedures, the same case-mix methodology and the same RUG rates that HHSC authorizes for reimbursing NFs receiving the direct care base rate with no enhancement levels. These hospitals are not subject to the staffing and spending requirements.

(L) Failure to Submit Report. Facilities that do not submit required reports completed in accordance with all applicable rules and instructions within 60 days of the due date will be subject to an immediate recoupment of funds related to participation paid to the facility for services provided during the reporting period in question. These facilities will remain nonparticipating facilities and recouped funds will not be restored until an acceptable report is received. Funds identified for recoupment based on the report will be deducted from recouped funds before the recouped funds are restored.
VII. Reimbursement Methodology for Pediatric Care Facilities

(a) Pediatric Care Facility Class. The purpose of this special class is to recognize, through the adoption of a special payment rate, the cost differences that exist in a nursing facility or distinct unit of a nursing facility that serves predominantly children.

(b) Definitions.

(1) Aged in place – The description of adults who were admitted to the pediatric care facility as children but who are no longer children.

(2) Children – For the purposes of this pediatric care facility class, children are defined as being at or below 22 years of age.

(A) For a pediatric care facility that is designated in its entirety as a pediatric care facility, the following apply.

(i) A limited number of individuals who have “aged in place” may be counted as children for purposes of determining if the facility meets the requirements for remaining a pediatric care facility as described in VII(b)(4).

(ii) The number of such individuals who may be counted as children for purposes of determining if the facility meets the requirements for remaining a pediatric care facility is limited to 33 percent of the average daily census of the facility.

(B) For a facility to initially become a pediatric care facility or to meet the requirements for a distinct unit to remain a pediatric care facility, individuals who have “aged in place” may not be counted toward meeting the requirements for such designations.

(3) Distinct unit – A portion of a nursing facility that is physically separate from, and beds are not commingled with, other units of the facility. The distinct unit can be an entire wing, a separate building, an entire floor, or an entire hallway. The distinct unit consists of all beds within the designated area. A distinct unit must consist of 28 or more Medicaid-contracted beds.
(4) Pediatric care facility – One of the two categories of facilities described below. To become a member of the pediatric care facility class, a contracted provider must send a request in writing by certified mail to the HHSC Provider Finance Department.

(A) An entire facility that has maintained an average daily census of 80 percent or more children for the six-month period prior to its entry into the pediatric care facility class based on the entire licensed facility. To remain a pediatric care facility, the entire facility must maintain an average daily census of 80 percent or more children.

(B) A distinct unit of a facility that has maintained an average daily census of 85 percent or more children for the six-month period prior to its entry into the pediatric care facility class based on the distinct unit of the facility. To remain a pediatric care facility, a distinct unit of a facility must maintain an average daily census of 85 percent or more children.

c (c) Payment rate determination. Payment rates will be determined in the following manner.

(1) Payment rate methodology. The payment rate methodology for this class of service is based upon the unadjusted federal per diem rate for rural Medicare skilled nursing facilities for the most recent federal fiscal year as published in the Federal Register. Payment rates determined in this manner will be:

(A) based on available funds and subject to legislative appropriations; and

(B) paid uniformly for all Medicaid residents of a qualifying pediatric care facility.

(2) Cost reports. Cost reports for pediatric care facilities are governed by the requirements specified in II and III. A nursing facility that contains a pediatric care facility distinct unit must complete two cost reports: one report for the distinct pediatric care facility unit and one report for the remainder of the facility.

(3) Additional reimbursements. A pediatric care facility will not be eligible for additional reimbursements from either of the following sources.

(A) The ventilator-dependent or the children-with-tracheostomies supplemental reimbursements.

(B) Enhanced rates from the Direct Care Staff Enhancement program.
VII. Reimbursement Rates for State Veterans Homes

(a) The following definitions apply to this section:

1. “State veterans home” means a nursing facility as defined in Title 40, Texas Administrative Code (T.A.C.) § 176.1 (relating to Veterans Homes Definitions) that is contracted with the Texas Department of Aging and Disability Services (DADS) to provide nursing facility services to eligible Medicaid recipients who reside in a state veterans home.

2. “Rate period” means the state fiscal year.

3. “VLB” means the Veterans Land Board, the state administrative agency to establish and operate state veterans homes.

4. “DADS” means the Department of Aging and Disability Services, the operating agency that contracts on behalf of HHSC for nursing facility services to Medicaid recipients.

5. “HHSC” means the Health and Human Services Commission, the state administrative agency authorized to adopt standards and rules to govern reimbursement rates and methodologies for Medicaid nursing facility services.

(b) DADS, as authorized by HHSC, will reimburse the VLB for nursing facility services provided by the VLB to Medicaid clients in state veterans homes.

(c) HHSC determines reimbursement rates for state veterans homes to provide nursing facility services.

(d) Interim reimbursement rates for state veterans homes are prospectively determined for each home based on the state veterans home semi-private room basic daily rate in effect on the first day of the rate period. Rates are retrospectively reconciled based upon actual costs in accordance with subsection (j) of this section.

(e) The facility-specific payment rate from subsection (d) of this section will be paid for all Medicaid eligible residents of a state veterans home regardless of the Texas Index for Level of Effort (TILE) level of the resident.
(f) Veterans Administration (VA) per diem payments to the VLB for nursing home care as defined in 38 Code of Federal Regulations (CFR) §51.40 (relating to monthly payment) are not offset against per diem payment rates for Medicaid eligible residents of a state veterans home.

(g) Residents of the state veterans home will not be eligible to receive the supplemental reimbursements for ventilator-dependent residents and for children with tracheostomies (as described in (IV)(B)(5) and (IV)(g) above).

(h) State veterans homes are not eligible to participate in the Enhanced Direct Care Staff Rate or the Performance-based Add-on Payment Program (as described in (VI) and (VII) above).

(i) The VLB will submit financial and statistical information in a format designated by HHSC. This information may be reviewed or audited in accordance with (II)(C) above. Financial and statistical information submitted by the VLB will not be included in the cost report databases used in the reimbursement determination process for the Texas Medicaid NF program.

(j) For each state veterans home, the interim reimbursement rate is adjusted retrospectively based upon actual costs accrued during the rate period.
IX. Supplemental payments to qualifying non-state government-owned nursing facilities

(a) The supplemental payments described in this section will be made in accordance with the applicable regulations regarding Medicaid upper payment limit provisions codified at Title 42 Code of Federal Regulations (CFR) § 447.272.

(b) Definitions. When used in this section, the following definitions apply.

(1) Adjudicated claim – A claim for a covered Medicaid nursing facility service that has been paid by the Texas Health and Human Services Commission (HHSC).

(2) HHSC – The Texas Health and Human Services Commission or its designee.

(3) Intergovernmental transfer (IGT) – A transfer of public funds from a non-state governmental entity to HHSC.

(4) Medicaid supplemental payment limit – The maximum supplemental payment available to a participating non-state government-owned nursing facility for a specific quarterly calculation period.

(5) Medicaid supplemental payment limit calculation period – The federal fiscal quarter determined by HHSC for which supplemental payment amounts are calculated based on adjudicated claims for days of service provided in the same quarter in the prior federal fiscal year. The earliest possible Medicaid supplemental payment limit calculation period under this section is the first quarter of federal fiscal year 2013.

(6) Non-state governmental entity – A hospital authority, hospital district, healthcare district, city, or county.

(7) Non-state government-owned nursing facility – A nursing facility where a non-state governmental entity holds the license and is party to the facility’s Medicaid contract.
Supplemental payments to qualifying non-state government-owned nursing facilities (continued)

(8) Public funds – Funds derived from taxes, assessments, levies, investments, and other public revenues within the sole and unrestricted control of the non-state governmental entity that holds the license and is party to the Medicaid contract of the nursing facility. Public funds do not include gifts, grants, trusts, or donations, the use of which is conditioned on supplying a benefit solely to the donor or grantor of the funds.

(9) Upper payment limit – A reasonable estimate of the amount that would be paid for the services furnished by a non-state government-owned nursing facility under Medicare payment principles.

(10) Upper payment limit calculation period – The federal fiscal quarter prior to the Medicaid supplemental payment limit calculation period. For example, October 1 – December 31, 2011, is the upper payment limit calculation period for the October 1 – December 31, 2012, Medicaid supplemental payment limit calculation period.
Supplemental payments to qualifying non-state government-owned nursing facilities (continued)

(c) Medicaid supplemental payment limits. A quarterly supplemental payment amount for each non-state government-owned nursing facility is calculated by taking the difference between the upper payment limit from paragraph (1) of this subsection and the Medicaid payment from paragraph (2) of this subsection.

(1) The upper payment limit for each non-state government-owned nursing facility will be calculated based on Medicare payment principles and in accordance with the Medicaid upper payment limit provisions codified at Title 42 Code of Federal Regulations (CFR) §447.272. A total Medicare-equivalent payment is determined for each non-state government-owned nursing facility as the sum of the products of Medicaid days of service by resource utilization group (RUG) for adjudicated Medicaid days of service provided by the facility during the upper payment limit calculation period multiplied by the Medicare payment rate for that RUG that will be in effect during the associated Medicaid supplemental payment limit calculation period. If the Center for Medicare and Medicaid Services has not adopted Medicare RUG rates for the Medicaid supplemental payment limit calculation period at the time the calculation is performed, the Medicaid days of service by RUG will be multiplied by the Medicare payment rate for that RUG in effect on the last day of the upper payment limit calculation period.

(2) The Medicaid payment for each non-state government-owned nursing facility prior to supplemental payment will be the sum of the following components calculated for that nursing facility from data derived from the upper payment limit calculation period:

(A) The sum of Medicaid RUG payments for adjudicated Medicaid days of service provided by the facility during the upper payment limit calculation period adjusted to reflect any changes in Medicaid RUG rates between the upper payment limit calculation period and the Medicaid supplemental payment limit calculation period; and

(B) Medicaid payments for pharmacy services, specialized services, customized equipment and emergency dental services not included in the Medicaid nursing facility rate in effect during the upper payment limit calculation period.
Supplemental payments to qualifying non-state government-owned nursing facilities (continued)

(i) Medicaid payments for pharmacy services are based on Texas specific pharmacy payment and rebate data for Texas Medicaid nursing facility residents during the upper payment limit calculation period.

(ii) Medicaid payments for emergency dental, customized equipment, and specialized services are based on Texas specific emergency dental, customized equipment, and specialized services payment data for Texas Medicaid nursing facility residents during the upper payment limit calculation period.

(3) Changes of ownership.

(A) For a nursing facility that changed ownership prior to the first day of the Medicaid supplemental payment limit calculation period but after the first day of the upper payment limit calculation period, the data used for the calculations described in paragraphs (1) and (2) of this subsection will include data from the facility for the entire upper payment limit calculation period including data relating to payments for days of service provided under the prior owner. The inclusion of data relating to payments for days of service provided under the prior owner will ensure that the calculation of the supplemental payment amount for the Medicaid supplemental payment limit calculation period reflects a full quarter of services.

(B) For a nursing facility that changes ownership on or after the first day of the Medicaid supplemental payment limit calculation period, the data used for the calculations described in paragraphs (1) and (2) of this subsection will include data from the facility for the entire upper payment limit calculation period relating to payments for days of service provided under the prior owner, pro-rated to reflect only the number of calendar days during the Medicaid supplemental payment limit calculation period that the facility is owned by the new owner.
Supplemental payments to qualifying non-state government-owned nursing facilities (continued)

(d) Payment frequency. HHSC will distribute Medicaid supplemental payments to participating non-state government-owned nursing facilities on a quarterly basis subsequent to the Medicaid supplemental payment limit calculation period.

(e) Required application. Before a non-state government-owned nursing facility may receive supplemental payments under this section, the appropriate governmental entity must certify certain facts, representations and assurances regarding program requirements.
EPSDT DIAGNOSTIC AND TREATMENT SERVICES NOT OTHERWISE COVERED UNDER THE STATE PLAN

Payment for authorized medically necessary services required to diagnose and treat a condition found on EPSDT medical screening will be based on existing Medicare and Medicaid reimbursement methodologies.
RESERVED
Augmentative Communication Device (ACD)

a. The department reimburses facilities for costs necessarily incurred to provide augmentative communication devices (ACDs) to residents of nursing facilities that demonstrate a verifiable medical need. This payment is not part of the facility reimbursement rate and is a separate payment amount reimbursed to the nursing facility through a voucher.

b. The nursing facility is required to request two bids for the ACD and the reimbursement of the device will be the lesser of the two bids. In the event that only one bid can be obtained due to lack of ACD providers, a request for an exception may be considered by HHSC or its designee. Prior authorization is still required if an exception is granted by HHSC or its designee.
Customized Adaptive Aids, Customized Power Wheelchairs and Associated Seating Assessments

a. Customized adaptive aids, customized power wheelchairs for Medicaid clients in nursing facilities are reimbursed in the same manner as the Health and Human Services Commission (HHSC) or its designee reimburses Medicaid fee-for-service providers for the same products and procedure codes. HHSC or its designee reimburses Medicaid fee-for-service providers for customized adaptive aids, customized power wheelchairs at the lesser of the provider's billed charges or the published Medicaid fee. The published Medicaid fee is determined using at least one of the following methods: the current Medicare fee or a percentage thereof, a review of manufacturers' suggested retail prices minus a discount, a review of providers' actual invoiced amounts, or other available data. If a Medicaid fee is not published, the provider is paid through manual pricing, with the manual pricing guidelines based on the manufacturer’s suggested retail price minus a discount or the provider’s actual invoiced amounts.

Physical therapists, speech therapists and occupational therapists providing assessments for customized adaptive aids and power wheelchairs for Medicaid clients in nursing facilities are reimbursed in the same manner as the HHSC or its designee reimburses Medicaid fee-for-service providers for the same services and procedure codes. HHSC or its designee reimburses Medicaid fee-for-service providers of wheelchair assessments at the lesser of the provider's billed charges or the published Medicaid fee. The published Medicaid fee is either a resource-based fee (RBF) or an access-based fee (ABF). RBFs are based on actual resources required by an economically efficient provider to provide each individual service and are calculated by multiplying the applicable Medicare relative value unit (RVU) times the applicable Medicaid conversion factor. ABFs are developed to account for deficiencies in RBFs relating to adequacy of access to healthcare services for Medicaid clients and are based on at least one of the following: the total Medicare fee (i.e., Medicare RVU times the Medicare conversion factor); survey of providers' costs to provide the individual service; and Medicaid fees for similar services.

c. All fee schedules are available through the agency’s website as outlined on Attachment 4.19-B, Page 1.

d. The agency’s fee schedule was revised with new fees for customized adaptive aids, customized power wheelchairs, and associated seating assessments effective October 1, 2013, and this fee schedule was posted on the agency’s website on October 15, 2013.
Nursing Facility Rehabilitative and Specialized Services

a. Reimbursement for nursing facilities that provide Medicaid specialized and rehabilitative therapy sessions through the use of independent occupational, physical, and speech therapists for Medicaid-only clients in nursing facilities is calculated as follows:

1. Hourly fees for occupational and physical therapy sessions are based on the current Medicare non-facility relative value units (RVUs) for these services times the applicable Medicaid conversion factor of $28.640 times four since the Medicare RVUs for these sessions are based on 15-minute increments.

2. The hourly fee for a speech therapy session is based on the current Medicare non-facility RVU for this service times the applicable Medicaid conversion factor of $28.640 times two since the Medicare RVU for a speech therapy session is based on 30-minute increments.

3. Rehabilitative and specialized therapy evaluations are reimbursed using the hourly fees for the applicable type of therapy session as calculated in paragraphs (1) and (2) of this subsection.

b. Reimbursement for nursing facilities that provide Medicaid specialized and rehabilitative therapy evaluations and sessions through the use of nursing facility employee or contract labor for Medicaid-only clients in nursing facilities is calculated as follows: Adjust the raw sum of therapist wage costs in all nursing facilities included in the rate base in order to account for inflation between the cost period and the rate period, and then divide the adjusted total by the sum of therapist hours in all facilities in the rate base. Multiply the resulting weighted, average per hour therapist wage by 1.20 to account for payroll taxes and benefits.
Specialized Add-On Services for Nursing Facility Residents

(a) Employment assistance, supported employment, day habilitation, independent living skills training, and behavioral support as described in Appendix 1 to Attachment 3.1-B, Pages 5e-5j, and habilitation coordination as described in Appendix 1 to Attachment 3.1-B, Pages 5k-5l, are reimbursed in the same manner as the Health and Human Services Commission (HHSC) or its designee reimburses Medicaid fee-for-service providers for the same services. HHSC or its designee reimburses Medicaid fee-for-service providers for employment assistance, supported employment, day habilitation, independent living skills training, behavioral support, and habilitation coordination at the published Medicaid rate. Each rate compensates a provider for all activities listed in the definition of the specialized service set out in Appendix 1 to Attachment 3.1, Pages 5e-5g, including transportation.

(b) All fee schedules are available through the agency’s website as outlined on Attachment 4.19-B, page 1.

(c) The agency’s fee schedule was revised with new rates for employment assistance, supported employment, day habilitation, independent living skills training, and behavioral support effective December 1, 2017, and this rate schedule was posted on HHSC’s website on October 1, 2017.

(d) No payment under this section is dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.

(e) There is no duplication of services or payments between the nursing home base rate and the items listed on Attachment 3.1-A pages Se through 5l.

(f) There is no duplication of services or payments between the State Plan case manager and a MCO case manager provider for Habilitation Coordination services.

(g) Rates for Day Habilitation, Independent Living Skills Training, Supported Employment, Employment Assistance and Behavioral Support were calculated using state developed Home and Community-based Services Cost Reports. The rate for Habilitation Coordination was developed using state developed cost reports submitted by Local IDD Authorities. The rates are developed from the most recent audited cost reports available at the time the proposed rates are calculated and projected to the rate period. HHSC adjusts reported expenses using a cost finding methodology to determine allowed costs. Providers are responsible for eliminating all unallowable expenses from the cost report. HHSC will exclude unallowable costs from the cost report and will exclude entire cost reports from rate determination if it believes that the cost reports do not reflect economic and efficient use of resources.

(h) Rates do not include costs related to room and board or other unallowable facility costs.

(i) In accordance with 42 CFR §431.107, each provider or organization furnishing services will agree to keep any records necessary to disclose the extent of services that the provider furnishes to beneficiaries and, on request, will furnish HHSC any information maintained and any information regarding payments claimed by the provider for furnishing services under this plan.
Specialized Add-On Services for Nursing Facility Residents (continued)

(j) In accordance with Section 2500.2(A) of the State Medicaid Manual, which prescribes the use of the quarterly CMS-64 Form:

(1) HHSC will report on the CMS-64 Form only expenditures for which all supporting documentation is available, in readily reviewable form, which has been compiled and which is immediately available when the claim is filed.

(2) The supporting documentation will include, as a minimum, the following data:

(A) Date of service;
(B) Name of recipient;
(C) Medicaid identification number;
(D) Name of provider agency and person providing the service;
(E) Nature, extent, or units of service; and
(F) The place of service.

(k) To develop and revise as necessary economic and efficient rates, HHSC will require providers to maintain all documentation necessary to support the allowable costs data that is submitted in state-developed cost reports, which providers file with HHSC in accordance with 42 CFR §447.253(f). Additionally, in accordance with 42 CFR §447.253(g), HHSC will conduct periodic audits of the financial and statistical records of participating providers. During the conduct of cost report audits by HHSC, if a provider is unable to furnish supporting documentation in a readily reviewable form and/or upon immediate request, HHSC will exclude any cost report data that cannot be validated.

Except as otherwise noted in the plan, state developed rate schedules are the same for both governmental and private providers.
INSTITUTIONAL STATE PLAN AMENDMENT
ASSURANCE AND FINDING CERTIFICATION STATEMENT

STATE: TEXAS

REIMBURSEMENT TYPE: Inpatient hospital
Nursing facility X
ICF/MR __

PROPOSED EFFECTIVE DATE: October 1, 1996

A. State Assurances and Findings. The State assures that it has made the following findings:

1. 447.253(b)(1)(i) - The State pays for inpatient hospital services and long-term care facility services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards. X

2. With respect to inpatient hospital services --

   a. 447.253(b)(1)(ii)(A) - The methods and standards used to determine payment rates take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs.

   b. 447.253(b)(1)(ii)(B) - If a State elects in its State plan to cover inappropriate level of care services (that is, services furnished to hospital inpatients who require a lower covered level of care such as skilled nursing services or intermediate care services) under conditions similar to those described in section 1861(v)(1)(G) of the Act, the methods and standards used to determine payment rates must specify that the payments for this type of care must be made at rates lower than those for inpatient hospital level of care services, reflecting the level of care actually received, in a manner consistent with section 1861(v)(1)(G) of the Act.

If the answer is "not applicable," please indicate:

"not applicable"

STATE: TEXAS
DATE REC'D: 3-19-96
DATE APP'ED: 4-4-96
DATE EFF.: 10-1-96
HCFA 179: A

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c. 447.253(b)(1)(ii)(C) - The payment rates are adequate to assure that recipients have reasonable access, taking into account geographic location and reasonable travel time, to inpatient hospital services of adequate quality.

3. With respect to nursing facility services --
   
a. 447.253(b)(1)(iii)(A) - Except for preadmission screening for individuals with mental illness and mental retardation under 42 CFR 483.20(f), the methods and standards used to determine payment rates take into account the costs of complying with the requirements of 42 CFR part 483 subpart B. X
   
b. 447.253(b)(1)(iii)(B) - The methods and standards used to determine payment rates provide for an appropriate reduction to take into account the lower costs (if any) of the facility for nursing care under a waiver of the requirement in 42 CFR 483.30(c) to provide licensed nurses on a 24-hour basis. X
   
c. 447.253(b)(1)(iii)(C) - The State has established procedures under which the data and methodology used to establish payment rates are made available to the public. X

4. 447.253(b)(2) - The proposed payment rate will not exceed the upper payment limits as specified in 42 CFR 447.272:
   
a. 447.272(a) - Aggregate payments made to each group of health care facilities (hospitals, nursing facilities, and ICFs/MR) will not exceed the amount that can reasonably be estimated would have been paid for those services under Medicare payment principles. X
   
b. 447.272(b) - Aggregate payments to each group of State-operated facilities (that is, hospitals, nursing facilities, and ICFs/MR) -- when considered separately -- will not exceed the amount that can reasonably be estimated would have been paid for under Medicare payment principles.

If there are no State-operated facilities, please indicate "not applicable:"

"not applicable"
c. 447.272(c) - Aggregate disproportionate share hospital (DSH) payments do not exceed the DSH payment limits at 42 CFR 447.296 through 447.299.

B. State Assurances. The State makes the following additional assurances:

1. For hospitals --

   a. 447.253(c) - In determining payment when there has been a sale or transfer of the assets of a hospital, the State's methods and standards provide that payment rates can reasonably be expected not to increase in the aggregate solely as a result of changes of ownership, more than payments would increase under Medicare under 42 CFR 413.130, 413.134, 413.153 and 413.157 insofar as these sections affect payment for depreciation, interest on capital indebtedness, return on equity (if applicable), acquisition costs for which payments were previously made to prior owners, and the recapture of depreciation.

2. For nursing facilities and ICFs/MR --

   a. 447.253(d)(1) - When there has been a sale or transfer of the assets of a NF or ICF/MR on or after July 18, 1984 but before October 1, 1985, the State's methods and standards provide that payment rates can reasonably be expected not to increase in the aggregate, solely as a result of a change in ownership, more than payments would increase under Medicare under 42 CFR 413.130, 413.134, 413.153 and 413.157 insofar as these sections affect payment for depreciation, interest on capital indebtedness, return on equity (if applicable), acquisition costs for which payments were previously made to prior owners, and the recapture of depreciation.

   b. 447.253(d)(2) - When there has been a sale or transfer of the assets of a NF or ICF/MR on or after October 1, 1985, the State's methods and standards provide that the valuation of capital assets for purposes of determining payment rates will not increase (as measured from the date of acquisition by the seller to
the date of the change of ownership) solely as a result of a change of ownership, by more than the lesser of:

(i) 1/2 of the percentage increase (as measured from the date of acquisition by the seller to the date of the change of ownership) in the Dodge construction index applied in the aggregate with respect to those facilities that have undergone a change of ownership during the fiscal year; or

(ii) 1/2 of the percentage increase (as measured from the date of acquisition by the seller to the date of the change of ownership) in the Consumer Price Index for All Urban Consumers (CPI-U) (United States city average) applied in the aggregate with respect to those facilities that have undergone a change of ownership during the fiscal year.

3. 447.253(e) - The State provides for an appeals or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with respect to such issues as the State determines appropriate, of payment rates.

4. 447.253(f) - The State requires the filing of uniform cost reports by each participating provider.

5. 447.253(g) - The State provides for periodic audits of the financial and statistical records of participating providers.

6. 447.253(h) - The State has complied with the public notice requirements of 42 CFR 447.205.

Notice published on: n/a
If no date is shown, please explain:

Public notice is not required for this amendment.

7. 447.253(i) - The State pays for inpatient hospital and long-term care services using rates determined in accordance with the methods and standards specified in the approved State plan.
C. Related Information

1. 447.255(a) - NOTE: If this plan amendment affects more than one type of provider (e.g., hospital, NF, and ICF/MR; or DSH payments) provide the following rate information for each provider type, or the DSH payments. You may attach supplemental pages as necessary.

Provider Type: NF

Estimated average proposed payment rate as a result of this amendment: $66.45

Average payment rate in effect for the immediately preceding rate period: $66.45 (see Attachment A)

Amount of change: $0.00  Percent of change: 0.00%

2. 447.255(b) - Provide an estimate of the short-term and, to the extent feasible, long-term effect the change in the estimated average rate will have on:

(a) The availability of services on a statewide and geographic area basis:
   no impact

(b) The type of care furnished:
   no impact

(c) The extent of provider participation:
   no impact

(d) For hospitals -- the degree to which costs are covered in hospitals that serve a disproportionate number of low income patients with special needs:

I HEREBY CERTIFY that to the best of my knowledge and belief, the information provided is true, correct, and a complete statement prepared in accordance with applicable instructions.

Completed by: Director, Rate Analysis

I HEREBY CERTIFY that to the best of my knowledge and belief, the information provided is true, correct, and a complete statement prepared in accordance with applicable instructions.

Completed by: Director, Rate Analysis

I HEREBY CERTIFY that to the best of my knowledge and belief, the information provided is true, correct, and a complete statement prepared in accordance with applicable instructions.

Completed by: Director, Rate Analysis

I HEREBY CERTIFY that to the best of my knowledge and belief, the information provided is true, correct, and a complete statement prepared in accordance with applicable instructions.

Completed by: Director, Rate Analysis

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State Assurances for Nursing Facilities (NFs)  

As required by 42 CFR 447.253(b)-(g):

- The department assures that the Title XIX NF payment rates are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

- The department assures that its proposed payment rates are reasonably expected to pay no more in the aggregate for NF care services than the amount that the department reasonably estimates would be paid under the Medicare principles of reimbursement.

- The department assures that it provides an appeals procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with respect to such issues that the department determines appropriate, of payment rates.

- The department assures that it requires in its state plan that each participating provider submit financial and statistical information at least annually in a uniform cost report prescribed by the department.

- The department assures that it provides for desk audit verification of each cost report, and for the on-site audit of a sufficient number of cost reports each year to ensure the fiscal integrity of the Texas Medicaid NF program.

- The department assures that it has provided public notice when proposing significant changes to the reimbursement methodology for NFs.

- The department assures that it has found the payment rate to be determined in accordance with methods and standards specified in the approved State plan.

- The department assures that for NFs, the payment methodology used by the state can reasonably be expected not to increase payments solely as a result of changes in ownership in excess of the increase which would result from applying the Social Security Act, §1861(v)(1)(O).
State Assurances for Nursing Facilities

Related Information:

- With regard to the requirements set forth at 42 CFR 255(a), the department submits that the estimated average payment amount for eligible recipients residing in facilities reimbursed under the proposed pediatric care reimbursement class is $63.00. This amount represents an increase of $7.56 over the estimated average payment amount paid on behalf of eligible recipients in such facilities under the previous case mix methodology.

- With regard to 42 CFR 255(b), the department estimates that rates generated as a result of this cost finding methodology will have no effect on the availability of services, on a statewide or geographic area basis, or sufficient care of adequate quality, or upon provider participation. It is further projected that rates generated as a result of this cost finding methodology will result in an increase of $204,158 for the period April through December 1990 over the rates in effect in the immediately preceding period.
Texas Department of Human Services

John H. Winters Human Services Center • 701 West 51st Street
Mailing Address: P.O. Box 2960 • Austin, Texas 78769

COMMISSIONER

March 31, 1989

Mr. Don Hearn, Chief
State Operations Branch
Health Care Financing Administration
Department of Health and Human Services
1200 Main Tower Building
Dallas, Texas 75202

Dear Mr. Hearn:

The Texas Department of Human Services (TDHS) submits transmittal 89-9 amendment number 229, which amends its State Plan for Medical Assistance as regards Attachment 4.19-D, Reimbursement Methodology for Intermediate Care Facilities and Skilled Nursing Facilities (ICF/SNF) by deleting §V, Allowable Costs, and substituting §V, Allowable and Unallowable Costs. Additionally, §III, Cost Finding Methodology, C., Adjustments to Certain Reported Expenses, is amended by adding subparagraph C.(2) regarding occupancy adjustments. Finally, §IV, Rate Setting Methodology, is amended by adding subsection IV, F. Rate Component Determination. (Amendments attached)

As required by 42 CFR 447.253(b)-(g):

- The department has made a finding that the Title XIX ICF/SNF payment rates are reasonable and adequate to meet the costs that are incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

- The department has made a finding that its proposed payment rates are reasonably expected to pay no more in the aggregate for ICF/SNF care services than the amount that the agency reasonably estimates would be paid for the services under the Medicare principles of reimbursement.

- The department assures that it provides an appeals procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with issues that the department determines appropriate, of payment rates.

- The department assures that it requires in its state plan that each participating provider submit financial and statistical information at least annually in a uniform cost report prescribed by the department.
The department assures that it provides for desk audit verification of each cost report, and for the on-site audit of a sufficient number of cost reports each year to ensure the fiscal integrity of the Texas Medicaid Long Term Care program.

The department assures that it has provided public notice when proposing significant changes to the Reimbursement Methodology for ICF/SNFs.

The department assures that it has found the payment rate to be determined in accordance with methods and standards specified in the approved state plan.

The department assures that for ICF/SNFs, the payment methodology used by the State can reasonably be expected not to increase payments solely as a result of changes in ownership in excess of the increase which would result from applying the Social Security Act, §1861(v)(1)(O).

Thank you for your prompt consideration.

Sincerely,

Charles Stevenson
Acting Commissioner

Attachments
Dear Mr. Hearn:

This is in response to your June 30, 1989, letter requesting further clarification of the State Plan Amendment 89-9, to Section 4.19-D, Reimbursement Methodology for Intermediate Care and Skilled Nursing Facilities (ICFs/SNFs), which was submitted by the Texas Department of Human Services (TDHS) on March 31, 1989. Your questions and our responses follow:

1. **Assurances.** Although the State made an upper limit assurance that its payment rates will not exceed the amount estimated under the Medicare principles, the State should clarify that it has made a separate finding and assurance as it applies to State operated facilities under 42 CFR 447.272(b).

   **Response:** As required under 42 CFR 447.272(b), the department has made a finding that payment rates which would be made to State operated facilities under this methodology would not exceed the amount that reasonably could be expected to have been paid under Medicare payment principles.

2. **Related Information.** The State must also provide related information in compliance with 447.255(a) showing an estimate of the average proposed rate and the amount by which that rate increased or decreased relative to the average rate in effect in the immediately preceding period. The State must also estimate the effect of the change on the availability of services on a statewide and geographic area basis, type of care furnished and the extent of provider participation.

   **Response:** As regards 447.255(a), the department submits that the estimated average payment rate for ICFs/SNFs under the proposed amendment is $39.63. This amount represents an increase of $2.29 over the estimated average payment rate in effect for the immediately preceding rate period.
Response: As regards 447.255(b), (1)-(3), the department estimates that rates generated as a result of this cost finding methodology will have no adverse effect on the availability of services, on a statewide or geographic area basis, or sufficient care of adequate quality, or upon provider participation.

3. Methods and Standards.

a. In Section C(2) of the plan amendment, the State is proposing to establish criteria in order to apply an occupancy adjustment to ICF/SNF providers. Please specify the precise methodology to be used in applying this occupancy adjustment. An example included in the plan would be most helpful to specify the mechanics of the adjustment.

Response: For each provider whose occupancy rate falls below the target occupancy rate, an adjustment factor is calculated.

\[ \text{Adjustment factor} = 1.00 - (\text{provider's occupancy rate} \times \text{appropriate target occupancy rate}) \]

This adjustment factor is then multiplied by each line item cost in the facility and administration cost areas, and the result of this calculation is subtracted from the line item amount.

b. In Section III(D), it would appear that some language has been omitted. Also, the State should revise this section to specify what it intended with regard to this section. Specifically, we would request clarification in the plan with regard to the projection of costs for substantively equal treatment.

Response. The language in Section III, Cost Finding Methodology, D. Projected Costs, was approved by HCFA on 8/16/85 (transmittal 85-2), and re-approved by HCFA effective July 1, 1988 (transmittal 88-13). No changes were made in this language.

c. In Section IV(F)(2), the State references subparagraphs (2)(B) and (C) of subsection (g) as the method for determining all-other cost centers. The State further indicates that the rate component determination process will be based on fiscal year 1987 cost report data adjusted as specified in subsection (f) of this section. We would ask the State to review these references because we can not determine from the citations how the all-other cost centers are determined, or adjusted.
Response. This language was submitted in error; it relates to processes in State agency rules, and should not appear in the State Plan at all. We apologize for the confusion this has caused, and request that Section IV F. 1 and 2 be deleted.

Additionally, under Section IV, Rate Setting Methodology, Paragraph D (Exceptions to the Reimbursement Rate Determined by the TDHS Board) was inadvertently deleted in a previous submittal (89-7, regarding a case mix method of reimbursement). The department requests that it be reinstated, as Paragraph E, same title. Submittal page attached.

Thank you for your prompt attention and approval.

Sincerely,

Ron Lindsey
Commissioner

Attachment
March 31, 1989

Mr. Don Hearn, Chief
State Operations Branch
Health Care Financing Administration
Department of Health and Human Services
1200 Main Tower Building
Dallas, Texas 75202

Dear Mr. Hearn:

The Texas Department of Human Services (TDHS) submits transmittal 89-7, amendment number 227, which amends its State Plan for Medical Assistance as regards attachment 4.19-D, Reimbursement Methodology for Intermediate Care Facilities and Skilled Nursing Facilities (ICF/SNF), by revising Section IV, Rate Setting Methodology, paragraphs A, B, C, to base reimbursement on a case-mix methodology for eligible recipients in Medicaid contracted nursing facilities. (Amendment attached.)

Additionally, as required by 42 CFR 447.253(b)-(g):

- The department has made a finding that the Title XIX ICF/SNF payment rates are reasonable and adequate to meet the costs that are incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

- The department has made a finding that its proposed payment rates are reasonably expected to pay no more in the aggregate for ICF/SNF care services than the amount that the agency reasonably estimates would be paid for the services under the Medicare principles of reimbursement.

- The department assures that it provides an appeals procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with issues that the department determines appropriate, of payment rates.

- The department assures that it requires in its state plan that each participating provider submit financial and statistical information at least annually in a uniform cost report prescribed by the department.
The department assures that it provides for desk audit verification of each cost report, and for the on-site audit of a sufficient number of cost reports each year to ensure the fiscal integrity of the Texas Medicaid Long Term Care program.

The department assures that it has provided public notice when proposing significant changes to the Reimbursement Methodology for ICF/SNFs.

The department assures that it has found the payment rate to be determined in accordance with methods and standards specified in the approved state plan.

The department assures that for ICF/SNFs, the payment methodology used by the State can reasonably be expected not to increase payments solely as a result of changes in ownership in excess of the increase which would result from applying the Social Security Act, §1861(v)(l)(O).

With regard to the requirements set forth in 42 CFR 255(a), the department submits that the estimated average payment amount for eligible recipients in ICF/SNFs under the proposed case mix methodology is $39.74. This amount represents an increase of $2.44 over the estimated average payment amount paid on behalf of eligible recipients in ICF/SNFs under the previous flat-rate prospective methodology.

With regard to 42 CFR 255(b), the department estimates that rates generated as a result of this cost finding methodology will have no effect on the availability of services, on a statewide or geographic area basis, or sufficient care of adequate quality, or upon provider participation. It is further projected that rates generated as a result of this cost finding methodology will result in an increase of $36,537,292 for CY 1989 over the rates in effect in the immediately preceding period.

Thank you for your prompt consideration.

Sincerely,

Charles Stevenson
Acting Commissioner

Attachments
August 4, 1989

Mr. Don Hearn, Chief
State Operations Branch
Health Care Financing Administration
Department of Health and Human Services
1200 Main Tower Building
Dallas, Texas 75202

Dear Mr. Hearn:

This is in response to your letter, dated June 30, 1989, regarding the Texas Department of Human Services' (TDHS) March 31, 1989, State Plan Amendment, Number 227, Transmittal 89-7. TDHS' amendment addressed reimbursement methodology under a Case Mix method of payment for Intermediate Care Facilities and Skilled Nursing facilities (ICF/SNF). Your requests for further information or clarification, and our responses, are as follows:

1. **Assurances:** The State made a general upper limit assurance that its payment rates will not exceed the amount it would have paid using Medicare principles. However, the State needs to submit a separate assurance that it has made an additional upper limit finding under 42 CFR 447.272(b), which applies to State-owned and operated facilities.

   **Response:** As required 42 CFR 447.253(c)(2) and 447.272(b), the department has made a finding that, as required by , aggregate payments which would have been made to state-owned and operated facilities under this methodology would not exceed the amount which reasonably could be expected to have been paid under Medicare payment principles.

2. **Case Mix Classification System:** The State is requested to revise its amendment to provide further information on its case mix classification system. Please provide a description of the four basic clinical categories and the eleven case mix groups including definitions of the types of cases assigned to each category.

   **Response:** See supplemental information Attachment A.

   A relative cost weight is established for each case mix group based on the staff time required on average to deliver direct care to patients in that group. Please explain how the average direct care staff time was determined. The amendment should also indicate how often the cost weights will be recalibrated. As related information, we would appreciate knowing the current case mix weights established for each TILB group.
Response: Average direct care staff time associated with each case mix group was determined by time studies conducted in 1987 in conjunction with assessments on 1377 patients in Texas Medicaid contracted facilities.

Response: In order to allow adequate time for adjustment to the new system, the relative cost weights will not be recalibrated during the first year following implementation of the case mix payment system. During the second and subsequent years following implementation, time studies will be conducted to determine the appropriateness of recalibrating the relative cost weights.

Response: The case mix weights established for each TILE group are equal to the relative patient care components of each TILE payment rate. These are:

<table>
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<tr>
<th>CASE MIX GROUP</th>
<th>PAT CARE RATE</th>
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<td>18.24</td>
<td>30.46</td>
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*FAD = Facility, Administrative, Dietary components ("All other" cost center).

Rate Components: The State is requested to clarify the period used to compute the initial patient care and the all-other-cost-component rates. Will these rates be recomputed or rebased annually or will base-period rates be recomputed or rebased periodically? The plan should specify how often rates will be rebased and how rates for intervening periods, if applicable, will be adjusted for inflation. Although it need not be included in the plan, we would appreciate a detailed example of how the patient care...
component was computed, including the Statewide average cost for this component, the adjustment for unallowable costs, the inflation factor, applied, the 1.07 percent adjustment, and case mix adjustment to the average cost per day. In this connection, the State is asked to explain the basis for or purpose of the 1.07 percent adjustment.

Response: The initial rates are based on fiscal year 1987 cost reports, with costs for the patient care component inflated to the April 1, 1989-to-December 31, 1989, effective dates and the all-other component inflated to the January 1, 1989-to-December 31, 1989, effective dates. The rates will be rebased and recomputed annually, as per the pertinent sections of the Texas Medicaid State Plan which have been in effect for some years.

Response: The average patient care component is defined in the Plan language as the sum of patient care costs from the rate base divided by the patient days of service delivered by those facilities included in the rate base. In other words, the average patient care component is a weighted average cost. For rates effective April 1, 1989, the average patient care component was $21.46. The patient care rate components for each of the 11 TILE groups were calculated by multiplying the $21.46 average by a relative level of effort index. The index associated with each of the 11 TILE groups is derived by (i) assigning to each TILE group an index of weighted average total minutes of care administered to patients in each group (weighted by average hourly compensation rates of nursing staff relative to nurse aides), as measured by time studies; (ii) calculating the average index for the current patient population; and (iii) dividing each of the initial TILE indexes referenced in (i) above by the average referenced in (ii) above. Thus TILE groups which require less average effort than the statewide average receive patient care payments of less than $21.46, while heavier-care TILEs receive payments greater than $21.46.

Response: The calculation of average patient care costs includes audit adjustments for unallowable costs and inflation, as per existing sections of the approved State Plan. The final step of enhancing projected costs by a seven percent "opportunity for profit" factor represents a longstanding effort to insure that the rate-setting process accommodates reasonably efficient operators. (If, for example, rates were determined year-after-year at the median of projected costs, with no enhancement, about 50 percent of providers would be expected to operate at a deficit in any given year. Such a situation would not be conducive to industry stability and would likely undermine quality care.)
4. **Case mix Rate Phase-In:** The plan amendment provides for paying the higher of case mix rates or a declining percentage of existing LOC rates during a five-year transition period. To implement this phase-in, the State would determine the higher payment level from a rolling three-month period. This determination would be used in computing payments for the given month of service. The procedure seems unduly complex. We would be interested in knowing why this determination could not be made for each month of service at the time payment is made.

**Response:** The rolling three-month period approach is designed to compensate for the fact that the billing process is not instantaneous. Some billings for service are incorrect as initially submitted and others are submitted late. Consequently, billings pertaining to a given month are substantially incomplete for several months following the end of the month in question. The use of a three-month moving average serves to minimize any errors and omissions which would otherwise be present if payments were based only on the most recent monthly average.

5. **Adequacy of Rates During the Phase-In:** The proposed phase-in for the case mix payment system is intended to minimize the impact of the revenue loss for the affected facilities. As indicated in section 4(a)(iii), the phase-in process would adjust the patient-care rate component downward by as much as 20 percent by 1993 for an unknown number of facilities. At that time, each ICF and SNF facility would be reimbursed according to the case mix methodology. Our concern is with the rate decrease of the phase-in process as it relates to the average proposed rate increase under this amendment. Therefore, the State is asked to explain how the average proposed rate can increase overall by 6.5 percent as the result of establishing a case mix methodology and still cause some facilities to experience a patient rate component decrease of 20 percent by the end of the phase-in period.

**Response:** Since the implementation of the case mix system on April 1, 1989, the proportion of Texas facilities paid the baseline rates has declined steadily from 9.1 to 82 percent of the total. With normal increases in the case mix rates due to inflation, it is anticipated that all facilities will be paid under the case mix system within two to three years. Consequently, before the end of the scheduled phase-in period, the decline of the baseline rates should become of little practical significance. In fact, of the eleven TILES groups, only the rates for the two lightest-care groups are lower than the baseline rates. Since no facility currently has a census consisting solely of clients in these two groups, average rates for the lightest-care facilities would be greater than the lowest TILES rate even in the absence of a baseline. Furthermore, the TILES weights are based on measured differences in resource utilization across TILES. Consequently, the case mix rates themselves should be adequate to meet the costs which must be incurred by economically and efficiently operated facilities. The primary function of the baseline
rates is to avert undue financial hardship on the part of those facilities which may find it necessary to alter their patterns of practice.

6. Supplemental SNF Rate: In Section IV.C, the State has established criteria for qualifying recipients for a supplemental reimbursement rate; however, it failed to include the process of how this rate is determined. We would request the State to specify in its plan language the methodology to be used in setting the supplemental rate for SNF recipients.

Response: The methodology for determining the supplemental SNF rate is a part of approved State Plan language. Consistent with the implementation of baseline rates under the case mix methodology, the basic supplemental rate is $7.59 per diem during the phase-in period.

Thank you for your consideration of this material, and for your prompt approval of State Plan Amendment Number 227, Transmittal 89-7.

Sincerely,

Charles Stevenson
Acting Commissioner
What is the TILE classification system?

The TILE (Texas Index for Level of Effort) model is a classification system developed by the Texas Department of Human Services to group nursing home residents on the basis of their medical conditions and functional abilities. The case mix groups were determined through statistical and clinical analyses of resident assessment and staff time measurement data collected in samples of Texas nursing facilities. Each of the case mix groups are associated with a case mix weight (effort index) indicating the relative amount of direct-care staff time required by residents in that group. The group weights represent the average amount of direct-care staff time devoted to caring for residents in each group.

The TILE classification system includes four clinical categories: (1) Heavy Care, (2) Rehabilitation, (3) Clinically Complex, and (4) Medically Stable. These clinical categories are subdivided on the basis of resident functioning on the Activities of Daily Living (ADLs) of eating, transferring, and toileting for a total of eleven case mix groups.

Who is included in each of the clinical groups?

The Heavy Care Group. To be classified as Heavy Care, a resident must have or be receiving one or more of the following:

- comatose,
- quadriplegia,
- stage 3 or 4 decubitus with decubitus care,
- non-oral nourishment,
- daily oral/nasal suctioning,
- daily tracheostomy care.

To qualify for the Heavy Care group, a resident must also have a total ADL score of 9 or greater. If a resident is not appropriate for the Heavy Care group, they are next considered for inclusion in the Rehabilitation group.

The Rehabilitation Group. To be considered for the Rehabilitation group, a resident must be receiving either physical or occupational therapy three or more times per week. This therapy must be provided or supervised by a licensed rehabilitation therapist. If a resident is not appropriate for either the Heavy Care or the Rehabilitation groups, they are next considered for inclusion in the Clinically Complex group.

The Clinically Complex Group. To be classified into the Clinically Complex group, a resident must have or be receiving one or more of the following:

- a recent amputation of a limb,
- seizures,
- dehydration with intake/output monitoring two or more times per day,
- incontinence with bowel and bladder training three or more times per day,
- urinary tract infection with intake/output monitoring three or more times per day,
- daily oxygen administration,
- respiratory therapy three or more times per day,
- wound dressing two or more times per day.
If a resident is not appropriate for the Heavy Care group, the Rehabilitation group or the Clinically Complex group, they are automatically included in the Medically Stable group.

The Medically Stable Group. This group includes all remaining residents. Medically Stable residents who have one or more of the following cognitive or behavioral characteristics and have an ADL score of 3 or 4 (see below) are included in the Mental/Behavioral Condition subgroup:

- Incoherent/Frequent Disorientation,
- Daily Disruptive Behavior,
- Daily Aggressive Behavior.

How does the Activity of Daily Living (ADL) scale work?

The TILE model considers a resident's functional ability in the three Activities of Daily Living (ADLs) of eating, transferring, and toileting. A resident's score on each ADL can range from 1 to 5. A score of 1 indicates the resident is independent on the ADL while a score of 5 indicates the resident is very dependent on the ADL. A simple 15 point additive ADL scale was developed to classify residents into one of eleven case mix groups on the basis of their combined score in eating, transferring, and toileting. A resident's combined score on all three of the ADLs can range from 3 to 15. A combined ADL score of 3 indicates a resident is very independent on all three ADLs while an ADL score of 15 indicates the resident is very dependent.

How does the TILE classification system work?

The TILE model uses a two-step approach to classify residents.

The first step is to determine the highest clinical group the resident qualifies for based on their current medical condition and service needs. For example, if a resident has one of the listed medical conditions or is receiving one of the therapeutic interventions specified for the Heavy Care group along with an ADL score of 9 or greater, the resident is included in the Heavy Care group. If the resident is not a candidate for the Heavy Care group, the TILE model then considers the resident for inclusion in the Rehabilitation group. If the resident is receiving physical or occupational therapy three or more times per week, the resident is included in the Rehabilitation group. If not, the resident is considered for inclusion in the Clinically Complex group. If the resident does not qualify for the Clinically Complex group, the TILE model automatically includes the resident in the Medically Stable group.

The second step is to determine the resident's combined ADL score by totalling their scores on eating, transferring, and toileting. Within the clinical category the resident qualified for, the TILE model then classifies the resident into the appropriate case mix group.
Texas Index for Level of Effort (TILE)

1. Cognitive
2. Quadruplegia
3. Stage 3-4 with Special Care and/or Rounded Dressings (2x or more Daily)
4. Non-Oral Nourishment
5. CPFL/ARFL Suctioning (Daily)
6. Tracheostomy Care/Suctioning (Daily)
7. and RDS Score = 6 or More

Heavy Care

Yes

Class 201
RDL 8-9
CHI = 2.10

No

Yes

Class 203
RDL 5-7
CHI = 1.74

No

Yes

Rehabilitation

Class 202
RDL 3-9
CHI = 1.88

No

Yes

Class 204
RDL 7-9
CHI = 1.33

No

Class 205
RDL 4-6
CHI = 1.18

No

Class 208
RDL 3
CHI = 0.85

Clinical Instability

No

Class 205
RDL 7-9
CHI = 1.23

No

Class 207
RDL 5-6
CHI = 1.03

Class 209
RDL 4
CHI = 0.87

No

Disruptive Behavior (Daily)

Class 210
RDL 3
CHI = 0.60

Mental/Behavioral Condition

Class 210
RDL 3
CHI = 0.60

No

Class 211
AOL 3
CHI = 0.52

ADL's

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State: 4 3 6 9
Date: 9 6 1 3 9
Date and Year: 9 8 7 4
HCFA 179
Prepared 10/20/88
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

STATE OF __________ TEXAS __________

DEFINITION OF A CLAIM—TIMELY CLAIMS PAYMENT

The State Agency has listed below specific services provided by this State plan which are most closely associated with a definition of a claim under the conditions governing the management and operation of the Texas Medical Assistance Program. In determining the correlation of a service to a definition of a claim, consideration has been given to the State Agency's interpretation of the language in 42CFR447.45 which defines a "claim" and to the State Agency's and its authorized representative's use of a "claim" under current contracts, agreements, policies, and procedures.

1. Services associated with the definition "all services for one recipient within a bill" are as follows:
   a. Inpatient, outpatient, emergency hospital
   b. Rural Health Clinic
   c. Other laboratory and x-ray
   d. EPSDT—Dental
   e. Family Planning
   f. Physician
   g. Podiatrist
   h. Optometrist
   i. Chiropractor
   j. Home Health
   k. Hearing Aid
   l. Eyeglasses
   m. Ambulance
   n. Certain transportation
   o. Ambulatory Surgery Center Services
   p. Services for individuals age 65 and over in institutions for mental diseases—inpatient hospital services

2. Services associated with the definition "a line item of service" are as follows:
   a. Skilled Nursing Facility
   b. Intermediate Care Facility
   c. Intermediate Care Facility—Mentally Retarded
   d. Prescribed Drugs
   e. Personal Care
   f. Rehabilitation
3. Services associated with the definition "a bill for service" are as follows:
   
a. EPSDT-screening
b. Certain transportation
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: TEXAS

Requirements for Third Party Liability
Identifying Liable Resources

(a) The Texas Medicaid agency meets all requirements of 42 CFR 433.138 for identification of liable third parties. (1) Section 433.138(d) -- The Texas Medicaid agency is apprised of potential third party resources from various sources. These referrals are used to identify and verify legally liable third party resources. Information regarding third party resources is incorporated into the eligibility case file.

The Texas Medicaid agency performs data matches with third parties in order to identify health insurance coverage. This information, including information for individuals on whose behalf medical child support enforcement is being carried out by the Texas State title IV-D agency, is entered into the State’s third-party database and used to process claims in accordance with third party payment procedures.

(2) Section 433.138(d)(l) -- The responsibilities of the State Wage Information Collection Agency (SWICA) as defined in 42 CFR 435.4 are administered by the Texas Workforce Commission (TWC). The State Medicaid eligibility data base is matched against the TWC wage file and against the TWC monthly unemployment pay file at least quarterly. Medicaid accretions that occur between the quarterly scheduling are periodically run against the TWC files. Worker-initiated wage and unemployment inquiries are run against the TWC files as needed, and Medicaid eligibility files are matched monthly against the Social Security Administration (SSA) wage and earnings files as specified in 42 CFR 435.948(a). The TWC and SSA matches provide information on Medicaid recipients that are employed and their employers. These matches include employed absent or custodial parents of recipients and their employers.

(3) Section 433.138(d)(3) -- The Texas State IV-A Program determines Title XIX eligibility and secures information on Medicaid recipients that are employed and their employer(s) on a continuous basis.

(4) Section 433.138(d)(4) -- The Texas Medicaid agency contracts with a vendor that conducts weekly and monthly data matching by utilizing a national data warehouse where multi-state casualty claims are recorded. If a match is made, the vendor notifies the responsible casualty insurance carrier of the State’s intent to recover from the insurance settlement.

Section 433.138(d)(5) -- Documentation has been submitted to the Centers for Medicare and Medicaid Services (CMS) Regional Office VI that demonstrates the agency has made a
reasonable attempt to perform a match with the State Motor Vehicle Accident Report files that are maintained by the Texas Department of Public Safety (DPS). No match is conducted with the State Motor Vehicle Accident Report files because neither the names nor the social security numbers (SSNs) are maintained by the DPS for conducting such a match.

(5) Section 433.138(e) -- The Texas Medicaid agency takes action monthly to identify paid claims of $1.00 or more for Medicaid recipients that were involved in an accident where there is a potential liable third party. Research is performed to determine the legal liability of third parties in order to pursue recovery.

(b) The Texas Medicaid agency meets all requirements of 42 CFR 433.138(g) for follow-up procedures for identification of liable third parties.

(1) Section 433.138(g)(1)(i) — Within 45 days from the date the data exchange is received, or as otherwise specified in 42 CFR 435.952(d), the Texas Medicaid agency follows up (if appropriate) on such information to identify legally liable third party resources and incorporates such information into the eligibility case file and into its third party database and third party recovery unit so that claims may be processed under the third party liability payment procedures specified in 433.139(b) through (f).

(2) Section 433.138(g)(2) — Within 60 days, the Texas Medicaid agency will follow up on health insurance information to identify legally liable third party resources and incorporate this information into the eligibility case file and into its third party database and third party recovery unit so the agency may process claims under the third party liability payment procedures specified in 433.139(b) through (f).

(3) All health insurance updates are entered into the Medicaid Management Information System (MMIS) within ten (10) work days of receipt and into the Texas Automated Recovery System (TARS) for post payment recovery monthly.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM
State: TEXAS

STATE LAWS REQUIRING THIRD PARTIES TO PROVIDE
COVERAGE ELIGIBILITY AND CLAIMS DATA

1902(a)(25)(I) The State has in effect laws that require third parties to comply with the provisions, including those which require third parties to provide the State with coverage, eligibility, and claims data, of 1902(a)(25)(I) of the Social Security Act.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: TEXAS

Requirements of Third Party Liability
Payment of Claims

The Texas Medicaid agency or designee meets all requirements of 42 CFR 433.139.

(1) Section 1902(a)(25)(E) -- Claims for prenatal services, including labor and delivery and postpartum care are processed using standard coordination of benefits cost avoidance.

(2) 42 CFR 433.139(b)(3)(i) -- Claims related to preventive pediatric services, including early and periodic screening, diagnosis and treatment services will be paid and not denied due to the existence of a third party unless the Medicaid agency has made a determination related to cost-effectiveness and access to care that warrants cost avoidance for up to 90 days.

(3) Section 433.139(b)(3)(ii) -- Claims related to individuals on whose behalf medical child support enforcement is known to be carried out by the State title IV-D agency will be paid and not denied due to the existence of a third party. The Texas Medicaid agency retains the flexibility to make payments without regard to potential third party liability for up to 100 days for claims related to child support enforcement beneficiaries.

(4) Reimbursement for paid claims related to preventive pediatric services and to individuals on whose behalf medical child support enforcement is known to be carried out by the State title IV-D agency will be pursued through the Texas Automated Recovery System (TARS) process. Procedures for seeking reimbursement will be initiated within sixty (60) days after the end of the month in which the health insurance carrier is identified, or within sixty (60) days after the end of the month in which payment was made.

(5) Section 433.139(a) and (b)(1) -- Providers are required to seek reimbursement from a liable third party that the provider knows about before billing the Texas Medicaid agency. When a provider submits a claim to the Texas Medicaid agency when probable liability of third party insurance exists, the claim is cost avoided. Through this process, the claim is denied and returned to the provider to determine the amount of liability. Once third party liability has been determined, the claim will be paid to the extent that payment is allowed under the Texas Medicaid agency’s payment schedule.

(6) Section 433.139(a) and (f) -- Post payment recovery of claims paid by the Texas Medicaid agency prior to the establishment of third party liability is pursued through the TARS process.

TN: _21-0046_ Approval Date: _02-02-2022_
Supersedes TN: _15-0007_ Effective Date: _12-01-2021_
Procedures for seeking reimbursement will be initiated within sixty (60) days after the end of the month in which the health insurance carrier is identified, or within sixty (60) days after the end of the month in which payment was made.

Requests for reimbursement will be initiated on all claims meeting cost effectiveness criteria. Claims for $100.00 or more will be pursued within sixty (60) days following the month of Medicaid payment. Claims for less than $100.00 will be accumulated until the amount reaches $100.00 or until six (6) months have elapsed (whichever comes first). If after six (6) months the accumulation has not reached $100.00, all accumulated claims will be billed. Initiation of post payment recovery activity of all claims will, however, begin during the month cycle when the $100.00 accumulation is reached.

A minimum dollar amount to be accumulated and minimum dollar amounts for follow-up on unresolved recovery attempts will be applied to ensure reasonable cost effectiveness of the third party reimbursement effort.

If no response is received by the twelfth (12th) month after the date of initial billing, the case will be closed and no further action taken.

When the provider has billed a third party prior to billing Medicaid and certifies that payment has not been received within 110 days after billing the third party, Medicaid will consider the claim for reimbursement.

(7) Section 433.139(a) -- When Medicare eligibility is established retroactively, claims that were paid by Medicaid are also identified. Eligible Medicaid claims are adjusted to deny the service and an Account Receivable is set up to recoup the Medicaid payment from the provider. The provider is notified to bill Medicare for the services. Medicaid services not covered by Medicare are not included in this process.

(8) Section 42 CFR 447.20 -- The Medicaid agency ensures that the provider furnishing a service for which a third party is liable follows the restrictions specified in 42 CFR 447.20.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE/TERRITORY: TEXAS

Requirements for Enrollment in Employer Base Group Health Insurance

(a) The Medicaid Agency meets all requirements of the Omnibus Budget Reconciliation Act (OBRA) of 1990, Section 4402.

(1) The Medicaid Agency pays all premiums, deductibles, coinsurance and other cost sharing obligations for items and services covered under the State plan for Medicaid eligible individuals in employer-base cost-effective group health plans.

(2) The Medicaid Agency pays premiums for enrollment of all family members eligible for insurance coverage when cost-effective regardless of whether all family members are Medicaid eligible.

(3) If all family members become ineligible for Medicaid, the Medicaid Agency stops the monthly premium reimbursement process. However, as long as at least one family member remains Medicaid eligible, premium reimbursement continues for a minimum period of 12 months.

(4) The Medicaid Agency evaluates cases for cost-effectiveness based on a Medical Insurance Input Form 1039 referral by the caseworker.

(5) Enrollment in an employer-based group health plan, if available, is a condition of eligibility for the policy holder and their dependents. The Medicaid Agency informs Eligibility caseworkers of any non-cooperation from the policy holder.

(6) The Medicaid Agency uses the following cost-effectiveness Methodology. The method provided in the State Medicaid Manual, Section 3910, is used to eliminate a case from consideration, not to select a case. The actual Medicaid expenditures for each case is being used to select cases that are cost-effective.
If both formulas state that cases are not cost effective, they are eliminated from further consideration. If the actual Medicaid expenditures formula states that cases are cost effective, the buyin procedures are started. If the method provided in the State Medicaid Manual states that cases are cost effective and the actual Medicaid expenditures formula states those same cases are not cost effective, they are held in suspense and re-evaluated in 9 months, at which point a final determination is made.

Below are the guidelines that the Medicaid Agency uses in determining cost effectiveness for employer group health plans. The Section 3910 formula and the actual Medicaid expenditures formula are run simultaneously for each case during the initial evaluation.

Section 3910 Formula:

**Step 1:** Information is obtained concerning the group health plan available to the Medicaid recipient. This information includes the effective date of the policy, exclusions to enrollment, the covered services under the policy and premiums due from the employee.

**Step 2:** Using the Medicaid Management Information System (MMIS), the average total expenditures per person per year for Medicaid services for persons in the same Risk Group as each client in the case are obtained.

**Step 3:** The total yearly Medicaid expenditures is determined.

**Step 4:** The expense amount (step 3) is adjusted for the higher prices employer plans pay. The expense is multiplied by the national factor of 1.6 (updated annually by HCFA) to produce an estimated expense as recognized by the employer plan.
Step 5: The health plan cost (step 4) is multiplied by the average employer health insurance payment rate to obtain the employer recognized covered expense amount. The average payment rate factor varies by how large the average employer recognized covered expense is.

<table>
<thead>
<tr>
<th>Health Plan Cost</th>
<th>Payment Factor</th>
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</thead>
<tbody>
<tr>
<td>$500 - $999.99</td>
<td>.750</td>
</tr>
<tr>
<td>$1000 - $1999.99</td>
<td>.795</td>
</tr>
<tr>
<td>$2000 - $2999.99</td>
<td>.835</td>
</tr>
<tr>
<td>$3000 and up</td>
<td>.850</td>
</tr>
</tbody>
</table>

Step 6: An administrative fee for processing Section 4402 is multiplied by the number of Medicaid Clients within each case.

Step 7: The Cost to the group health plan (step 4) is subtracted from the employer recognized amount (step 5) to determine the deductible, coinsurance, and other costs sharing, within types of service covered under the plan. The result is added to the employee’s premium (step 1) and to the administrative fee (step 6) to determine the costs to the State Agency under the group health plan.

Step 8: To determine if the group health plan is cost effective, the Cost to the State for Medicaid (step 3) is subtracted from the Cost to the State under the group health plan (step 7). If the answer is a positive net savings the Medicaid Agency considers this group health plan as cost effective and the buyin process is begun.
Actual Medicaid Expenditures Formula:

The Medicaid Agency uses the same steps that are used in the section 3910 formula except for Step 2 which is:

Step 2: Using the Medicaid Management Information System (MMIS), the actual Medicaid expenditures for each client in the case are obtained.
Sanctions for Psychiatric Hospitals

(a) The State assures that the requirements of section 1902(y)(1), section 1902(y)(2)(A), and section 1902(y)(3) of the Act are met concerning sanctions for psychiatric hospitals that do not meet the requirements of participation when the hospital's deficiencies immediately jeopardize the health and safety of its patients or do not immediately jeopardize the health and safety of its patients.

(b) The State terminates the hospital's participation under the State plan when the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies immediately jeopardize the health and safety of its patients.

(c) When the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies do not immediately jeopardize the health and safety of its patients, the State may:
   1. terminate the hospital's participation under the State plan; or
   2. provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding; or
   3. terminate the hospital's participation under the State plan and provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding.

(d) When the psychiatric hospital described in (c) above has not complied with the requirements for a psychiatric hospital within 3 months after the date the hospital is found to be out of compliance with such requirements, the State shall provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the end of such 3-month period.
Sanctions for MCOs and PCCMs

(a) The State will monitor for violations that involve the actions and failure to act specified in 42 CFR Part 438 Subpart I and to implement the provisions in 42 CFR 438 Subpart I, in manner specified below:

(b) The State uses the definition below of the threshold that would be met before an MCO is considered to have repeatedly committed violations of section 1903(m) and thus subject to imposition of temporary management:

(c) The State's contracts with MCOs provide that payments provided for under the contract will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by CMS under 42 CFR 438.730(e).

Not applicable; the State does not contract with MCOs, or the State does not choose to impose intermediate sanctions on PCCMs.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Texas

INCOME AND ELIGIBILITY VERIFICATION SYSTEM PROCEDURES
REQUESTS TO OTHER STATE AGENCIES

Not applicable

APPROVED BY DHHS/HCFA/DPO
DATE: OCT 01, 1986
TRANSMITTAL NO: 86-19

HCFA ID: 0123P/0002P
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Texas

METHOD FOR ISSUANCE OF MEDICAID ELIGIBILITY CARDS TO HOMELESS INDIVIDUALS

The Texas Department of Human Services mails Medicaid eligibility cards to the address provided by the client, whether a residence or not, i.e., Salvation Army office.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Texas

REQUIREMENTS FOR ADVANCE DIRECTIVES UNDER STATE PLANS FOR MEDICAL ASSISTANCE

The following is a written description of the law of the State (whether statutory or as recognized by the courts of the State) concerning advance directives. If applicable States should include definitions of living will, durable power of attorney for health care, durable power of attorney, witness requirements, special State limitations on living will declarations, proxy designation, process information and State forms, and identify whether State law allows for a health care provider or agent of the provider to object to the implementation of advance directives on the basis of conscience.

See attached pages 1a through 1e
STATE OF TEXAS
GENERAL INFORMATION ON RIGHTS TO MAKE TREATMENT DECISIONS

In Texas, there are only three ways in which an individual's right to make treatment decisions may be transferred to another person:

- The competent individual may make the decision in the form of properly executed directives (verbal or written, such as Directive to Physicians/Living Will or Durable Power of Attorney for Health Care),
- The individual may be declared incompetent by a court of law and have a guardian appointed who can make his/her treatment decisions, or
- The individual is determined by his/her physician to be medically or physically incapable of communication and in a terminal condition.

I. DIRECTIVE TO PHYSICIANS/LIVING WILL

The Directive to Physicians/Living Will found in the Texas Natural Death Act (Texas Health and Safety code §672.001-021), was originally enacted in 1977 and amended since then - most recently in 1989. The statute does not require an individual to follow precisely the form it contains, but permits the individual to add specific instructions of his/her own choosing - including designation of another person to make treatment decisions on the individual's behalf when the individual becomes comatose, incompetent, or otherwise physically or mentally incapable of communication.

Additionally, the individual may want to list particular treatment to be withheld or withdrawn if in a terminal condition - for example, "I do not want antibiotics, surgery, cardiac resuscitation, a respirator, artificial feeding . . ." (See Attorney General Opinion No. JM837 relating to artificial feeding as a life-sustaining procedure.) The individual may emphasize the desire to be kept comfortable and pain-free even though medication may shorten life.

The Directive to Physicians/Living Will must be signed in the presence of two witnesses, who must also sign the Directive to Physicians/Living Will. The witnesses may not be:

[Redacted]

[Redacted]
ATTACHMENT 4.34-A

Page 1b

(1) related by blood or marriage;
(2) entitled to any portion of the individual's estate on
upon death of the individual;
(3) a claimant against the estate at the time of signing;
(4) the individual's physician or any of the physician's
employees;
(5) an employee in a health care facility in which the
individual is a patient, if the employee is providing
direct patient care to the individual or is directly
involved in the facility's financial affairs.

The individual should discuss the Directive to
Physicians/Living Will with his/her doctor, who should make a
copy of it as part of the medical record.

Properly signed and witnessed, a Directive to
Physicians/Living Will remains in effect until or unless the
individual revokes it. As long as an individual is competent,
his/her own expressed wishes (verbal or written) always
supersede a Directive to Physicians/Living Will.

If a female is diagnosed as pregnant, and that diagnosis is
known to the physician, the directive will have no force or
effect during the course of the pregnancy.

II. DURABLE POWER OF ATTORNEY

Texas has a Durable Power of Attorney (PoA) law that
permits an individual to designate another individual as his or
her attorney in fact or agent by power of attorney, to be in
effect beyond the point of the individual's disability or
incompetence. In such a case, the document must specify "this
power of attorney shall not terminate on disability of the
principal" or similar words showing the intent of durability of
the power of attorney beyond the point of disability or
incompetence. A PoA must be filed for record in the county in
which the principal resides, except for a power of attorney
executed for Medical Care. A durable PoA executed for Medical
Care must meet the requirements found as Tex. Rev. Civ. Stat.
Act 4590h-1.
III. DURABLE POWER OF ATTORNEY FOR HEALTH CARE

Texas also has a Durable Power of Attorney for Health Care law (Tex. Rev. Stat. Art. 4590h-1) that permits an individual to appoint an agent specifically authorized to make medical treatment decisions on the individual's behalf. These decisions can include the decision to refuse or withdraw consent to medical treatment. The agent can make medical decisions for the individual when the individual lacks the capacity to make decisions himself/herself, regardless of whether or not the individual is in a terminal condition. The agent may not be one of the following persons:

(1) the individual's health care provider;
(2) an employee of the individual's health care provider unless the person is the individual's relative;
(3) the individual's residential care provider; or
(4) an employee of the residential care provider unless the person is the individual's relative.

The Durable Power of Attorney for Health Care can be an extremely useful complement to a Directive to Physicians/Living Will. It can broaden and strengthen control over treatment choices when an individual is unable to exercise the right of informed consent. A disclosure statement must be signed as part of a Durable Power of Attorney for Health Care.

Both parts, the Disclosure Statement and the Durable Power of Attorney for Health Care portions, must be properly executed and witnessed. Witnesses may not be:

(1) the individual's agent;
(2) the individual's health or residential care provider or an employee of the health or residential care provider who is providing direct care;
(3) a spouse or heir;
(4) a person entitled to any part of the estate, you the death of the individual under a will or deed in existence or by operation of law; or
(5) any other person who has any claim against the estate of the individual.
IV. GENERAL INSTRUCTIONS FOR ADVANCE DIRECTIVES

- Keep signed originals with important personal papers at home.
- Give signed copies to doctors, family, agent, or other health care providers.
- If possible, the individual should review the Directive to Physicians/Living Will or Durable Power of Attorney for Health Care from time to time to make sure it continues to properly express the individual's intent.
- If an individual executes both a Directive to Physicians/Living Will and a Durable Power of Attorney for Health Care and names an agent on the Directive to Physicians/Living Will, it is best to execute them both on the same date, and to designate the same person to act. Otherwise, inconsistencies may cause interpretive difficulties, and the document executed on the latest date will control.

V. WHEN A PERSON IS INCOMPETENT AND HAS NO DIRECTIVE AND HAS NO LEGAL GUARDIAN

(a) If an adult qualified patient has not executed or issued a directive and is comatose, incompetent, or otherwise mentally or physically incapable of communication, the attending physician and the patient's legal guardian may make a treatment decision that may include a decision to withhold or withdraw life-sustaining procedures from the patient. A qualified patient is one who has been determined to be in a terminal condition, in accordance with the Texas Natural Death Act.

(b) If the patient does not have a legal guardian, the attending physician and at least two persons, if available, of the following categories, in the following priority, may make a treatment decision that may include a decision to withhold or withdraw life-sustaining procedures:

1. the patient's spouse;
2. a majority of the patient's reasonably available adult children;
(3) the patient's parents; or
(4) the patient's nearest living relative.

(c) A treatment decision made under paragraph (a) or (b) must be based on knowledge of what the patient would desire, if known.

(d) A treatment decision made under paragraph (b) must be made in the presence of at least two witnesses who are not:

(1) related to the patient by blood or marriage;
(2) entitled to any part of the patient's estate after the patient's death under a will or codicil (amendment to a will) executed by the patient, or by operation of law;
(3) the attending physician;
(4) an employee of the attending physician or health care facility in which the patient is receiving services;
(5) a patient in the same health care facility;
(6) a person who, at the time of treatment decision and witnessing, has a claim against any part of the patient's estate after the patient's death.

VI. CONSCIENTIOUS OBJECTION

The only reference to conscientious objection in Texas law concerning advanced directives is in the Natural Death Act (Health and Safety Code §672.016(c), and this citation addresses conscientious objection only in relation to physicians.
The State uses other factors described below to determine the seriousness of deficiencies in addition to those described at §488.404(b)(1):

NONE
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Texas

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Termination of Provider Agreement: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

XX Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)
Temporary Management: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

XX Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE: Texas

DATE SIGNED: JAN 12 1996

DATE ENTERED: JUL 01 1995

TN No. 95-24

SUPERSEDES: NONE - NEW PAGE

JAN 1 2 1996 Effective Date JUL 01 1995
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Texas

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Denial of Payment for New Admissions: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

___ Specified Remedy
(Will use the criteria and notice requirements specified in the regulation.)

___ Alternative Remedy
(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

SUPERSEDES: NONE - NEW PAGE
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: Texas

ELIGIBILITY CONDITIONS AND REQUIREMENTS
Enforcement of Compliance for Nursing Facilities

Civil Money Penalty: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

Specified Remedy
(Will use the criteria and notice requirements specified in the regulation.)

Alternative Remedy
(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

State/Territory: Texas

JUL 01 1995

SUPERSEDES: NONE - NEW PAGE

JAN 12 1996

Effective Date: JUL 01 1995

Approval Date: JAN 12 1996

HCFA 179

JUL 01 1995

SUPERSEDES: NONE - NEW PAGE

HCFA 179

JUL 01 1995
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Texas

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

State Monitoring: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

XX Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Texas

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Enforcement of Compliance for Nursing Facilities

Transfer of residents; Transfer of residents with closure of facility: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

XX Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)
Additional Remedies: Describe the criteria (as required at \(1919(h)(2)(A)\)) for applying the additional remedy. Include the enforcement category in which the remedy will be imposed (i.e., category 1, category 2, or category 3 as described at 42 CFR 488.408).

Procedures Following Termination of the Provider Agreement. When a facility's provider agreement is terminated by DHS, the department will not enter into a provider agreement with the facility until 30 days have expired. The facility will be notified according to the requirements in 42 CFR 488.402. If the facility reapplies for a provider agreement, DHS conducts an on-site visit to determine if the facility is complying with Medicaid requirements. If the facility is complying with Medicaid requirements and a provider agreement with the facility is not prohibited by DHS debarment rules, DHS enters into a provider agreement with the facility. This remedy will be applied in any category which results in the termination of the provider agreement.

Termination of Provider Agreement on the Basis of the Imposition of Enforcement Actions Three Times Within an Accountability Period.

(a) When the Provider Enrollment Section of DHS determines that DHS or HCFA has imposed required Category II or III remedies on a facility three times within an accountability period, a recommendation is made to terminate the facility's provider agreement.

(b) DHS notifies the facility in writing of its intention to terminate the facility's provider agreement. Notification occurs within:
   (1) 3 calendar days from receipt of the recommendation of remedies for facilities found in immediate jeopardy.
   (2) 15 calendar days from receipt of the recommendation of remedies for facilities not found in immediate jeopardy.

(c) The provider agreement is terminated on the 20th day after the facility receives notice of DHS's decision to terminate the provider agreement.

(d) The appeal for this remedy is the appeal on the issue of noncompliance that led to the imposition of enforcement actions for the third time within the accountability period. Appeals for this remedy follow the federal procedures in 42 CFR 498 for dually-participating facilities or in 42 CFR 431 for Medicaid-only facilities.

(e) Accountability period - A 24-month period which begins each time a required Category II or III remedy is imposed on a facility. Accountability periods may overlap.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Texas

DISCLOSURE OF ADDITIONAL REGISTRY INFORMATION

The State will disclose the following information to the nursing facility upon request in addition to that required in 42 CFR 483.156 (c)(1)(iii) and (iv):

Whether the individual was waived or not
The type of training program
Date of Birth
Social Security Number
Address
Employment history if appropriate
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Texas

COLLECTION OF ADDITIONAL REGISTRY INFORMATION

The State's Registry contains the following information to the nursing facility upon request in addition to that required in 42CFR 483.156 (c):

Whether the individual was waived or not

The type of training program

Date of Birth

Social Security Number

Address

Employment history if appropriate
PASRR: Level II Evaluation
The preadmission screening and resident review (PASRR) Level II evaluation is provided to all individuals who are suspected of having mental illness (MI) or an intellectual or developmental disability who seek admission to a Medicaid-certified nursing facility (NF). The PASRR Level II evaluation accomplishes the following tasks:

1. Confirms that an individual meets the PASRR definition of MI or has an intellectual or developmental disability.
2. Determines whether the individual’s needs could be met in a setting other than a NF.
3. Determines if the individual has a medical necessity for admission to the NF.
4. Identifies all specialized services from which the individual can benefit while receiving services in a NF.

The PASRR Level II evaluation includes both preadmission and resident review evaluations.

\footnote{This term has the same meaning as “mental retardation,” defined at 42 C.F.R. § 483.102(b)(3).}
PASRR Level II Preadmission Screening by Categorical Determination

The following categories developed by the state mental health or mental retardation authorities may be made applicable to individuals identified by Level I as possibly having serious mental illness/mental retardation when existing data on the individual appear to be current and accurate and are sufficient to allow the reviewer readily to determine that the individual fits into the category. The data available includes physical, mental, and functional assessments as required by 42 CFR 483.132(c). An adequate inspection of records for a categorical determination takes the place of the nursing facility (NF) or the specialized services individualized Level II evaluation. The state mental health or mental retardation authority produces categorical evaluation and determination reports as required by 42 CFR 483.128 and 483.130. When existing data is not adequate, or any judgment is required about the presence of serious mental illness/mental retardation, the individual is referred for individualized Level II evaluation. Individuals are either discharged or evaluated by Level II Resident Review within the specified time limits (if any). (Check each that applies, and supply definitions and time limits as required.)

I. Categorical determination that NF placement is appropriate. Specialized services evaluation and determination by the SMH/MRA is individualized.

☑ Convalescent care from an acute physical illness which required hospitalization and does not meet all the criteria for an exempt hospital discharge (as specified in 42 CFR 483.106(b)(2) is not subject to preadmission screening).

<table>
<thead>
<tr>
<th>Definition</th>
<th>Time limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual is admitted from an acute care hospital to an NF for convalescent care with an acute physical illness or injury which required hospitalization and is expected to remain in the NF for greater than 30 days. An individualized Level II determination must be completed within 7 working days.</td>
<td>7 days</td>
</tr>
</tbody>
</table>

☑ Terminal illness, as defined for hospice purposes in 42 CFR 418.3.

<table>
<thead>
<tr>
<th>Additional Definition (optional)</th>
<th>Time limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Terminally ill means that the individual has a medical prognosis that his or her life expectancy is six months or less if the illness runs its normal course. An individual's medical prognosis is documented by a physician's certification, which is kept in the individual's medical record maintained by the nursing facility. An individualized Level II determination must be completed within 7 working days.</td>
<td>7 days</td>
</tr>
</tbody>
</table>
PASRR Level II Preadmission Screening by Categorical Determination (continued)

- Severe physical illness resulting in ventilator dependence or diagnosis such as chronic obstructive pulmonary disease, Parkinson's disease, Huntington's disease, amyotrophic lateral sclerosis, congestive heart failure, which result in a level of impairment so severe that the individual could not be expected to benefit from specialized services.

<table>
<thead>
<tr>
<th>Definition</th>
<th>Time limit</th>
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</thead>
<tbody>
<tr>
<td>The individual's level of physical impairment is so severe that it is evident that the individual requires NF services and is not likely to benefit from specialized services. An individualized Level II determination must be completed within 7 working days.</td>
<td>7 days</td>
</tr>
</tbody>
</table>

II. Categorical determination that NF placement is appropriate. Option to also categorically determine by the SMH/MRA that specialized services are not needed. No categorical determinations are made that specialized services (SS) are needed.

- Provisional admission pending further assessment in case of delirium where an accurate diagnosis cannot be made until the delirium clears.

<table>
<thead>
<tr>
<th>Additional Definition (optional)</th>
<th>Categorical SS</th>
<th>Time limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals whose stay in the nursing facility exceeds seven days must have a PASRR Resident Review.</td>
<td>✗</td>
<td>7 days</td>
</tr>
</tbody>
</table>

- Provisional admission pending further assessment in emergency situations requiring protective services, with placement in the nursing facility not to exceed 7 days.

<table>
<thead>
<tr>
<th>Additional Definition (optional)</th>
<th>Categorical SS</th>
<th>Time limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals whose stay in the nursing facility exceeds seven days must have a PASRR Resident Review.</td>
<td>✗</td>
<td>7 days</td>
</tr>
</tbody>
</table>
PASRR Level II Preadmission Screening by Categorical Determination (continued)

- Very brief and finite stays of up to a fixed number of days to provide respite to in-home caregivers to whom the individual with MI or MR is expected to return following the brief NF stay.

<table>
<thead>
<tr>
<th>Definition</th>
<th>Categorical SS Not Needed</th>
<th>Time limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals whose stay in the nursing facility exceeds fourteen days must have a PASRR Resident Review.</td>
<td>×</td>
<td>14 days</td>
</tr>
</tbody>
</table>

- Coma or functioning at brain stem level

<table>
<thead>
<tr>
<th>Definition</th>
<th>Categorical SS Not Needed</th>
<th>Time limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe illness or injury resulting in inability to respond to external communication or stimuli, such as coma or functioning at brain stem level. The state categorically determines that NF services are needed and specialized services are not needed. Significant improvements in client status resulting in a significant change in status assessment require PASRR resident review to be completed within 7 working days.</td>
<td>×</td>
<td>7 days after minimum data set significant change in status assessment is submitted and shows improvement in status.</td>
</tr>
</tbody>
</table>

III. Categorical determination that specialized services are not needed. No categorical determinations are made that specialized services are needed. Determination by the SMH/MRA that NF placement is appropriate is individualized.

- Dementia and MR. The state mental retardation authority (not Level I screeners) may make categorical determinations that individuals with dementia, which exists in combination with mental retardation or a related condition, do not need specialized services.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Survey and Certification Education Program

The State has in effect the following survey and certification periodic educational program for the staff and residents (and their representatives) of nursing facilities in order to present current regulations, procedures, and policies.

The Texas Department of Human Services and the Texas Department of Health have in effect the following educational programs in order to present current regulations, procedures, and policies:

a.) Quarterly, three-day seminars co-sponsored with the Board of Nurse Examiners for the state of Texas, the Texas Association of Homes for the Aging, and the Texas Health Care Association. These seminars focus on regulatory update, quality resident care, survey process, policies and procedures, care planning, resident assessment, documentation, medication administration and quality assurance. These seminars are mainly directed to facility staff.

b.) The Texas Department of Human Services and the Texas Department of Health jointly sponsor monthly training sessions the first Tuesday of each month that there is not a three-day seminar. The focus of these sessions is regulatory update, policy and procedure updates and clarifications. The seminars are directed to facility staff, residents, advocates, consultants, attorneys, and the public in general.

c.) The Texas Department of Health regional offices conduct on-site educational programs in conjunction with open hearings in the nursing facilities. These open hearing/training sessions are provided on a scheduled and targeted or request basis.

d.) The Texas Department of Health and the Texas Department of Human Services provide state-wide training for facility staff and residents/advocates on a scheduled basis and as requested. These training sessions are done individually by agency, jointly by agency and in collaboration with the industry representatives.
The State has in effect the following process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide or a resident in a nursing facility or by another individual used by the facility in providing services to such a resident.

The Texas Department of Health (the Survey and Certification Agency) is responsible for the investigation of allegations of resident abuse and neglect and misappropriation of resident property in nursing facilities. The state licensing law (Health and Safety Code) Chapter 242 and 247 specifically addresses: (1) the reporting of complaint allegations (2) the receipt and processing of investigations, (3) the referral to appropriate state and local policy authorities, and (4) other administrative functions.

Any individual (general public, facility staff, surveyors, etc.) is required to report any allegation of resident abuse or neglect and misappropriation of resident property. Facilities participating in Medicare and/or Medicaid are also mandated by federal and state Medicare/Medicaid requirements to report such allegations. The Texas Department of Health (TDH) provides a toll-free telephone hot-line for use by the public in reporting allegations. Written allegations are also accepted. There is a centralized intake process in Austin where each complaint/incident is given a code number and a priority for investigation. Reporting of complaints/incidents is possible 24 hours a day, seven days a week either directly to intake staff or through a telephone recorder. All collected data, the code number and priority are entered into an automated system. An investigation is begun within 24 hours of receipt, for complaints/incidents that are considered serious or an immediate threat to resident health and safety. Other complaints/incidents, depending on their nature, are investigated within 14 days to 60 days of receipt.

A complaint/incident is assigned for investigation to the Public Health Regional Long Term Care Unit (LTCU) in which the facility is located. Investigations are performed by staff who are trained in all pertinent state and federal laws, and requirements for licensure and Medicare/Medicaid certification. Investigators also receive specialized training in investigation and documentation techniques. Following a thorough LTCU investigation, a complete report of the findings along with a recommendation(s) for corrective action is written and sent to the Austin Central Office. The recommendation(s) for corrective action may range from a deficiency with a plan of correction to proposed termination of the Medicare/Medicaid contract.

Reports are reviewed for consistency and quality. Based on the final recommendation, referral(s) are made to the appropriate local/state enforcement agency and pertinent state licensure/certification board(s). If the facility is licensed-only, the Texas Department of Health initiates the licensing action necessary to correct the situation. In these cases, the department works closely with the Attorney General's Office and/or local district attorneys. On-site follow-up visits are conducted as needed.
The State has in effect the following procedures for the scheduling and conduct of standard surveys to assure that it has taken all reasonable steps to avoid giving notice.

The Texas Department of Health has in effect the following procedures for the scheduling and conduct of surveys to assure that it has taken all reasonable steps to avoid giving notice:

a.) Survey schedules are never posted.

b.) Survey staff are notified at the latest possible time regarding where and when a survey is scheduled.

c.) Efforts are made to not schedule annual surveys the same week of the same month of the year.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: Texas

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Programs to Measure and Reduce Inconsistency

The State has in effect the following programs to measure and reduce inconsistency in the application of survey results among surveyors:

a.) The Texas Department of Health has a structured orientation, training, and continuing education program for all surveyor/investigators.

b.) Validation surveys are done on a scheduled targeted basis.

c.) Desk reviews are done to assess for technical and professional accuracy.

d.) On-site monitoring visits are made to assess survey protocol, accuracy of findings, and personnel performance.

e.) Regional office total survey/certification program reviews are done regularly.

f.) Data is collected from the above-mentioned activities and comparisons are made between regional offices and individual surveyors.

g.) Information gathered at the state office level from review and monitoring activities are shared with the regional offices (Form AG2A) to plan necessary training and counseling.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Texas

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Process for Investigations of Complaints and Monitoring

The State has in effect the following process for investigating complaints of violations of requirements by nursing facilities and monitors onsite on a regular, as needed basis, a nursing facility's compliance with the requirements of subsection (b), (c), and (d) for the following reasons:

(i) the facility has been found not to be in compliance with such requirements and is in the process of correcting deficiencies to achieve such compliance;

(ii) the facility was previously found not to be in compliance with such requirements and has corrected deficiencies to achieve such compliance, and verification of continued compliance is indicated; or

(iii) the State has reason to question the compliance of the facility with such requirements.

JUL 29 1992   Effective Date OCT 01 1990

HCFA ID: __________
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Texas

Employee Education About False Claims Recoveries

The State Medicaid Agency is responsible for monitoring and oversight of compliance with the requirements specified in Attachment 4.42A. Monitoring and oversight will be conducted in the following manner:

(a) The Health and Human Services Commission (HHSC) requires entities as defined in State plan section 4.42 and in the State Medicaid Directors Letters (SMDL) #06-025 and #07-003, to comply with the provisions as specified in section 1902(a)(68) of the Social Security Act (SSA).

(b) In order to ensure compliance by an entity with the provisions in section 1902(a)(68) of the SSA and the state plan requirements in section 4.42 including establishing and disseminating written policies to its employees, contractors and agents regarding the false claims laws, HHSC, or its designee, and HHSC's operating agencies will incorporate these requirements into new contracts with any entity as defined in section 4.42.

HHSC, or its designees, and HHSC's operating agencies have or will provide notification as described below to entities with existing contracts that per their contracts, they must comply with the provisions in section 1902(a)(68) of the SSA and the state plan requirements in section 4.42.

i. The 2007 Texas Medicaid Provider Procedures Manual (TMPPM), which was distributed to all Medicaid enrolled providers that receive payments from the Health and Human Services Commission (HHSC) Claims Administrator, included a notice to providers about DRA Section 6032. The HHSC Claims Administrator also plans to include an additional notice to providers in an upcoming Provider Bulletin. These Provider Bulletins are sent to all enrolled providers, and they update the TMPPM throughout the year.

ii. A notice to the public and all Medicaid providers is posted on the HHSC Medicaid website (http://www.hhsc.state.tx.us/medicaid/index.html).

iii. HHSC has sent a notice to the Managed Care Organizations.

iv. HHSC has sent a notice to its disease management contractor.

v. The HHSC Vendor Drug Program will send a general notification to its contracted providers.
vi. The Department of Aging and Disability Services (DADS) posted a general notification for Home and Community-Based Services/Texas Home Living waiver providers on the agency's Resources for DADS Service Providers website (http://www.dads.state.tx.us/providers/communications/). In addition, DADS mailed a letter to Home and Community-Based Services/Texas Home Living waiver program providers who meet the $5,000,000 threshold informing them of the law and the requirement to submit their attestation of compliance to DADS by June 30, 2007.

vii. The Department of State Health Services (DSHS) has sent a notice to its affected entities.

viii. The Department of Assistive and Rehabilitative Services (OARS) providers were notified through the notifications posted on the HHSC Medicaid website and in the TMPPM. The OARS providers also will receive the upcoming Provider Bulletin that the Claims Administrator will distribute.

ix. The Department of Family Protective Services (DFPS) does not currently contract with external entities to provide Medicaid services.

x. HHSC and its operating agencies will notify agency staff, who are part of a governmental component that is considered an entity, of the new requirements.

(c) In order to ensure compliance by an entity with the provisions in section 1902(a)(68) of the SSA and the state plan requirements in section 4.42 including establishing and disseminating written policies and procedures, the State will use the following oversight methodology to assess compliance on an ongoing and annual basis according to each agency's current review process. Monitoring activities will begin in June 2007.
Employee Education About False Claims Recoveries (continued)

i. HHSC will incorporate monitoring and review procedures into existing quality plan reviews and administrative interviews of the managed care organizations.

ii. HHSC will incorporate monitoring and review procedures into existing review procedures for entities not paid by the HHSC Claims Administrator. Entities that contract with HHSC for all activities will submit their policies, procedures, and any relevant pages from existing employee handbooks.

iii. HHSC Vendor Drug Program will incorporate monitoring and review procedures into existing on-site reviews for pharmacy providers and contractors.

iv. The HHSC Claims Administrator, on behalf of the State Medicaid Agency and its operating agencies, will require entities to submit an attestation by October 2007 demonstrating compliance with section 1902(a)(68) of the SSA and the state plan requirements in section 4.42. In December 2007, the Claims Administrator will notify entities that failed to submit the attestation and begin enforcement procedures. The HHSC Claims Administrator will review the policies and procedures and any relevant pages of existing employee handbooks of a sample of all contracted entities referenced in subsection (a) above.

v. DADS, on behalf of HHSC, will require entities not paid by the HHSC Claims Administrator: (1) to submit a signed affidavit by June 30, 2007, attesting to compliance with section 1902(a)(68) of the SSA and the state plan requirements in section 4.42; and (2) to incorporate compliance monitoring into existing on-site review procedures. DADS will review these entities’ written policies, procedures, and any relevant pages of existing employee handbooks during the annual onsite review.

vi. DSHS, on behalf of HHSC, will incorporate monitoring and review procedures into existing quality plan reviews and administrative interviews for entities not paid by the HHSC Claims Administrator. Entities that contract with DSHS for all activities will submit their
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Texas

Employee Education About False Claims Recoveries (continued)

policies, procedures, and any relevant pages from existing employee handbooks.

vii. DARS, on behalf of HHSC, will incorporate monitoring and review procedures into existing reviews for entities not paid by the HHSC Claims Administrator as applicable.

viii. DFPS will comply with the monitoring activities and reporting requirements conducted by HHSC, its oversight agency, as described below.

(d) In order to ensure that any governmental component that qualifies as an entity complies with section 1902(a)(68) of the SSA and the state plan requirements in section 4.42, HHSC and its operating agencies will:

i. Conduct an annual assessment and determine whether any governmental component of these agencies would qualify as an "entity."

ii. Review the policies/procedures/employee handbooks to ensure that any governmental component that qualifies as an entity has established policies and procedures and has amended any existing employee handbooks as directed by section 1902(a)(68) of the SSA and the state plan requirements in section 4.42.

iii. Require any governmental component that qualifies as an entity to submit an annual report that states when the governmental component disseminated the notice about the law and related requirements to staff and contractors and in what format the notice was distributed.

iv. Notify any governmental component that qualifies as an entity of the requirements listed above by August 1, 2007.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Texas

Employee Education About False Claims Recoveries (continued)

(e) If an entity is determined to be out of compliance with the requirements of section 1902(a)(68) of the SSA, a corrective action plan will be required from the entity and must be approved by HHSC or its designee. Remedies and damages may be imposed against the entity under the entity’s contract with HHSC or its designee. The remedies and damages will be based on the severity or repeated non-compliance with the stated requirements.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

State of TEXAS

CITATIONS OF STATE LAWS, RULES, REGULATIONS AND POLICY STATEMENTS
PROVIDING ASSURANCE OF CONFORMITY TO FEDERAL MERIT SYSTEM STANDARDS

The citation of the Texas law which provides assurance of conformity to Federal Merit System Standards and any standards issued by the U.S. Civil Service Commission is Article 695c, Section 4(10), Vernon's Texas Civil Statutes.

APPROVED BY DHHS/HCFA/DPO
DATE: 11-6-74
TRANSMITTAL NO: 74-50
SECTION 6  FINANCIAL ADMINISTRATION

Citation  
42 CFR 433.32
AT-79-29

6.1 Fiscal Policies and Accountability

The Medicaid agency and, where applicable, local agencies administering the plan, maintains an accounting system and supporting fiscal records adequate to assure that claims for Federal funds are in accord with applicable Federal requirements. The requirements of 42 CFR 433.32 are met.
Revision: HCFA-AT-81- (BPP)

State: TEXAS

6.2 Cost Allocation

There is an approved cost allocation plan on file with the Department in accordance with the requirements contained in 45 CFR Part 95, Subpart E.

Approval Date: 1-7-83
Effective Date: 7-1982

STATE: Texas
DATE REC'D: 12/22/82
DATE APPV'D: 1/7/83
PCO-11: 82-12
6.3 State Financial Participation

(a) State funds are used in both assistance and administration.

☑ State funds are used to pay all of the non-Federal share of total expenditures under the plan.

☐ There is local participation. State funds are used to pay not less than 40 percent of the non-Federal share of the total expenditures under the plan. There is a method of apportioning Federal and State funds among the political subdivisions of the State on an equalization or other basis which assures that lack of adequate funds from local sources will not result in lowering the amount, duration, scope or quality of care and services or level of administration under the plan in any part of the State.

(b) State and Federal funds are apportioned among the political subdivisions of the State on a basis consistent with equitable treatment of individuals in similar circumstances throughout the State.
A description of the methods of administration to insure that the provisions of Section 7.2 of this State plan are adhered to is already on file in the Department of Health, Education and Welfare Regional Office, Dallas, Texas.

APPROVED BY DHHS/HCFA/DPO
DATE: 11-6-74
TRANSMITTAL NO: 74-50