

PROPOSED PREAMBLE

The Executive Commissioner of the Health and Human Services Commission, on behalf of the Department of State Health Services (department), proposes amendments to §§38.1-38.14 and 38.16, concerning the Children with Special Health Care Needs Services Program (CSHCN Services Program).

BACKGROUND AND PURPOSE

Government Code, §2001.039, requires that each state agency review and consider for re-adoption each rule adopted by that agency pursuant to the Government Code, Chapter 2001 (Administrative Procedure Act). Sections 38.1-38.14 and 38.16 have been reviewed, and the department has determined that reasons for adopting the sections continue to exist because rules on this subject are needed.

The amendments are made in compliance with the Government Code, §2001.039, and they clarify language, make corrections of fact, make changes to grammar or syntax, and improve consistency in the rules.

SECTION-BY-SECTION SUMMARY

The following changes to names and addresses have been made throughout §§38.1-38.14 and 38.16. For simplicity and uniformity, the common name of the Children with Special Health Care Needs Services Program has been changed to “CSHCN Services Program.” References to legacy agencies now part of the Health and Human Services Commission have been amended to reflect the department’s name change from “Texas Department of Health” to “Department of State Health Services,” and references to the Board of Health have been deleted. Since the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) and the Civilian Health and Medical Program of the Veterans Administration (CHAMPVA) are no longer identified by these acronyms, these programs will be identified only as “United States Department of Defense or Department of Veterans Affairs benefit plans.”

The identification of the CSHCN Services Program Division Director has been changed to “the manager of the department unit having responsibility for oversight of the CSHCN Services Program.” The professional designation for “master social worker-advanced clinical practitioner” has been corrected to “licensed clinical social worker (LCSW),” the current professional nomenclature. The CSHCN Services Program mailing address has been corrected. Minor textual changes to punctuation, grammar, syntax, and/or spelling have also been made.

In addition to the name and other changes identified above, amendments to §38.2 include deletion of the definitions for “advisory committee” and “board,” because those entities no longer exist. The definition for “newborn screening” has been deleted, because the term is no

longer used in the chapter. A definition for “commission” has been added to identify the Texas Health and Human Services Commission. The definitions have been renumbered to reflect these additions and deletions.

The definition for “applicant” has been amended to be more comprehensive by including individuals who are seeking to establish initial or continuing eligibility as well as to re-establish lapsed eligibility.

The definition for “effective date of eligibility for applicants with spenddown” at §38.2(23)(D) has been amended to clarify that medical bills qualifying to meet “spenddown” requirements must have dates of service 12 months prior to the date of receipt of the application or within 6 months after the date eligibility was previously denied. This change is consistent with a statutory requirement that changed the eligibility period from 12 to 6 months.

The definition of “medical home” has been amended to update the definition and incorporate elements recommended by the American Academy of Pediatrics and the Medical Home Work Group of the CSHCN Services Program. In the definition of “natural home” at §38.2(34), “the eligible person” has been changed to “a person.” Eligibility for the CSHCN Services Program has no bearing on this definition.

In addition to name changes identified above, the definition of “other benefit” at §38.2(36) has been amended to clarify that the intended costs of services are those “included in the scope of coverage of” the CSHCN Services Program. The phrase “but not limited to” has been incorporated in the introductory sentence before the listing of some types of “other benefits.” At new §38.2(34)(B), home, auto, and other liability insurance have been added as “other benefits,” and subsequent subparagraphs have been renumbered.

The definition for “specialty center” has been amended to clarify that the centers are designated for use “by CSHCN Services Program clients” as part of comprehensive services for a specific medical condition.

In addition to name and other changes identified previously, amendments to §38.3 of this title (relating to Eligibility for CSHCN Program Services) include the following. The title of the section has been changed from “Eligibility for CSHCN Program Services” to “Eligibility for Services.” Section 38.3(a)(1) has been amended to clarify the requirements for a dentist or physician who certifies that a person meets the medical criteria for certification as a “child with special health care needs.” The medical criteria certification must be made at least annually and must be based upon a physical examination conducted within the 12 months immediately preceding the date of certification. The certifying physician or dentist must provide not only the diagnosis code, but also the descriptor, and the section has been amended to clarify that the requirement applies to each of the person’s medical conditions. These changes are consistent

with current CSHCN Services Program instructions for completion of the form that supplies this documentation.

Section 38.3(a)(1) also has been amended to authorize the CSHCN Services Program Medical Director to accept written documentation of medical certification criteria from a physician or dentist licensed to practice in a state or jurisdiction of the United States other than Texas. The individual for whom the subparagraph describes medical criteria eligibility has been changed from “child/applicant” or “applicant” to “person” throughout. Section 38.3(a)(1) also has been amended to clarify that the CSHCN Services Program may not reimburse physicians or dentists for providing written documentation of medical criteria certification, and to reaffirm that only a physician or dentist who is a CSHCN Services Program participating provider may be reimbursed for services.

At §38.3(a)(2), in accordance with requirements of the 79th Texas Legislature in Regular Session (2005), Appropriations Act, DSHS Rider 63, paragraph d, compliance with financial eligibility criteria must be determined “every six months, or as directed by statutory requirements” rather than “annually.” Section 38.3(2) also has been amended to delete explanations concerning net income and insurance premium payments in connection with the Children’s Health Insurance Program, as they are now both inaccurate and superfluous.

Section 38.3(a)(2)(A) has been amended to make provisions concerning documentation of a family’s income and relating to the length of time that financial criteria must be determined consistent with the amendments to §38.3(a)(2).

Section 38.3(a)(2)(B)(i) has been amended to clarify that the subparagraph applies to “an ongoing” client “currently not eligible for Medicaid;” to delete “medical condition” as a factor relevant to whether a client must apply to Medicaid; and to replace the reference to “Medicaid, specifically including the Medically Needy program” with “any applicable Medicaid programs.”

Section 38.3(a)(2)(B)(ii) has been amended to clarify that its provisions apply to “an ongoing” client.

At §38.3(a)(3)(B), concerning health insurance coverage, the subparagraph has been amended to clarify that both Medicaid and the Children’s Health Insurance Program (CHIP) are among the types of health insurance coverage for which an applicant/client must apply and remain eligible, if not exempt from such coverage. Concerning when the program may extend the deadline, the phrase “and/or continue CSHCN program coverage” has been deleted, because it is not relevant to this deadline extension. The subparagraph also has been amended to state that, if the applicant/client is eligible for “any other health insurance,” the applicant/client must be enrolled. The subparagraph formerly specified only that the eligible applicant/client must be enrolled in the CHIP.

At §38.3(a)(3)(C), the paragraph has been amended to clarify that its provisions apply to “ongoing clients,” and to delete the statement that a family support services plan may not be implemented until the determination of program eligibility is complete. The statement is not relevant to the determination of program eligibility requirements.

Section 38.3(a)(7)(C) has been amended to state more clearly that applicants or clients who are financially eligible for Medicaid, CHIP, or other programs with eligibility income guidelines that meet the CSHCN Services Program’s income eligibility guidelines, and who also meet the

CSHCN Services Program's age and residency requirements, will be considered financially eligible for the CSHCN Services Program.

Section 38.3(a)(8) has been amended to distinguish between the lengths of time for which financial and medical eligibility may be reestablished. As required by the 79th Texas Legislature in Regular Session (2005), Appropriations Act, SB1, DSHS Rider 63, paragraph (d), financial eligibility must be reestablished "every six months, or as directed by statutory requirements," rather than "at least annually." The determination of medical criteria for eligibility continues to be at least annually. Requirements concerning notification and deadlines for determination of continuing eligibility have been amended by deleting "annual," so that they are applicable to both financial or medical criteria.

In addition to name and other general changes identified previously, amendments to §38.4 of this title (relating to Covered Services) include the following. At §38.4(b)(3), the phrase "with a chronic physical or developmental condition as specified in §38.3(a)(1) of this title (relating to Eligibility for CSHCN Program Services)" has been deleted, because the term "client" is defined in §38.2 of this title (relating to Definitions).

At §38.4(b)(3)(B), the phrase "in a calendar year" has been added to specify the time period within which no more than 30 outpatient mental health service encounters may be provided.

At §38.4(b)(3)(E)(i)(II), regarding inpatient psychiatric care, the phrase "Texas Department of Mental Health and Mental Retardation programs or other" has been deleted and replaced with "public or private mental health program" as a referral resource. In addition, the specificity of the five-day limitation on care has been deleted; however, the requirement that all admissions be prior authorized remains.

Although coverage of medical foods is not a new benefit, a description of the coverage for medical foods previously stated only in program policy has been added at new §38.4(b)(3)(J). Subsequent subparagraphs have been re-alphabetized.

At §38.4(b)(3)(L)(ii), the benefit limitation of one eye examination with refraction has been clarified by stating that the benefit shall be available during "a calendar" year, rather than during "the state fiscal" year. The same limitation for one pair of non-prosthetic eye wear per year has been applied per "calendar" year at §38.4(b)(3)(L)(iii).

Also, for consistency and clarification, the home health services benefit limitations have been changed from hours per year to hours per "calendar" year at §38.4(b)(3)(Q).

Section 38.4(b)(5)(A)(i), concerning eligibility for family support services, has been deleted as redundant, and subsequent subparagraphs have been renumbered.

At §38.4(b)(5)(A)(ii), a reference to family support programs received through the Texas Department of Human Services or the Texas Department of Mental Health and Mental Retardation has been deleted and replaced with references to the Primary Home Care Program and the Medically Dependent Children's Program, as examples of other family support services programs.

At §38.4(b)(5)(A)(iii), the reference to family "support services plan" has been replaced by a family "assessment and service" plan to describe more accurately the plan that is actually

developed.

Also relating to family support services, §38.4(b)(5)(B)(i) concerning the processing and evaluation of requests for family support services has been amended by adding “of clients” to describe the families for whom the subparagraph applies, and by deleting the time limit within which a family must indicate in writing the need for family support services. Families of clients may request family support services at any time.

At §38.4(b)(5)(B)(iv), the descriptor for §38.16 of this title, “(relating to Procedures to Address CSHCN Services Program Budget Alignment),” has been added.

Sections 38.4(b)(5)(C)(i) and 38.4(b)(5)(C)(vi) also have been amended to replace “written family support services” plan is with “family assessment and service” plan.

Sections 38.4(b)(5)(C)(ii)(II) and 38.4(b)(5)(C)(iii) have been amended by adding “calendar” to describe the year in which the service plan and cost allowance limitations apply.

Section 38.4(b)(5)(C)(iv)(II) has been amended to further define the term “vendor” by adding the descriptor, “enrolled as a CSHCN Services Program provider.”

Section 38.4(b)(5)(D)(iii)(V) has been amended by replacing “the Texas Rehabilitation Commission” with “the Department of Assistive and Rehabilitation Services (DARS).”

Section 38.4(b)(5)(E)(ix), concerning unallowable services, has been amended to clarify that costs for allowable services must be incurred before the “requested family support service is prior authorized,” rather than before the “written service plan is approved.”

At §38.4(b)(5)(F)(iii), the descriptor for §38.16 of this title, “(relating to Procedures to Address CSHCN Services Program Budget Alignment),” has been added, and at §38.4(b)(5)(F)(ix), the “written family support services” plan has been changed to the “family assessment and service” plan.

Section 38.4(b)(6)(B), concerning the CSHCN Services Program transportation benefit, has been amended to clarify that the benefit may include transportation “to” as well as “from” the nearest medically appropriate facility. Further description of the facility and benefit has been added by the phrase, “(in Texas or in the United States 50 or fewer miles from the Texas border) to obtain medically necessary and appropriate health care services that are within the scope of the coverage of the CSHCN Services Program and are provided by a CSHCN Services Program enrolled provider.” The section also has been clarified by adding that transportation to services available more than 50 miles from the Texas border will not be approved, except as specified in §38.6(e) of this title (relating to Providers).

At §38.4(b)(6)(C), new language clarifies that the benefit for meals and lodging must be directly related to medically necessary treatment for the client “that is provided by program enrolled providers and covered by the program.” New language also provides that coverage for meals and lodging associated with travel more than 50 miles from the Texas border will not be approved, except as specified in §38.6(e) of this title (relating to Providers).

Regarding transportation of the remains of a deceased client, §38.4(b)(6)(D)(i) has been amended by replacing “while receiving CSHCN program services” with “while receiving

CSHCN Services Program health care benefits,” to more correctly indicate the applicable circumstances. The scope of this benefit also has been clarified by adding that such transportation is, “from the facility to the place of burial in Texas that is designated by the parent or other person legally responsible for interment.”

Section 38.4(b)(6)(E), concerning payment of insurance premiums, coinsurance, co-payments, and/or deductibles, has been amended by inserting phrases to improve the specifications for payment of coinsurance and deductible amounts when the total amount paid “(including all payers)” to the provider does not exceed the maximum allowed “by the CSHCN Services Program” for the covered service.

Section 38.4(c)(5) has been amended to clarify that, although pregnancy prevention in general is not a covered service, an exception exists for the specific treatment of “a condition meeting the parameters of the ‘child with special health care needs’ definition.”

Section 38.4(c)(6) has been amended to further define the scope of the exclusion of “maternity care” as a covered service by addition of the description, “services specific to routine pregnancy care, labor and delivery, and maternal post-partum care.”

Section 38.4(c)(7) has been amended to clarify that infertility treatment or other reproductive services are covered if directly related to “a condition meeting the parameters of the ‘child with special health care needs’ definition.”

Section 38.4(d)(2) has been amended to clarify that requests for authorization of certain services must be submitted prior to the date of service.

Section 38.4(d)(4) has been deleted as repetitive, and the subsequent subparagraph has been renumbered.

At §38.4(d)(5), the reference to “ineligible “recipients” has been changed to “ineligible persons,” and application of the term “denied authorization requests” to those “clients who do not qualify for the health care benefit requested” has been clarified.

In addition to the CSHCN Services Program name change identified previously, §38.5, relating to Rights and Responsibilities of Parents/Foster Parents/Guardian/Managing Conservator or the Adult Client, §38.5(a)(4) has been amended to include representatives of “the commission or” the department among those whom a parent/foster parent/guardian/managing conservator or the adult client may refuse entry into the home.

Section 38.6(a)(3) has been amended to clarify that providers must agree to accept the CSHCN Services Program “allowed amount of” payment “(regardless of payer)” as payment in full for services “provided to CSHCN Services Program clients.” The following sentence also has been added concerning payment for services: “Providers may not request or accept payment from the client or client’s family for completing any CSHCN Services Program forms.”

Section 38.6(a)(4) has been amended to identify more specifically all other “public or private” benefits available to the client, including “but not limited to” Medicaid or Medicaid waiver programs, CHIP, or Medicare, “and casualty or liability coverage” prior to requesting payment from the CSHCN Services Program, which is the payer of last resort.

Section 38.6(e)(1) has been amended by adding the following phrases to clarify the scope of out-of-state coverage: 50 “or fewer” miles “from the Texas state border” and “the CSHCN Services Program may cover services that are within the scope of the program and provided by health care providers” in New Mexico, Oklahoma, Arkansas, or Louisiana located “50 or fewer miles from” the Texas state border. The last sentence of the current section has been moved and redesignated as new subparagraph 38.6(e)(4).

At §38.6(e)(2), pertaining to travel “more than” 50 miles from the Texas border, the manager of the department unit having responsibility for oversight of the CSHCN Services Program, instead of the commissioner of health, has been authorized to approve payment to out-of-state providers, and coverage has been limited to “services that are within the scope of the CSHCN Services Program and provided by health care providers located within the United States and more than 50 miles from the Texas border.” The current §38.6(e)(3) has been deleted and redesignated as new §38.6(e)(2)(B) stating, “the medical literature indicates that the out-of-state treatment is accepted medical practice and is anticipated to improve the client’s quality of life,” and subsequent subparagraphs have been renumbered.

New §38.6(e)(3) states that the out-of-state limitations do not apply to coverage or payment for selected products or devices including, but not limited to, medical foods or hearing amplification devices, which either are less costly and/or may only be available, from out-of-state sources.

Section 38.6(e)(5) has been restated to more clearly and comprehensively describe the coverage for costs of transportation and associated meals and lodging for a client and, if necessary, a responsible adult for travel to and from the location of out-of-state services that meet program approval parameters.

Changes to §38.7, relating to Ambulatory Surgical Care Facilities, include only changes to the CSHCN Services Program previously identified.

Section 38.8, relating to Inpatient Rehabilitation Centers, includes only name and minor grammatical changes identified previously, except for the amendment to §38.8(b)(8) stating that a center serving pediatric clients shall have at least one recreational area or playroom “that is bed and wheelchair accessible.”

Changes to §38.9 of this title (relating to Cleft/Craniofacial Center Teams) include only changes to the name of the CSHCN Services Program and minor grammatical changes.

In addition to name and other changes identified previously, §38.10 (relating to Payment of Services) has been amended by adding the following sentence to the introductory paragraph of §38.10: “Providers may not request or accept payment from the client or the client’s family for completing any CSHCN Services Program forms.”

At §38.10(1)(B), the reference to ineligible “recipients” has been changed to ineligible “persons,” and the definition of “denied claims” has been expanded by adding those “for clients who do not qualify for the health care benefit claimed.”

Section 38.10(2), concerning claims involving health insurance coverage, CHIP or Medicaid, has been amended by stating that the CSHCN Services Program may pay covered health care benefits during a CHIP or other health insurance enrollment waiting period, and that during such

periods, providers may file claims directly with the CSHCN Services Program without evidence of denial by the other insurer.

At §38.10(3)(C), “recipient” has been changed to “client.”

Section 38.10(6) concerning CSHCN Services Program fee schedules, has been amended by adding, simplifying, or correcting reimbursement or pricing methodologies to reflect current practice. The amendments do not represent increases or decreases in reimbursement to individual provider types. In many instances, the phrase, “the lower of the billed amount or the maximum amount allowed by the Texas Medicaid Program,” replaces more detailed language that describes the way(s) in which the Medicaid maximum reimbursement amounts were derived.

At new §38.10(6)(G), a pricing methodology has been added for medical foods, which is the lower of the billed amount, the manufacturer’s suggested retail price, or the maximum charge allowed by the Texas Medicaid program up to a maximum of \$200 per client per month. Subsequent subparagraphs have been re-alphabetized throughout the section.

At §38.10(6)(H), the methodology for expendable medical supplies has been changed to the lower of the billed amount or the maximum amount allowed by the Texas Medicaid program.

At §38.10(6)(I), current language has been deleted and new language concerning the reimbursement methodology for durable medical equipment has been added to improve accuracy and to reflect current program practice. The penalty for delayed delivery has been deleted.

The reimbursement methodology for orthotics and prosthetics, formerly §38.10(6)(I)(iii), has been redesignated as §38.10(6)(K), and subsequent subparagraphs have been re-alphabetized.

At new §38.10(6)(M), the limitation for home health nursing services has been clarified by adding “calendar” to describe the maximum allowable number of hours per year.

At new §38.10(6)(O), the state reimbursement methodology for audiological testing and amplification devices has been changed to the lower of the billed amount or the amount allowed by the Program for Amplification for Children of Texas (PACT).

At new §38.10(6)(U), “Centers for Medicare and Medicaid Services” has been substituted for the abbreviation “CMS.”

At new §38.10(6)(X), the reimbursement methodology for independent laboratory services has been changed to the lower of the billed amount or the maximum allowed by the Texas Medicaid program.

At new §38.10(6)(AA), the reimbursement methodology for vision services has been amended to add an exception for high-powered lenses.

Section 38.11 of this title (relating to Contracts, Written Agreements, and Donations) includes no amendments other than name and general grammatical changes described previously.

Section 38.12 of this title (relating to Denial/Modification/Suspension/ Termination of Eligibility for Health Care Benefits and/or Health Care Benefits) includes no amendments other than name

or general grammatical changes described previously.

In addition to name and other general changes described previously, §38.13 of this title (relating to Right of Appeal) includes the following amendments. At §38.13(a)(1)(A), citations to other sections have been corrected. At §38.13(a)(1)(D), the reference to “the department” as the entity that establishes by rule provider reimbursement and the program’s budget alignment methodologies has been updated to refer to “the commission.” The terms “reimbursement” or “reimbursement methodologies” have been included, replacing “fee schedules” at §38.13(a)(1)(D) because “fee schedules” are more detailed, frequently changing lists that evolve from stated reimbursement methodologies.

There are no additional amendments to Section 38.14 of this title (relating to Development and Improvement of Standards and Services) includes no amendments other than name or general grammatical changes described previously.

Section 38.16(c)(3) has been clarified to state that provision of “health care benefits” may “or may not” include “coverage,” rather than “payment,” of outstanding bills in all cases.

At §38.16(c)(4), the process for providing limited health care benefits and/or payment of outstanding bills for health care benefits to as many clients with urgent need for health care benefits as possible who are on the waiting list and remain on the waiting list has been amended by adding the requirement that if family support services are included among limited health care benefits provided for clients with urgent need for health care benefits who are on the waiting list and remain on the waiting list, the coverage of family support services must be limited according to the parameters set forth in §38.16(b)(2)(C)(i). Those parameters require that family support services be provided to ongoing clients only to continue services already being provided, and/or when the specific services are required to prevent out-of-home placement of the client, and/or when the provision of such services is cost effective for the program.

At §38.16(d), the phrase “as described in subsection (a)(2) of this section” concerning funding analysis” has been deleted.

Sections 38.16(d)(1)(A)(iii) and 38.16(d)(1)(A)(iv), concerning the order in which groups of clients shall be taken off the waiting list, have been deleted because they present administrative obstacles to implementation of §38.16(d) as a whole, and deletion causes neither favorable or adverse consequences for clients to whom the sections were applicable. Sections 38.16(d)(1)(A)(v) and 38.16(d)(1)(A)(vi) have been renumbered as §38.16(d)(1)(A)(iii) and §38.16(d)(1)(A)(iv).

Sections 38.16(d)(1)(B)(i) and 38.16(d)(1)(B)(ii), concerning providing health care benefits for clients taken off the waiting list, have been deleted as superfluous because §38.16(d)(1)(B) also has been amended by addition of the phrase, “as long as program unobligated funds are available,” and the rule addressed at §38.16(d)(1)(B)(ii) repeats §38.16(c)(3)(B).

Section 38.16(d)(1)(C) has been amended to authorize payment of limited health care benefits for “clients who are on the waiting list and remain on the waiting list;” payment of outstanding bills for health care benefits for clients who are on the waiting list and remain on the waiting list; and/or “payment of outstanding bills for health care benefits for clients who have been taken off the waiting list.” Consistent with changes to §38.16(c)(4), coverage of family support services must be limited according to the parameters set forth in §38.16(b)(2)(C)(i), if family support

services are included among limited health care benefits. The requirement that clients on the waiting list be served in the same order as in paragraph (1) of the subsection and the limitation that only clients on the waiting list may be served by this provision have been deleted, and the reference to paragraphs (1)-(2) has been corrected.

Section 38.16(d)(1) has been amended to enable the program to expend unobligated funds after or while removing clients from the waiting list and providing them with health care benefits; only when projected unobligated funds are insufficient to take clients off the waiting list and also maintain continuous program health care benefits or when projected unobligated funds may lapse if not expended by the end of the fiscal year; only as long as program unobligated funds are available; and only if the outstanding bills for health care benefits are for dates of service that are within the time period that program unobligated funds are available and provided that the client is eligible for health care benefits at the time of the dates of service. The new language improves administrative efficiency and permits needed flexibility to expend unobligated funds near the end of a budget term.

At §38.16(d)(2)(B), the parenthetical phrase describing health care benefits has been amended by clarifying that “coverage,” rather than “payment,” of outstanding bills for health care benefits may “or may not” be included. “Or” at the end of §38.16(d)(2)(B) has been deleted as grammatically unnecessary.

Section 38.16(d)(2)(C) has been amended to be consistent with §38.16(d)(1)(C), as amended, and to provide limited health care benefits to clients “identified in subsections (d)(2)(A)(i) and (ii) who are on the waiting list and remain on the waiting list;” and/or “payment of outstanding bills for health care benefits for clients who have been taken off the waiting list.” Section 38.16(d)(2)(C) has also been amended by the addition of a sentence providing that the coverage of family support services must be limited according to the parameters set forth in §38.16(b)(2)(C)(i) if family support services are included among limited health care benefits.

Consistent with the requirements of §38.16(d)(1)(C), as amended, §38.16(d)(2)(C) has been amended by deletion of the requirement that clients on the waiting list be served in the same order as in paragraphs (2)(A) of the subsection and the limitation that only clients on the waiting list may be served. These amendments make §38.16(d)(2) consistent with other sections, as amended, and increase the efficiency and flexibility with which the program may expend unobligated funds resulting from program cost savings near the end of a budget term.

FISCAL NOTE

Sam B. Cooper, III, MSW, LMSW, Unit Manager, Purchased Health Services Unit, Specialized Health Services Section, has determined that for each year of the first five-year period that the sections will be in effect, there will be no fiscal implications to state or local governments as a result of enforcing and administering the sections as proposed.

The department allocates legislative appropriations for the CSHCN program according to the following general budgetary categories: (1) health care benefits services for CSHCN who are uninsured or underinsured; (2) essential public health services including, but not limited to, case management, quality assurance, needs assessment, education/ training, and information and referral for children with special health care needs and their families; and (3) program administration. CSHCN budgeting decisions are guided by the following principles: the CSHCN Program is not an entitlement program; the cost of services required to serve the needs of all the clients eligible to

receive them is expected to exceed anticipated funding; and the program establishes and manages waiting lists according to the procedures to address CSHCN Services Program budget alignment as specified in rule.

MICRO-BUSINESS AND SMALL BUSINESS IMPACT ANALYSIS

Mr. Cooper has also determined that there will be no effect on small businesses or micro-businesses required to comply with the sections as proposed, because neither small businesses nor micro-businesses that are providers of CSHCN services will be required to alter their business practices in order to comply with the sections. There are no anticipated economic costs to persons who are required to comply with the sections as proposed. There is no anticipated negative impact on local employment.

PUBLIC BENEFIT

Mr. Cooper has determined that for each year of the first five years the sections are in effect, the public will benefit from adoption of the sections. The public benefit anticipated as a result of enforcing or administering the sections is improved accuracy and consistency in the rules, and more accurate interpretation of their intent. In addition, amendments to the rules will allow the program to function more efficiently and effectively.

REGULATORY ANALYSIS

The department has determined that this proposal is not a "major environmental rule" as defined by Government Code, §2001.0225. "Major environmental rule" is defined to mean a rule the specific intent of which is to protect the environment or reduce risk to human health from environmental exposure and that may adversely affect, in a material way, the economy, a sector of the economy, productivity, competition, jobs, the environment or the public health and safety of a state or a sector of the state. This proposal is not specifically intended to protect the environment or reduce risks to human health from environmental exposure.

TAKINGS IMPACT ASSESSMENT

The department has determined that the proposed amendments do not restrict or limit an owner's right to his or her property that would otherwise exist in the absence of government action and, therefore, do not constitute a taking under Government Code, §2007.043.

PUBLIC COMMENT

Comments on the proposal may be submitted by mail to Kathy Griffis-Bailey, MS, Purchased Health Services Unit MC1938, Department of State Health Services G31000, 1100 West 49th Street, Austin, Texas 78756, by telephone at 512/458-7111, extension 3069, or by email to kathy.griffisbailey@dshs.state.tx.us. Comments will be accepted for 30 days following publication of the proposal in the Texas Register.

PUBLIC HEARING

A public hearing to receive comments on the proposal is scheduled for December 19, 2005, at 9:00 a.m., at the Department of State Health Services, Room K-100, 1100 West 49th Street, Austin, Texas 78756. Persons who require disability-related accommodations or a language

interpreter should contact Kathy Griffis-Bailey at 512/458-7111 at least three working days prior to the scheduled hearing time.

LEGAL CERTIFICATION

The Department of State Health Services General Counsel, Cathy Campbell, certifies that the adoption has been reviewed by legal counsel and found to be within the state agencies' authority to adopt.

STATUTORY AUTHORITY

The Health and Safety Code, §§35.003, 35.004, 35.0041, 35.005, 35.006, 35.007, 35.009, and 12.001, authorizes the executive commissioner of the Health and Human Services Commission to adopt rules for the performance of every duty imposed by law on the department and the commissioner of health. The Government Code, §531.0055(e), and the Health and Safety Code, §1001.075, also authorize the executive commissioner of the Health and Human Services Commission to adopt rules and policies necessary for the operation and provision of health and human services by the department and for the administration of Chapter 1001, Health and Safety Code.

The proposed amendments affect Health and Safety Code, Chapter 35.

Legend:

Single Underline = Proposed new language

[Bold Print and Brackets] = Current language proposed for deletion

Regular Print = Current language

(No change.) = No changes are being considered for the designated subdivision

§38.1. Purpose and Common Name.

(a) Purpose. The purpose of this chapter is to implement the Services Program for Children with Special Health Care Needs (CSHCN) that **[which]** is authorized by Health and Safety Code, Chapter 35 to provide the following services to eligible children:

(1)-(7) (No change.)

(b) (No change.)

§38.2. Definitions. The following words and terms, when used in this chapter, shall have the following meanings, unless the context clearly indicates otherwise.

(1)-(2) (No change.)

[(3) Advisory committee--Those persons appointed by the Texas Board of Health to serve in an advisory capacity to the Children with Special Health Care Needs (CSHCN) Program staff.]

(3)[(4)]Applicant--A person making an initial application or re-application for CSHCN Services Program **[program]** services[, **but who has not been determined eligible**].

[(5) Board--The Texas Board of Health.]

(4)[(6)]Bona fide resident--A person who:

- (A) is physically present within the geographic boundaries of the state;
- (B) has an intent to remain within the state;
- (C) maintains an abode within the state (i.e., house or apartment, not merely a post office box);
- (D) has not come to Texas from another country for the purpose of obtaining medical care, with the intent to return to the person's native country;
- (E) does not claim residency in any other state or country; and

§38.2

(i) is a minor child residing in Texas whose parent(s), managing conservator, guardian of the child's person, or caretaker (with whom the child consistently resides and plans to continue to reside) is a bona fide resident;

(ii) is a person residing in Texas who is the legally dependent spouse of a bona fide resident; or

(iii) is an adult residing in Texas, including an adult whose parent(s), managing conservator, guardian of the adult's person, or caretaker (with whom the adult consistently resides and plans to continue to reside) is a bona fide resident or who is his/her own guardian.

(5)~~[(7)]~~Case management services--Case management services include, but are not limited to:

(A) planning, accessing, and coordinating needed health care and related services for children with special health care needs and their families. Case management services are performed in partnership with the child, the child's family, providers, and others involved in the care of the child and are performed as needed to help improve the well-being of the child and the child's family; and

(B) counseling for the child and the child's family about measures to prevent the transmission of AIDS or HIV and the availability in the geographic area of any appropriate health care services, such as mental health care, psychological health care, and social and support services.

(6)~~[(8)]~~Child with special health care needs--A person who:

(A) is younger than 21 years of age and who has a chronic physical or developmental condition; or

(B) has cystic fibrosis, regardless of the person's age; and

(C) may have a behavioral or emotional condition that accompanies the person's physical or developmental condition. The term does not include a person who has behavioral or emotional condition without having an accompanying physical or developmental condition.

(7)~~[(9)]~~CHIP--The Children's Health Insurance Program administered by the Texas Health and Human Services Commission under Title XXI of the Social Security Act.

(8)~~[(10)]~~Chronic developmental condition--A disability manifested during the developmental period for a child with special health care needs which results in impaired intellectual functioning or deficiencies in essential skills, which is expected to continue for a period longer than one year, and which causes a person to need assistance in the major activities of daily living and/or in meeting personal care needs. For the purpose of this chapter, a chronic

§38.2

developmental condition must include physical manifestations and may not be solely a delay in intellectual, mental, behavioral and/or emotional development.

(9)~~(11)~~ Chronic physical condition--A disease or disabling condition of the body, of a bodily tissue or of an organ which will last or is expected to last for at least 12 months; that results, or without treatment, may result in limits to one or more major life activities; and that requires health and related services of a type or amount beyond those required by children generally. Such a condition may exist with accompanying developmental, mental, behavioral, or emotional conditions, but is not solely a delay in intellectual development or solely a mental, behavioral and/or emotional condition.

(10)~~(12)~~ Claim form--The document approved by the CSHCN Services Program **[CSHCN program-approved document]** for submitting the unpaid claim for processing and payment.

(11)~~(13)~~ Client--A person who has applied for program services and who meets all CSHCN Services Program **[program]** eligibility requirements and is determined to be eligible for program services.

(A) New client:

(i) a person who has applied to the program for the first time and who is determined to be eligible for program services; or

(ii) a person who has re-applied to the program (after a lapse in eligibility) and who is determined to be eligible for program services.

(B) Ongoing client--A client who currently is not on the program's waiting list.

(C) Waiting list client--A client who currently is on the program's waiting list.

(12) Commission--The Texas Health and Human Services Commission.

(13)~~(14)~~ Commissioner--The Commissioner of Health.

(14)~~(15)~~ Co-insurance--A cost-sharing arrangement in which a covered person pays a specified percentage of the charge for a covered service. The covered person may be responsible for payment at the time the health care service is provided.

(15)~~(16)~~ Co-pay/Co-payment--A cost-sharing arrangement in which a client pays a specified charge for a specified service. The client is usually responsible for payment at the time the health care service is provided.

§38.2

~~(16)~~~~(17)~~ CSHCN Services Program **[program]**--The services program for children with special health care needs described in §38.1 of this title (relating to Purpose and Common Name).

~~(17)~~~~(18)~~ Date of service (DOS)--The date a service is provided.

~~(18)~~~~(19)~~ Deductible--A cost-sharing arrangement in which a client is responsible for paying a specific amount annually for covered services before an insurance carrier or plan begins to pay for covered services.

~~(19)~~~~(20)~~ Dentist--An individual licensed by the State Board of Dental Examiners to practice dentistry in the State of Texas.

~~(20)~~~~(21)~~ Department--The Department of State Health Services **[Texas Department of Health]**.

~~(21)~~~~(22)~~ Diagnosis and evaluation services--The process of performing specialized examinations, tests, and/or procedures to determine whether a CSHCN Services Program **[program]** applicant for health care benefits has a chronic physical or developmental condition as determined by a physician or dentist participating in the CSHCN Services Program **[program]** and/or to help determine whether a waiting list client has an “urgent need for health care benefits”, according to the criteria and protocol described in §38.16(e) of this title (relating to Procedures to Address CSHCN Services Program **[Program]** Budget Alignment).

~~(22)~~~~(23)~~ Eligibility date for the CSHCN Services Program **[program]** health care benefits--The effective date of eligibility for the CSHCN Services Program **[program]** health care benefits is 15 days prior to the date of receipt of the application, except in the following circumstances.

(A) The effective date of eligibility for newborns who are not born prematurely will be the date of birth. Newborn means a child 30 days old or younger.

(B) The effective date of eligibility following traumatic injury will be the day after the acute phase of treatment ends, but no earlier than 15 days prior to the date of receipt of the application.

(C) The effective date of eligibility for an applicant that is born prematurely will be the day after the applicant has been out of the hospital for 14 consecutive days, but no earlier than 15 days prior to the date of receipt of the application.

(D) The effective date of eligibility for applicants with spenddown is the day after the earliest DOS on which the cumulative bills are sufficient to meet the spenddown amount, but no earlier than 15 days prior to the date of receipt of the application. Only medical bills having a DOS within 12 months prior to **[from]** the date of receipt of the application, or a DOS within 6 **[12]** months after the financial eligibility denial date may be included to satisfy spenddown requirements. Medical bills for any member of the household for which the

§38.2

applicant, parent(s), guardian or managing conservator of the CSHCN Services Program applicant is responsible may be included. Medical bills used to meet spenddown cannot be paid by the CSHCN Services Program [program].

(E) Excluding applications for clients who are known to be ineligible for Medicaid and/or the CHIP due to age, citizenship status or insurance coverage, all applications must include a determination of eligibility from Medicaid and/or the CHIP. If the CSHCN Services Program application is received without a Medicaid determination, a CHIP determination, or other data/documents needed to process the application, it will be considered incomplete. The applicant will be notified that the application is incomplete and given 60 days to submit the Medicaid determination, CHIP denial or enrollment, or other missing data/documents to the CSHCN Services Program. If the application is made complete within the 60-day time limit, the client's eligibility effective date will be established as 15 days prior to the date the CSHCN Services Program application was first received. If the application is made complete more than 60 days after initial receipt, the eligibility effective date will be established as 15 days prior to the date the application was made complete.

~~(23)~~**(24)** Emergency--A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent person with average knowledge of health and medicine could reasonably expect that the absence of immediate medical care could result in:

- (A) placing the person's health in serious jeopardy;
- (B) serious impairment to bodily functions; or
- (C) serious dysfunction of any bodily organ or part.

~~(24)~~**(25)** Emotional or behavioral condition--Behavior which varies significantly from normal, that is chronic and does not quickly disappear, and that is unacceptable because of social or cultural expectations. Emotional or behavioral responses which are so different from those of the generally accepted, age-appropriate norms of people with the same ethnic or cultural background as to result in significant impairment in social relationships, self-care, educational progress, or classroom behavior. Examples include but are not limited to the following:

- (A) an inability to build or maintain satisfactory age-appropriate interpersonal relationships with peers or adults;
- (B) dangerously aggressive, self-destructive, severely withdrawn, or noncommunicative behaviors;
- (C) a pervasive mood of unhappiness or depression; or
- (D) evidence of excessive anxiety or fears.

§38.2

~~(25)~~**(26)** Facility--A hospital, psychiatric hospital, rehabilitation hospital or center, ambulatory surgical center, renal dialysis center, specialty center and/or outpatient clinic.

~~(26)~~**(27)** Family--For the purpose of this chapter, the family includes the following persons who live in the same residence:

- (A) the applicant;
- (B) those related to the applicant as a parent, step-parent or spouse who have a legal responsibility to support the applicant or guardians/managing conservators who have a duty to provide food, shelter, education, and medical care for the applicant;
- (C) children of the applicant; and
- (D) children of a parent, step-parent or spouse.

~~(27)~~**(28)** Family support services--Disability-related support, resources, or other assistance provided to the family of a child with special health care needs. The term may include services described by Part A of the Individuals with Disabilities Education Act (20 U.S.C. § **[Section]** 1400 *et seq.*), as amended, and permanency planning, as that term is defined by Government Code, §531.151.

~~(28)~~**(29)** Financial independence--A person who currently files his or her own personal U.S. income tax return and is not claimed as a dependent by any other person on his or her U.S. income tax return.

~~(29)~~**(30)** Health care benefits--CSHCN Services Program benefits consisting of diagnosis and evaluation services, rehabilitation services, medical home care management services, family support services, transportation related services, and insurance premium payment services.

~~(30)~~**(31)** Health insurance/health benefits plan—A policy or plan, either individual, group, or government-sponsored, that an individual purchases or in which an individual participates that provides benefits when medical and/or dental costs are or would be incurred. Sources of health insurance include, but are not limited to, health insurance policies, health maintenance organizations, preferred provider organizations, employee health welfare plans, union health welfare plans, medical expense reimbursement plans, United States Department of Defense or Department of Veterans Affairs benefit plans **[the Civilian Health and Medical Program of the Uniformed Services/Veterans Administration (CHAMPUS, CHAMPVA) or their successor plans]**, Medicaid, the Children’s Health Insurance Program (CHIP), and Medicare. Benefits may be in any form, including, but not limited to, reimbursement based upon cost, cash payment based upon a schedule, or access without charge or at minimal charge to providers of medical and/or dental care. Benefits from a municipal or county hospital, joint municipal-county hospital, county hospital authority, hospital district, county indigent health care programs, or the facilities of a medical school shall not constitute health insurance for purposes of this chapter.

§38.2

(31)[(32)] Household--The living unit in which the applicant resides and which also may include one or more of the following:

- (A) mother;
- (B) father;
- (C) stepparent;
- (D) spouse;
- (E) foster parent(s), managing conservator, or guardian;
- (F) grandparent(s);
- (G) sibling(s);
- (H) stepbrother(s); or
- (I) stepsister(s).

(32)[(33)] Medical home--A respectful partnership between a client, the client's family as appropriate, and the client's primary health care setting. A medical home is family centered health care that is accessible, continuous, comprehensive, coordinated, compassionate, and culturally competent. A medical home includes a licensed medical professional who accepts responsibility for the provision and/or coordination of primary, preventive, and/or specialty care for a client, and coordination of care with other community services providers. [A source of ongoing routine health care in the community in which providers and families work as partners to meet the needs of children and families. The medical home assists in early identification of special health care needs; provides ongoing primary care; and coordinates with a broad range of other specialty, ancillary, and related services.]

(33)[(34)] Natural home--The home in which a **[the eligible]** person lives that is either the residence of his/her parent(s), foster parent(s) or guardian(s), or extended family member(s), or the home in the community where the person has chosen to live, alone or with other persons. A natural home may utilize natural support systems such as family, friends, co-workers, and services available to the general population as they are available.

[(35) Newborn screening--The process required by law through which newborn children are screened for congenital anomalies, including but not limited to hearing impairment, congenital adrenal hyperplasia, congenital hypothyroidism, galactosemia, phenylketonuria, and hemoglobinopathies, such as sickle cell disease.]

(34)[(36)] Other benefit--A benefit, other than a benefit provided under this chapter, to which a person is entitled for payment of the costs of services included in the scope of coverage

§38.2

of **[provided under]** the CSHCN Services Program **[program]** including, but not limited to, benefits available from:

(A) an insurance policy, group health plan, health maintenance organization, or prepaid medical or dental care plan;

(B) home, auto, or other liability insurance;

(C)**[(B)]** Title XVIII, Title XIX, or Title XXI of the Social Security Act (42 U.S.C. §§ **[Sections]** 1395 *et seq.*, 1396 *et seq.*, and 1397aa *et seq.*), as amended;

(D)**[(C)]** the United States Department of Veterans Affairs;

(E)**[(D)]** the United States Department of Defense **[the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)]**;

(F)**[(E)]** workers' compensation or any other compulsory employers' insurance program;

(G)**[(F)]** a public program created by federal or state law or under the authority of a municipality or other political subdivision of the state, excluding benefits created by the establishment of a municipal or county hospital, a joint municipal-county hospital, a county hospital authority, a hospital district, or the facilities of a publicly supported medical school; or

(H)**[(G)]** a cause of action for the cost of care, including medical care, dental care, facility care, and medical supplies, required for a person applying for or receiving services from the department, or a settlement or judgment based on the cause of action, if the expenses are related to the need for services provided under this chapter.

(35)**[(37)]** Permanency planning--A planning process undertaken for children with chronic illness or developmental disabilities who reside in institutions or are at risk of institutional placement, with the explicit goal of securing a permanent living arrangement that enhances the child's growth and development, which is based on the philosophy that all children belong in families and need permanent family relationships. Permanency planning is directed toward securing: a consistent, nurturing environment; an enduring, positive adult relationship(s); and a specific person who will be an advocate for the child throughout the child's life. Permanency planning provides supports to enable families to nurture their children; to reunite with their children when they have been placed outside the home; and to place their children in family environments.

(36)**[(38)]** Person--An individual, corporation, government or governmental subdivision or agency, business trust, partnership, association, or any other legal entity.

(37)**[(39)]** Physician--A person licensed by the Texas State Board of Medical Examiners to practice medicine in this state.

§38.2

(38)[(40)] Prematurity/born prematurely--A child born at less than 36 weeks gestational age and hospitalized since birth.

(39)[(41)] Program--The services program for Children with Special Health Care Needs (CSHCN).

(40)[(42)] Provider--A person and/or facility as defined in §38.6 of this title (relating to Providers) that delivers services purchased by the CSHCN Services Program [program] for the purpose of implementing the Act.

(41)[(43)] Rehabilitation services--The process of the physical restoration, improvement, or maintenance of a body function destroyed or impaired by congenital defect, disease, or injury which includes the following acute and chronic/rehabilitative services:

(A) facility care, medical and dental care, and occupational, speech, and physical therapies;

(B) the provision of medications, braces, orthotic and prosthetic devices, durable medical equipment, and other medical supplies; and

(C) other services specified in this chapter.

(42)[(44)] Respite care--A service provided on a short-term basis for the purpose of relief to the primary care giver in providing care to individuals with disabilities. Respite services can be provided in either in-home or out-of-home settings on a planned basis or in response to a crisis in the family where a temporary caregiver is needed.

(43)[(45)] Routine child care--Child care for a child who needs supervision while the parent/guardian is at work, in school, or in job training.

(44)[(46)] Services--The care, activities, and supplies provided under the Act, including but not limited to both acute and chronic/rehabilitative medical care, dental care, facility care, medications, durable medical equipment, medical supplies, occupational, physical, and speech therapies, family support services, case management services, and other care specified by program rules.

(45)[(47)] Social service organization--For purposes of this chapter, a for-profit or nonprofit corporation or other entity, not including individual persons, that provides funds for travel, meal, lodging, and family supports expenses in advance to enable CSHCN Services Program clients to obtain program services.

(46)[(48)] Specialty center--A facility and staff that meets the CSHCN Services Program [program] minimum standards established in this chapter and are designated for [CSHCN program] use by CSHCN Services Program clients as part of the comprehensive services for a specific medical condition.

§§38.2-38.3

(47)[(49)] Spenddown--Financial eligibility achieved when household income exceeds 200% of the federal poverty level, if the applicant's family can document its responsibility for household medical bills that are equal to or greater than the amount in excess of the 200% level.

(48)[(50)] State--The State of Texas.

(49)[(51)] Supplemental Security Income Program (SSI)--Title XVI of the Social Security Act which provides for payments to individuals (including children under age 18) who are disabled and have limited income and resources.

(50)[(52)] Support--The contribution of money or services necessary for a person's maintenance, including, but not limited to, food, clothing, shelter, transportation, and health care.

(51)[(53)] Treatment plan--The plan of care for the client (time and treatment specific) as certified by and implemented under the supervision of a physician or other practitioner participating in the CSHCN Services Program [program].

(52)[(54)] United States Public Health Service (USPHS) price--The average manufacturer price for a drug in the preceding calendar quarter under Title XIX of the Social Security Act, reduced by the rebate percentage, as authorized by the Veterans Health Care Act of 1992 (P.L. 102-585, November 4, 1992).

(53)[(55)] Urgent need for health care benefits--A client need that fits the criteria and protocol described in §38.16(e) of this title.

§38.3. Eligibility for [CSHCN Program] Services.

(a) Eligibility for health care benefits. In order to be determined eligible for CSHCN Services Program [program] health care benefits, applicants must meet the medical, financial, and other criteria in this section.

(1) Medical criteria. At least annually, a [A] physician or dentist must certify [annually] that the person meets the definition of "child with special health care needs" as defined by §38.2(6) [§38.2(8)] of this title (relating to Definitions). The medical criteria certification must be based upon a physical examination conducted within the 12 months immediately preceding the date of certification. The physician or dentist must document the [The CSHCN program must receive a] medical diagnosis code and descriptor from the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM), or its successor, for the person's primary diagnosis that meets the medical criteria certification definition and for each of the person's other medical conditions [on each condition] for statistical and referral purposes. To facilitate application to the CSHCN Services Program for certain applicants, the CSHCN Services Program Medical Director may accept written documentation of medical criteria certification submitted by a physician or dentist who is licensed to practice in a state or jurisdiction of the United States of America other than Texas. The CSHCN Services Program does not reimburse for written documentation of medical criteria certification. If a physician or dentist requests coverage of diagnosis and evaluation services to determine if the person

§38.3

[child/applicant] meets the definition of a "child with special health care needs", and the person [applicant] meets all other eligibility criteria for health care benefits, then the person [applicant] may be given up to 60 days of program coverage for diagnosis and evaluation services only. Only CSHCN Services Program participating providers as specified in §38.6 of this title (relating to Providers), may be reimbursed for services as defined in §38.2 of this title (relating to Definitions).

(2) Financial criteria. Financial criteria are determined every six months, or as directed by statutory requirements. **[annually and]** Financial criteria are based upon the same determinations of income, family size, and disregards as the CHIP. **[The CHIP net income is the family's gross income minus disregards. For applicants who are not eligible for CHIP, premiums]** Premiums paid for health insurance may be included as a **[an additional]** disregard. All families must verify their income and disregards, if applicable.

(A) The income level for eligibility is 200% of the federal poverty level. If the family income exceeds this level, and the applicant's family can document its responsibility for household medical bills incurred within 12 months prior to [of] the application date or within 6 [12] months after the financial eligibility denial date that are equal to or greater than the amount in excess of the 200% level, the applicant may be determined financially eligible for a period of 6 [12] months, or as directed by statutory requirements, beginning on the eligibility date.

(B) Applications to Medicaid and the Supplemental Security Income (SSI) programs.

(i) If actual or projected CSHCN Services Program [program] expenditures for an ongoing [a] client currently not eligible for Medicaid exceed \$2,000 per year, and the client's age and [the client whose age, medical condition, or] citizenship status meet [do not exceed] Medicaid eligibility criteria, the client shall be required to apply for any applicable Medicaid programs [Medicaid, specifically including the Medically Needy program] and, if eligible, to participate in those programs in order to remain eligible for further CSHCN Services Program [program] benefits. Within 60 days of the date of the notification letter, the client must submit to the CSHCN Services Program [program] documentation of an eligibility determination from Medicaid. During this 60-day period, CSHCN Services Program [program] coverage will continue. If the client does not provide documentation of an eligibility determination from Medicaid within the 60-day time limit, CSHCN Services Program [program] coverage shall be terminated and may not be reinstated unless an eligibility determination is received. The program may grant the client a 30-day extension to obtain the determination.

(ii) The CSHCN Services Program [program] also may require an ongoing [a] client for whom actual or projected expenditures exceed \$2,000 per year to apply for the SSI program, and, if eligible, to participate in that program in order to remain eligible for further CSHCN Services Program [program] benefits. Within 60 days of the date of the notification letter, the client must submit to the CSHCN Services Program [program] verification of a timely and complete application to SSI. During this 60-day period, CSHCN

§38.3

Services Program [program] coverage will continue. If the client does not provide this verification within the 60-day time limit, CSHCN Services Program [program] coverage may be terminated. With verification of an application to SSI, the program may continue coverage, pending receipt of an SSI eligibility determination.

(3) Health insurance.

(A) All health insurance coverage insuring the applicant and/or family must be listed on the application. If insurance coverage was effective prior to CSHCN Services Program [program] eligibility, such coverage must be kept in force. Noncompliance with this requirement may result in the termination of CSHCN Services Program [program] benefits. If insurance cannot be maintained, the applicant or parent/guardian/managing conservator must, upon request, provide to the CSHCN Services Program [program] proof of:

(i)-(iv) (No change.)

(B) If the applicant/client does not have health insurance at the time of application or eligibility renewal, but coverage may be available, including coverage under Medicaid or CHIP, the applicant/client that is not ineligible for such coverage by reason of age, citizenship, or residency status must apply for coverage and receive an eligibility determination within 60 days of the date of notification. With verification of an application to Medicaid, CHIP, or an available health insurance plan, the program may extend this deadline [**and/or continue CSHCN program coverage**], pending receipt of an insurance eligibility determination. If the applicant/client is eligible for any other health insurance [CHIP], the applicant/client must be enrolled [**in CHIP**]. Such insurance must be kept in force as though it were effective prior to CSHCN Services Program [program] eligibility.

(C) The CSHCN Services Program [program] will assist in determining possible eligibility for insurance and may provide CSHCN Services Program [program] benefits for ongoing clients during insurance application, enrollment, and/or limited or excluded coverage periods. [**A family support services plan for an applicant may not be implemented until the determination of program eligibility, including eligibility for available insurance plans is complete.**]

(D) Before canceling, terminating, or discontinuing existing health insurance, or electing not to enroll a client in available health insurance, including canceling, terminating, discontinuing, or not enrolling in CHIP, the parent/guardian/managing conservator must notify the CSHCN Services Program [program] 30 days prior to cancellation, termination, discontinuance, or end of the enrollment period. When the CSHCN Services Program [program] provides assistance in keeping or acquiring health insurance, the parent/guardian/managing conservator must maintain or enroll in the health insurance.

(4)-(5) (No change.)

(6) Application.

§38.3

(A) Applications are available to anyone seeking assistance from the CSHCN Services Program [program]. To be considered by the CSHCN Services Program [program], the application must be made on forms currently in use.

(B) A person is considered to be an applicant from the time that the CSHCN Services Program [program] receives an application. The CSHCN Services Program [program] will respond in writing regarding eligibility status within 30 working days after the completed application is received. Applications will be considered:

(i)-(iii) (No change.)

(C) The denial of any application submitted to the CSHCN Services Program [program] shall be in writing and shall include the reason(s) for such denial. The applicant has the right of administrative review and a fair hearing as set out in §38.13 of this title (relating to Right of Appeal).

(D) Any person has the right to reapply for CSHCN Services Program [program] coverage at any time or whenever the person's situation or condition changes.

(7) Verification of information.

(A) The CSHCN Services Program [program] shall make the final determination on a person's eligibility using the information provided with the application. The CSHCN Services Program [program] may request verification of any information provided by the applicant to establish eligibility.

(B) The CSHCN Services Program [program] shall verify selected information on the application. Documentation of date of birth, residency, income, and income disregards shall be required. The CSHCN Services Program [program] shall notify the applicant/family in writing when specific documentation is required. It is the applicant's/family's responsibility to provide the required information.

(C) Those applicants/clients financially eligible for CHIP, Medicaid, or other programs with eligibility [similar] income guidelines that [who also] meet the CSHCN Services Program's eligibility income guidelines, who also meet the CSHCN Services Program's age and residency requirements, [of the CSHCN program] will be considered financially eligible. The applicant/client/family must notify the CSHCN Services Program [program], if the applicant/client is no longer eligible for such programs.

(8) Determination of continuing eligibility for health care benefits. Financial [Medical and financial] criteria for eligibility for health care benefits must be re-established every six months, or as directed by statutory requirements. Medical criteria must be re-established at least annually (i.e., within 365 days from the first day of the client's current eligibility period, or within 366 days during a leap year). Ongoing clients for health care benefits will be notified of CSHCN Services Program [program] deadlines for [annual] re-establishment of eligibility. If an ongoing client for health care benefits does not meet CSHCN

§§38.3-38.4

Services Program [program] deadlines for submitting information required for the [annual] determination of continuing eligibility, the client's eligibility for health care benefits will end. If the then former client re-applies to the CSHCN Services Program [program] after such lapse in eligibility and is determined eligible for health care benefits, the former client will be considered a new client. If the CSHCN Services Program [program] has a waiting list for health care benefits, the new client will be placed on the waiting list in order according to the date/time the client is determined eligible for [the program] health care benefits.

(b) Eligibility for case management services. The CSHCN Services Program [program] may provide and/or reimburse for case management services to persons in need of such services who are bona fide residents and who are determined not to have another primary provider and/or funding source for such services. The program's case management services are focused on individuals (and their families) who are eligible, seeking eligibility, or potentially seeking eligibility for the program's health care benefits (includes clients who are on the waiting list for health care benefits). However, the program may offer and provide case management services to individuals (and their families) who are neither eligible nor seeking eligibility for the program's health care benefits.

§38.4. Covered Services.

(a) Introduction. The CSHCN Services Program [program] provides no direct medical services, but reimburses for services rendered by CSHCN Services Program [program] participating providers and/or contractors. Clients must receive services as close to their home communities as possible, unless CSHCN Services Program [program] contracts or policies require treatment at specific facilities or specialty centers and/or the clients' conditions require specific specialty care.

(b) Types of service.

(1) Early identification. The CSHCN Services Program [program] may conduct outreach activities to identify children for program enrollment, increase their access to care, and help them use services appropriately. Outreach services may include, but are not limited to:

(A) CSHCN Services Program [program] promotion to the general public, or targeted to potential clients and providers;

(B)-(E)(No change.)

(2) Diagnosis and evaluation services. May be covered for the purpose of determining whether a CSHCN Services Program [program] applicant for health care benefits meets the CSHCN Services Program [program] definition of a child with special health care needs. Diagnosis and evaluation services must be prior authorized and coverage is limited in duration. If a physician or dentist requests coverage of diagnosis and evaluation services to determine if the child/applicant meets the definition of a "child with special health care needs,"[,] and the applicant meets all other eligibility criteria, then the applicant may be given up to 60

§38.4

days of program coverage for diagnosis and evaluation services only. The program medical director or other designated medical staff may prior authorize limited coverage of diagnosis and evaluation services for waiting list clients if needed to help determine "urgent need for health care benefits" as described in §38.16(e) of this title (relating to Procedures to Address CSHCN Services Program Budget Alignment). Only CSHCN Services Program [program] participating providers may be reimbursed for diagnosis and evaluation services.

(3) Rehabilitation services. Rehabilitation services means a process of physical restoration, improvement, or maintenance of a body function destroyed or impaired by congenital defect, disease, or injury which includes the following acute and chronic/rehabilitative services: facility care, medical and dental care, occupational, speech, and physical therapies, the provision of medications, braces, orthotic and prosthetic devices, durable medical equipment, other medical supplies, and other services specified in this chapter. To be eligible for CSHCN Services Program [program] reimbursement, treatment must be for a client **[with a chronic physical or developmental condition as specified in §38.3(a)(1) of this title (relating to Eligibility for CSHCN Program Services),]** and must have been prescribed by a provider in compliance with all applicable laws and regulations of the State of Texas. Services may be limited, and the availability of certain services described in the following subparagraphs is contingent upon implementation of automation procedures and systems.

(A) Medical assessment and treatment. Medical assessment and treatment services, including medically necessary laboratory and radiology studies, must be provided by physicians and other practitioners licensed by the State of Texas, enrolled as participating providers in the CSHCN Services Program [program], and within the scope of their respective licenses or registrations.

(B) Outpatient mental health services. Outpatient mental health services are limited to no more than 30 encounters in a calendar year by all professionals licensed to provide mental/behavioral health services, including psychiatrists, psychologists, licensed clinical social workers (LCSW) [master social worker-advanced clinical practitioners], licensed marriage and family therapists, and licensed professional counselors, per eligible client per calendar year. Coverage includes, but is not limited to psychological or neuropsychological testing, psychotherapy, psychoanalysis, counseling, and narcosynthesis.

(C) Preventive and therapeutic dental services (including oral/maxillofacial surgery). Preventive and therapeutic dental services must be provided by licensed dentists enrolled to participate in the CSHCN Services Program [program]. Coverage for therapeutic dental services, including prosthetics and oral/maxillofacial surgery, follows the Texas Medicaid program guidelines. Orthodontic care may be provided only for CSHCN eligible clients with diagnoses of cleft/craniofacial abnormalities and/or late effects of fractures of the skull and face bones.

(D) Podiatric services. Podiatric services must be provided by licensed podiatrists enrolled to participate in the CSHCN Services Program [program]. Coverage is limited to the medically necessary treatment of foot and ankle conditions and follows the Texas

§38.4

Medicaid program guidelines. Supportive devices, such as molds, inlays, shoes, or supports, must comply with coverage limitations for foot orthoses.

(E) Treatment in CSHCN Services Program [program] participating facilities. Non-emergency hospital care must be provided in facilities **[which] that** are enrolled as CSHCN Services Program [program] participating providers. The length of stay is limited according to diagnosis, procedures required, and the client's condition.

(i) Inpatient hospital care and inpatient psychiatric care.

(I) (No change.)

(II) Inpatient psychiatric care. Coverage is limited to inpatient assessment and crisis stabilization and is to be followed by referral to **[the Texas Department of Mental Health and Mental Retardation programs or other]** an appropriate public or private mental health program. Admission must be prior authorized **[and is limited to five days]**. Services include those medically necessary and furnished by a Medicaid psychiatric hospital/facility under the direction of a psychiatrist.

(ii) Inpatient rehabilitation care. Medically necessary inpatient rehabilitation care is limited to an initial admission not to exceed 30 days, based on the functional status and potential of the client as certified by a physician participating in the CSHCN Services Program [program]. Services beyond the initial 30 days may be approved by the CSHCN Services Program [program] based upon the client's medical condition, plan of treatment, and progress. Payment for inpatient rehabilitation care is limited to 90 days during a calendar year.

(iii) Ambulatory surgical care. Ambulatory surgical care is limited to the medically necessary treatment of a client and may be performed only in CSHCN Services Program [program] approved ambulatory surgical centers as defined in §38.7 of this title (relating to Ambulatory Surgical Care Facilities).

(iv) Emergency care. Care including, but not limited to hospital emergency departments, ancillary, and physician services, is limited to medical conditions manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent person with average knowledge of health and medicine could reasonably expect that the absence of immediate medical care could result in placing the client's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. If a client is admitted to a non-participating CSHCN Services Program [program] hospital provider following care in that provider's emergency room, and the admitting facility declines to enroll or does not qualify as a CSHCN Services Program [program] provider, the client must be discharged or transferred to a participating CSHCN Services Program [program] provider as soon as the client's medical condition permits. All providers must enroll in order to receive reimbursement.

§38.4

(v) Care for renal disease. Renal dialysis is limited to the treatment of acute renal disease or chronic (end stage) renal disease through a renal dialysis facility and includes, but is not limited to dialysis, laboratory services, drugs and supplies, dec clotting shunts, on-site physician services, and appropriate access surgery. Renal transplants may be covered in approved renal transplant centers if the projected cost of the transplant and follow-up care is less than that of continuing renal dialysis. Renal transplants must be prior authorized.

(F)-(G)(No change.)

(H) Nutrition services and nutritional products, excluding hyperalimentation/total parenteral nutrition (TPN).

(i) (No change.)

(ii) Nutritional products. Nutritional products, including over-the-counter products, are limited to those covered by the CSHCN Services Program [program] and prescribed by a practitioner licensed to do so, for the treatment of an identified metabolic disorder or other medical condition and serving as a medically necessary therapeutic agent for life and health, or when part or all nutritional intake is through a tube.

(I) (No change.)

(J) Medical foods. Coverage for medical foods is limited to the treatment of inborn metabolic disorders. Treatment for any other condition with medical foods requires documentation of medical necessity and prior authorization. Medical foods are approved products listed in enrolled providers' catalogs and are lacking in the compounds that cause complications of a covered metabolic disorder.

(K)[(J)] Durable medical equipment. All equipment must be prescribed by a practitioner licensed to do so. Some equipment may be supplied on a contract basis, and therefore, shall be ordered from a specific supplier.

(L)[(K)] Medical supplies. Supplies must be medically necessary for the treatment of an eligible client.

(M)[(L)] Professional vision services. Vision services medically necessary for the treatment of a client include, but are not limited to:

(i) medically necessary eye examinations with refraction for diagnoses of refractive error, aphakia, diseases of the eye, or eye surgery;

(ii) one eye examination with refraction for the purpose of obtaining eyewear during a calendar [the state fiscal] year; and

§38.4

(iii) one pair of non-prosthetic eye wear per calendar year prescribed by a practitioner licensed to do so.

(N)~~(M)~~ Speech-language pathology/audiology. Speech-language pathology and audiology services medically necessary for the treatment of a client must be prescribed by a practitioner licensed to do so and provided by a speech-language pathologist or audiologist licensed by the State of Texas. CSHCN Services Program **[program]** coverage of speech-language pathology and audiology services may be limited to certain conditions, by type of service, by age, by the client's medical status, and whether the client is eligible for services for which a school district is legally responsible.

(O)~~(N)~~ Audiological testing, hearing exams, and amplification devices. Services for clients under 21 years of age are coordinated through the Program for Amplification for Children of Texas (PACT). For clients 21 years of age and older and those ineligible for the PACT, covered services are the same as those available through the PACT.

(P)~~(O)~~ Occupational and physical therapy. Occupational and physical therapy medically necessary for the treatment of a client must be prescribed by a practitioner licensed to do so and provided by a therapist licensed by the State of Texas. CSHCN Services Program **[program]** coverage of physical and occupational therapy may be limited to certain conditions, by type of service, by age, by the client's medical status, and whether the child is eligible for services for which a school district is legally responsible.

(Q)~~(P)~~ Certified respiratory care practitioner services. Respiratory therapy medically necessary for the treatment of a client must be prescribed by a practitioner licensed to do so and provided by a certified respiratory care practitioner. CSHCN Services Program **[program]** coverage of respiratory therapy may be limited to certain conditions, by type of service, by age, by the client's medical status, and whether the child is eligible for services for which a school district is legally responsible.

(R)~~(Q)~~ Home health nursing services. Home health nursing services must be medically necessary, be prescribed by a physician, and be provided only by a licensed and certified home and community support services agency participating in the CSHCN Services Program **[program]**. Home health nursing services are limited to 200 hours per client per calendar year. Up to 200 additional hours of service per client per calendar year may be approved with documented justification of need and cost effectiveness.

(S)~~(R)~~ Hospice care. Hospice care includes palliative care for clients with a presumed life expectancy of six months or less during the last weeks and months before death. Services apply to care for the hospice terminal diagnosis condition or illnesses. Treatment for conditions unrelated to the terminal condition or illnesses is unaffected. Hospice care must be prescribed by a practitioner licensed to do so who also is enrolled as a CSHCN Services Program provider.

(4) Care management.

§38.4

(A) Medical home. Each CSHCN Services Program **[program]** client should receive care in the context of a medical home.

(i) Comprehensive coordinated health care of infants, children, and adolescents should encompass the following services:

(I)-(V) (No change.)

(VI) maintenance of a central record and database **[data base]** containing all pertinent medical information about the client, including information about hospitalizations.

(ii) The CSHCN Services Program **[program]** may require periodic reports from the medical home.

(B) (No change.)

(5) Family support services. Family support services include disability-related support, resources, or other assistance and may be provided to the family of a client with special health care needs.

(A) Eligibility. A client is eligible to receive family support services if:

[(i) the client is fully eligible for the CSHCN program health care benefits;]

[(i)][(ii)] the client is not receiving services from a Medicaid home and community-based waiver program, and the requested service does not duplicate services received from other family support programs, such as the In-Home and Family Support program, the Primary Home Care Program, or the Medically Dependent Children's Program **[at the Texas Department of Human Services or the Texas Department of Mental Health and Mental Retardation]**; and

[(ii)][(iii)] the client's family collaborates with the assigned case manager to identify and pursue other sources of support and to develop a family assessment and service **[support services]** plan.

(B) Processing and evaluation of requests.

(i) Families of clients indicate their need for family support services **[in writing at the time of their application or renewal for the CSHCN program, or at any time during their eligibility period for the CSHCN program].**

(ii) (No change.)

§38.4

(iii) All requests for family support services must be prior authorized (approved by the CSHCN Services Program **[program]** prior to delivery).

(iv) While there is a waiting list for health care benefits, limitations in reimbursement and/or prior authorization may be instituted as provided in §38.16 of this title.

(v)-(ix)(No change.)

(C) Service plan and cost allowances.

(i) In order to obtain prior authorization for family support services, the case manager and the client/family must develop a family assessment and service **[written family support services]** plan.

(ii) The CSHCN Services Program **[program]** may establish annual cost allowances based upon the client's/family's level of assessed need for family support services, not to exceed:

(I) (No change.)

(II) assistance of up to \$3,600 per calendar year per eligible client to purchase other allowable services. This limit may increase to no more than \$7,200 for the purchase of vehicle lifts and modifications;

(iii) Service plan cost allowances may be prorated for plans that cover less than one calendar year.

(iv) Disbursement of assistance:

(I) (No change.)

(II) may be made to the family or to the vendor enrolled as a CSHCN Services Program provider; and

(III) (No change.)

(v) (No change.)

(vi) The annual family assessment and service plan may be amended at any time, but will be reevaluated by the client/family and case manager at least annually to coincide with the client's reapplication for the CSHCN Services Program **[program]**.

(D) Allowable services.

§38.4

(i) Family support services for CSHCN Services Program clients and their families include those allowable services and items that:

(I)-(III) (No change.)

(ii) (No change.)

(iii) Allowable services include:

(I)-(IV) (No change.)

(V) vehicle lifts and modifications consistent with those available through the Department of Assistive and Rehabilitative Services (DARS) [Texas Rehabilitation Commission], limited to lifts, wheelchair tie-downs, occupant restraints, accessories/modifications such as raising roofs or doors if necessary for lift installation or usage, hand controls, and repairs of covered modifications not related to inappropriate handling or misuse of equipment and not covered by other resources;

(VI)-(VII) (No change.)

(E) Unallowable services. Family support funds may not be used to provide those services that do not relate to the client's disability and do not directly support the client's living in his/her natural home and participating in family life and integrated/inclusive community activities. Examples of unallowable services include, but are not limited to:

(i)-(viii) (No change.)

(ix) costs for allowable services incurred before the requested family support service is prior authorized [written service plan is approved];

(x) (No charge.)

(xi) medical benefit items or services paid for or reimbursed by private insurance, Medicaid, Medicare, CHIP, the CSHCN Services Program [**program**] or other health insurance programs for which the client is eligible;

(xii) services, equipment, or supplies that have been denied by Medicaid, CHIP, or the CSHCN Services Program [**program**] because a claim was received after the filing deadline, insufficient information was submitted, or because an item was considered inappropriate or experimental;

(xiii)-(xx) (No change.)

(F) Reduction/termination of services. Reasons for terminating or reducing family support services may include, but are not limited to:

§38.4

(i) the client no longer meets the eligibility criteria for the CSHCN Services Program **[program]**;

(ii) (No change.)

(iii) While there is a waiting list for health care benefits, limitations in reimbursement and/or prior authorization may be instituted as provided in §38.16 of this title;

(iv)-(viii) (No change.)

(ix) the family knowingly does not comply with the family assessment and service **[written family support services]** plan, in which case the family may also be liable for restitution.

(6) Other types of services. The following services also are available through the CSHCN Services Program **[program]**.

(A) (No change.)

(B) Transportation. The CSHCN Services Program **[program]** may provide transportation for a client and, if needed, a responsible adult, to and from the nearest medically appropriate facility (in Texas or in the United States 50 or fewer miles from the Texas border) to obtain medically necessary and appropriate health care services that are within the scope of coverage of the CSHCN Services Program and are provided by a CSHCN Services Program enrolled provider. The lowest-cost appropriate conveyance should be used. The CSHCN Services Program **[program]** shall not assist if transportation is the responsibility of the client's school district or can be obtained through Medicaid. Transportation to out-of-state services located more than 50 miles from the Texas border will not be approved, except as specified in §38.6(e) of this title (relating to Providers).

(C) Meals and lodging. The CSHCN Services Program **[program]** may provide meals and lodging to enable a parent, guardian, or their designee to obtain inpatient or outpatient care for a client at a facility located away from their home. The reason for the inpatient or outpatient visit must be directly related to medically necessary treatment for the client that is provided by program enrolled providers and covered by the program. Meals and lodging associated with travel to services that are provided more than 50 miles from the Texas border will not be approved, except as specified in §38.6(e) of this title.

(D) Transportation of deceased. The CSHCN Services Program **[program]** may provide the following services:

(i) transportation cost for the remains of a client who expires in a CSHCN Services Program participating facility while receiving CSHCN Services Program health care benefits **[program services]**, if the client was not in the family's city of residence in Texas, and the transportation cost of a parent or other person accompanying the remains, from

§38.4

the facility to the place of burial in Texas that is designated by the parent or other person legally responsible for interment;

(ii)-(iv)(No change.)

(E) Payment of insurance premiums, coinsurance, co-payments, and/or deductibles. The CSHCN Services Program [program] may pay public or private health insurance premiums to maintain or acquire a health benefit plan or other third party coverage for the client, if the parent/foster parent/guardian/managing conservator is financially unable to do so, and if paying for such health insurance can reasonably be expected to be cost effective for the CSHCN Services Program [program]. The CSHCN Services Program [program] may pay for coinsurance and deductible amounts when the total amount paid (including all payers) to the provider does not exceed the maximum allowed by the CSHCN Services Program for the covered service. The CSHCN Services Program [program] may reimburse clients for co-payments paid for covered services. The CSHCN Services Program [program] may not pay premiums, deductibles, coinsurance or co-payments for clients enrolled in CHIP.

(c) Services not covered. Services which are not covered by the CSHCN Services Program [program] even though they may be medically necessary for and provided to a client include, but are not limited to:

(1)-(4) (No change.)

(5) pregnancy prevention, except when medically necessary for the specific treatment of a **[covered]** condition meeting the parameters of the “child with special health care needs” definition;

(6) maternity care services specific to routine pregnancy care, labor and delivery, and maternal post-partum care; and

(7) infertility treatment or other reproductive services, unless directly related to a **[covered chronic physical or developmental]** condition meeting the parameters of the “child with special health care needs” definition.

(d) Service authorization. The CSHCN Services Program [program] may require authorization (including prior authorization) of reimbursement for selected services for clients.

(1) Provider's responsibility. A CSHCN Services Program provider must request services in specific terms on department-prepared forms so that an authorization may be issued and sufficient monies encumbered to cover the cost of the service. If a service is authorized, payment may be made to the provider as long as the service is not covered by a third party resource, and all billing requirements are met. Program authorization should not be considered an absolute guarantee of payment. Once a service is delivered and if the service requires authorization for payment, the authorization request for that service must be submitted within 90 days of the date of service.

§§38.4-38.5

(2) Required prior authorization for selected services. At the CSHCN Services Program's [program's] option, selected services may require authorization prior to the delivery of services in order for payment to be made. Prior authorization [Authorization] requests must be submitted prior to the date of service.

(3) (No change.)

[(4) Use of other benefits. The CSHCN program is the payer of last resort. The Children with Special Health Care Needs Services Act provides that any health insurance or other benefits including, but not limited to commercial health insurance, health maintenance organizations, preferred provider organizations, CHAMPUS/CHAMPVA, Medicaid or Medicaid waiver programs, CHIP, liability insurance, or worker's compensation insurance available to the client must be used prior to payment by the CSHCN program.]

~~(4)~~[(5)] Denied authorization requests are authorization requests which are incomplete, submitted on the wrong form, lack necessary documentation, contain inaccurate information, fail to meet authorization request submission deadlines, and/or are for ineligible persons [recipients], services, or providers, and/or are for clients who do not qualify for the health care benefit requested. Denied authorization requests may be corrected and resubmitted for reconsideration. However, authorization requests must meet authorization request submission deadlines. If the results of the reconsideration process are unsatisfactory, denied authorization requests may be appealed according to §38.13 of this title (relating to Right of Appeal).

(e) Pilot projects. The CSHCN Services Program [program] may initiate and participate in pilot projects to determine the fiscal impact of changes in eligibility criteria and the types of services provided. New projects are possible only if funds are available in the current fiscal year. All pilot projects are limited to no more than 10% of the fiscal year appropriation.

§38.5. Rights and Responsibilities of Parents/Foster Parents/Guardian/Managing Conservator or the Adult Client.

(a) Rights. The parent/foster parent/guardian/managing conservator or the adult client shall have the right to:

(1) (No change.)

(2) choose providers subject to CSHCN Services Program [program] limitations;

(3) (No change.)

(4) refuse entry into the home to any employee, agent, or representative of the commission or the department;

§§38.5-38.6

(5) appeal CSHCN Services Program **[program]** decisions and receive a response within the **[CSHCN program-specified]** deadline as described in §38.13 of this title (relating to Right of Appeal); and

(6) (No change.)

(b) Responsibilities. The parent/foster parent/guardian/managing conservator or adult client shall have the responsibility to:

(1) provide accurate medical information to providers and notify all providers of CSHCN Services Program **[program]** coverage prior to delivery of services;

(2) provide the CSHCN Services Program **[program]** with accurate information regarding any change of circumstance which might affect eligibility, within 30 days of such change;

(3) receive and utilize services as close to the client's home community as possible, unless CSHCN Services Program **[program]** contracts, policies, or a referral by a CSHCN Services Program provider requires the use of specific facilities or specialty centers;

(4) reimburse the CSHCN Services Program **[program]**, if payments from health insurance or other benefits are made directly to the client or parent/guardian/managing conservator for services or equipment purchased by the CSHCN Services Program **[program]**;

(5) consult with the provider regarding authorization of service from the CSHCN Services Program **[program]** prior to service delivery;

(6) utilize services provided by the CSHCN Services Program **[program]** appropriately, including keeping appointments and using supplies and equipment judiciously;

(7) (No change.)

(8) notify the CSHCN Services Program **[program]** of any other benefits, as defined in §38.2 of this title (relating to Definitions), available to the client at the time of application or thereafter, and any lawsuit(s) contemplated or filed concerning the cause of the medical condition for which the CSHCN Services Program **[program]** has paid for services; and

(9) bear a portion of the expense of medical or dental care, if deemed financially able by the CSHCN Services Program **[program]**. Items of routine daily living are not covered by the CSHCN Services Program **[program]**.

(c) (No change.)

§38.6. Providers.

§38.6

(a) General requirements for participation. The Children with Special Health Care Needs Services (CSHCN) Act, Health and Safety Code, §35.004, authorizes the approval of [Texas Board of Health to approve] physicians, dentists, podiatrists, dietitians, facilities, specialty centers, and other providers to participate in the CSHCN Services Program [program] according to its criteria and procedures.

(1) Providers seeking approval for CSHCN Services Program [program] participation must submit a completed application to the CSHCN Services Program [program] or its designee, including a signed provider agreement and all documents requested on the application.

(2) All approved CSHCN Services Program [program] providers must agree to abide by CSHCN Services Program [program] rules and regulations, and not to discriminate against clients based on source of payment.

(3) All CSHCN Service Program [program] providers must agree to accept the CSHCN Services Program [program] allowed amount of payment (regardless of payer) as payment in full for services provided to CSHCN Services Program clients. Providers may collect allowable insurance or health maintenance organization co-payments in accordance with those plan provisions. Providers may not request or accept payment from the client or client's family for completing any CSHCN Services Program forms.

(4) The CSHCN Services Program [program] is the payer of last resort, and CSHCN Services Program [program] providers must agree to utilize all other public or private benefits available to the client, including but not limited to Medicaid or Medicaid waiver programs, CHIP, or Medicare, and casualty or liability coverage prior to requesting payment from the CSHCN Services Program [program]. [Program] Providers [providers] must agree to attempt to collect payment from the payer of other benefits. The CSHCN Services Program [program] may pay for certain [CSHCN program] services for which other benefits may be available but have not been definitively determined. If other benefits become available after the CSHCN Services Program [program] has paid for the [program] services, the CSHCN Services Program [program] shall recover its costs directly from the payer of other benefits or shall request the provider of [CSHCN program] services to collect payment and reimburse the CSHCN Services Program [program].

(5) Overpayments made on behalf of clients to CSHCN Services Program [program] participating providers must be reimbursed to the CSHCN Services Program [program] refund account by lump sum payment or, at the discretion of the department, in monthly installments or out of current claims due to be paid the provider. All providers must consent to on-site visits and/or audits by CSHCN Services Program [program] staff or its designees.

(6) All CSHCN Services Program providers of [CSHCN program] services also covered by Medicaid must enroll and remain enrolled as Title XIX Medicaid providers. In order to be reimbursed by Medicaid as the primary payer, a provider must be enrolled on the date of service. The CSHCN Services Program [program] will not reimburse an enrolled provider for

§38.6

any service covered under Medicaid that **[which]** was provided to a CSHCN Services Program client eligible for Medicaid at the time of service. If a **[CSHCN program]** service covered by the CSHCN Services Program is not covered by Medicaid, the provider of that service is not required to enroll as a Medicaid provider. Any provider excluded by Medicaid for any reason shall be excluded by the CSHCN Services Program **[program]**.

(7) (No change.)

(8) All providers shall be responsible for the actions of members of their staffs who provide CSHCN Services Program **[program]** services.

(9) Any provider may withdraw from CSHCN Services Program **[program]** participation at any time by so notifying the CSHCN Services Program **[program]** in writing.

(b) Denial, modification, suspension, and termination of provider approval.

(1) The CSHCN Services Program **[program]** may deny, modify, suspend, or terminate a provider's approval to participate for the following reasons:

(A)-(B) (No change.)

(C) not adhering to the provider agreement signed at the time of application or renewal for CSHCN Services Program **[program]** participation;

(D)-(E) (No change.)

(2) The CSHCN Services Program **[program]** may deny or suspend approved provider status based on the CSHCN Services Program's **[program's]** knowledge of disciplinary action taken against the provider by the licensing authority under which the provider practices in the State of Texas or by the Texas Medicaid Program.

(3) Prior to taking an action to deny, modify, suspend, or terminate the approval of a provider, the CSHCN Services Program **[program]** shall give the provider written notice of an opportunity of appeal in accordance with §38.13 of this title (relating to Right of Appeal). In addition, a fair hearing is available to any provider for the resolution of conflict between the CSHCN Services Program **[program]** and the provider.

(c) Provider types. Approved providers include, but are not limited to:

(1)-(3) (No change.)

(4) mental/behavioral health professionals, including psychiatrists, licensed psychologists, licensed clinical social workers **[master level social worker-advanced clinical practitioners]**, licensed marriage and family therapists, and licensed professional counselors;

(5)-(24) (No change.)

§38.6

(d) Requirements for specialty centers.

(1) The CSHCN Services Program **[program]** may accept as participating providers diagnostically specific specialty centers, such as bone marrow or other transplant centers, approved under the credentialing and/or approval standards and processes of the Texas Medicaid Program, if such specialty centers also submit a CSHCN Services Program provider enrollment application.

(2) Other specialty center standards. The CSHCN Services Program **[program]** may establish standards to insure quality of care for children with special health care needs in the comprehensive diagnosis and treatment of specific medical conditions for specialty centers with Texas Medicaid Program separate credentialing standards as well as other specialty centers for which the Texas Medicaid Program has not established separate credentialing or approval standards for providers.

(e) Out-of-state coverage.

(1) Fifty or fewer **[Within 50]** miles from the Texas state border. For clients **[Clients]** who would otherwise experience financial hardship or be subject to clear medical risk, the CSHCN Services Program may cover services that are within the scope of the program and provided by health care providers **[may be transported to medical facilities]** in New Mexico, Oklahoma, Arkansas, or Louisiana located **[within]** 50 or fewer miles from **[of]** the Texas state border. **[All CSHCN program policies and procedures will apply, including the requirement that all providers be Medicaid and CSHCN program participating providers.]**

(2) More than **[Outside]** 50 miles from **[of]** the Texas state border. The manager of the department unit having responsibility for oversight of the CSHCN Services Program **[commissioner of health]** may approve coverage of services that are within the scope of the CSHCN Services Program and provided by health care providers located within the United States and more than 50 miles from the Texas border **[CSHCN program payment to out-of-state providers]** in unique circumstances in which the CSHCN Services Program **[program]** participating physician(s), the client, parent or guardian, and the CSHCN Services Program medical director agree that:

(A) (No change.)

(B) the medical literature indicates that the out-of-state treatment is accepted medical practice and is anticipated to improve the client's quality of life;

(C)[(B)]the same treatment or another treatment of equal benefit or cost is not available from Texas CSHCN Services Program providers; and

(D)[(C)]the out-of-state treatment should result in a decrease in the total projected CSHCN Services Program **[program]** cost of the client's treatment.

§§38.6-38.7

(3) The limitations of this paragraph do not apply to coverage for or payment to CSHCN Services Program providers of selected products or devices including, but not limited to, medical foods or hearing amplification devices, which either are always less costly and/or are only available, from out-of-state sources.

(4) For CSHCN Services Program reimbursement, all program policies and procedures will apply, including the requirement that all providers be CSHCN Services Program participating providers, as defined by this section.

[(3) The medical literature must indicate that the out-of-state treatment is accepted medical practice and is anticipated to improve the patient's quality of life.]

(5)[(4)] The CSHCN Services Program may cover costs of transportation and associated meals and lodging for a client and, if necessary, a responsible adult for travel to and from the location of out-of-state services that meet the program approval parameters above. [The cost of transportation, meals, and lodging may be reimbursed for the CSHCN approved out-of-state treatment.] Travel costs will be negotiated, with approval of specific travel options based on overall cost effectiveness.

§38.7. Ambulatory Surgical Care Facilities.

(a) Ambulatory surgery services may be utilized by the CSHCN Services Program [program] as a cost-efficient means of providing surgical care, as long as quality of care is assured. Any hospital participating in the CSHCN Services Program [program] whose accreditation by the Joint Commission on Accreditation of Health Care Organizations includes hospital-sponsored ambulatory care services may provide ambulatory surgery services for CSHCN Services Program clients. Freestanding ambulatory surgical care (ASC) facilities, even if governed by or affiliated with a hospital participating in the CSHCN Services Program [program], must apply for CSHCN Services Program [program] approval. The CSHCN Services Program [program] may contract with a limited number of facilities to contain [program] costs. For approval to participate in the CSHCN Services Program [program], a freestanding ASC facility must meet the following criteria:

(1)-(3) (No change.)

(4) Staff requirements.

(A) Surgical staff participating in the CSHCN Services Program [program] must perform all surgical procedures.

(B) An anesthesiologist or certified registered nurse anesthetist participating in the CSHCN Services Program [program] must be present in the operating room for the induction and completion of anesthesia and must remain on the premises (immediately available) during the surgical procedure until the client leaves the facility.

(C) (No change.)

§38.7

(5) (No change.)

(6) Client transfer. The facility must have client transfer agreements with CSHCN Services Program **[program]** participating hospitals in the area.

(b) ASC facilities seeking approval for CSHCN Services Program **[program]** participation must submit documentation concerning their compliance with the criteria stated in subsection (a)(1)-(6) of this section to the CSHCN Services Program **[program]** or its designee as required by the application process described in subsection (d) of this section.

(c) CSHCN Services Program reimbursement for care at freestanding ASC facilities shall be limited to:

(1)-(2) (No change.)

(d) Applications for approval for CSHCN Services Program **[program]** participation shall be processed according to the following procedures:

(1) Applications will be reviewed by the CSHCN Services Program **[program]** to assure that:

(A)-(B) (No change.)

(C) copies of documents have been provided verifying the facility's state licensure, Medicare certification, and client transfer agreements with CSHCN Services Program **[program]** participating hospitals.

(2) The CSHCN Services Program **[program]** shall review all complete applications and shall approve or deny each application in writing within 15 working days of receipt. An incomplete application will be returned to the applicant with an explanation of the information required. The application may be resubmitted with the required documentation for reconsideration.

(3) (No change.)

(e) Those providers that have not received any CSHCN Services Program **[program]** payment for services rendered during the prior year will be given the option of withdrawing from CSHCN Services Program **[program]** approved status, becoming inactive, or providing updated information to remain active. If updated information is not received within 60 days of the date of notification, the provider will be considered inactive. This action will not terminate a provider's approval, but the provider may be reinstated to active status only by providing current information to the CSHCN Services Program **[program]**.

(1) Updated information may include, but is not limited to, the following:

(A) (No change.)

§§38.7-38.9

(B) current listing of CSHCN Services Program [program] participating medical staff;

(C)-(D) (No change.)

(2) The provider will be given a current copy of CSHCN Services Program [program] rules to review at the time reinstatement is requested.

§38.8. Inpatient Rehabilitation Centers.

(a) Introduction. The CSHCN Services Program [program] shall reimburse only an approved inpatient rehabilitation center for services provided to clients.

(b) Criteria. The criteria for inpatient rehabilitation center approval include the following.

(1)-(2) (No change.)

(3) The center shall agree to allow on-site visits and/or audit privileges to the CSHCN Services Program [program] staff.

(4) A physician who is a CSHCN Services Program [program] participating provider, board certified or eligible in his/her specialty, and able to demonstrate experience in rehabilitation shall be available as medical director.

(5) A center which serves pediatric clients (clients less than 14 years old), shall have a designated CSHCN Services Program [program] participating pediatrician available to participate in direct client care and consultation. The physician shall be either certified or eligible for certification by the American Board of Pediatrics.

(6)-(7) (No change.)

(8) A center [which] that serves pediatric clients shall have at least one recreational area or playroom that is bed and wheelchair accessible, with age-appropriate and safe materials for clients who are at different stages in rehabilitation [**which is bed and wheelchair accessible**].

(9) A center [which] that serves pediatric clients shall have specialized age-appropriate equipment necessary for provision of care.

(10) (No change.)

§38.9. Cleft/Craniofacial Center Teams. To assure that clients with craniofacial anomalies, including cleft lip and/or cleft palate, receive quality, comprehensive services, cleft/craniofacial (C/C) teams requesting approval from the CSHCN Services Program [program] shall comply with the following standards:

§§38.9-38.10

(1) Approval process. All C/C teams and affiliated providers must submit a completed CSHCN Services Program C/C provider application packet as specified by the CSHCN Services Program [program]. Applications shall include an application form, CSHCN Services Program provider agreements, documentation of licensure, board certifications for physicians, documentation of dental specialty for dentists, and a description of the C/C team composition.

(2) C/C team administrator responsibility.

(A) The C/C team shall clearly identify an administrator who is responsible for coordinating and maintaining all records associated with C/C team activities and assuring that the C/C team abides by the CSHCN Services Program [program] rules and regulations.

(B) (No change.)

(3)-(4) (No change.)

(5) Affiliated providers.

(A) To facilitate statewide coverage, providers may be approved as C/C team members when affiliated with an approved C/C team. Affiliated providers must meet the CSHCN Services Program [program] provider enrollment requirements found in §38.6 of this title (relating to Providers).

(B) (No change.)

(C) As part of its application, an affiliated provider must specify the comprehensive C/C team(s) with which it is linked. A letter of agreement between the affiliated provider and the C/C team [which] that verifies the linkage and specifies the method of communication and consultation must accompany the application.

§38.10. Payment of Services. The CSHCN Services Program [program] reimburses participating providers for covered services for [CSHCN] clients. Payment may be made only after the delivery of the service, with the exception of meals, transportation, and lodging and insurance premium payments. Excluding allowable insurance or health maintenance organization co-payments, the client or client's family must not be billed for the service or be required to make a preadmission or pretreatment payment or deposit. Providers may not request or accept payment from the client or the client's family for completing any CSHCN Services Program forms. Providers must agree to accept established fees as payment in full. The program may negotiate reimbursement alternatives to reduce costs through requests for proposals, contract purchases, and/or incentive programs.

(1) Payment or denial of claims. All payments made on behalf of a client will be for claims received by the CSHCN Services Program [program] or its payment contractor within 95 days of the date of service, within 95 days from the date of discharge from inpatient hospital and

§38.10

inpatient rehabilitation facilities, within 95 days from the date the client's eligibility is added to program automation systems, or within the submission deadlines listed in paragraphs (1)(B)(ii) and (2) of this section, whichever is later. If the 95th day for receipt of a claim falls on a weekend or holiday, the deadline shall be extended to the next business day following the weekend or holiday. Claims will either be paid or denied within 30 days. The manager of the department unit having responsibility for oversight of the CSHCN Services Program [CSHCN Division Director] or his/her designee(s) may waive the filing deadlines according to the conditions and circumstances specified in paragraphs (3) - (5) of this section. A claim must be processed and paid within 24 months of the date of service. Claims received by the CSHCN Services Program [program] or its payment contractor after this time frame will not be considered for payment by the CSHCN Services Program [program].

(A) Claims will be paid, if submitted on claim forms approved by the CSHCN Services Program [the CSHCN program-approved claim form] (including electronic claims submission systems), and if the required documentation is received with the claim.

(B) Denied claims are claims which are incomplete, submitted on the wrong form, lack necessary documentation, contain inaccurate information, fail to meet the filing deadline, **[and/or]** are for ineligible persons [recipients], services, or providers, and/or are for clients who do not qualify for the health care benefit claimed.

(i) Corrected claims must be submitted on claim forms approved by the CSHCN Services Program, [the CSHCN program-approved claim form] along with required documentation, within the filing deadline established in clause (ii) of this subparagraph.

(ii) (No change.)

(2) Claims involving health insurance coverage, CHIP or Medicaid. Any health insurance that provides coverage to the client must be utilized before the CSHCN Services Program [program] can pay for services. Providers must file a claim with health insurance, CHIP, or Medicaid prior to submitting any claim to the CSHCN Services Program [program] for payment. Claims with health insurance must be received by the CSHCN Services Program [program] within 95 days of the date of disposition by the other third party resource, and no later than 365 days from the date of service. The CSHCN Services Program [program] will consider claims received for the first time after the 365-day deadline, if a third party resource recoups a payment made in error; however, the claim must be received by the CSHCN Services Program [program] within 95 days from the third party's disposition. The CSHCN Services Program may pay for covered health care benefits during CHIP or other health insurance enrollment waiting periods. During these periods, providers may file claims directly with the CSHCN Services Program without evidence of denial by the other insurer.

(A) Health insurance denial or nonresponse. If a claim is denied by health insurance, the provider may bill the CSHCN Services Program [program], if the letter of denial also is submitted with the claim form. If the denial letter is not available, the provider must include on the claim form the date the claim was filed with the insurance company, the reason for the denial, name and telephone number of the insurance company, the policy number, the

§38.10

name of the policy holder and identification numbers for each policy covering the client, the name of the insurance company employee who provided the information on the denial of benefits, and the date of the contact. If more than 110 days have elapsed from the date a claim was filed with the third party resource and no response has been received, the claim may be submitted to the CSHCN Services Program **[program]** for consideration of payment. Claims must be submitted with documentation indicating the third party resource has not responded.

(B) Explanation of benefits (EOB). The health insurance EOB must accompany any claim sent to the CSHCN Services Program **[program]** for payment, if available. If the EOB is unavailable, the provider must include on the claim form the name and telephone number of the insurance company, the amount paid, the policy number, and name of the insured for each policy covering the client.

(C) Late filing. Claims denied by health insurance on the basis of late filing will not be considered for payment by the CSHCN Services Program **[program]**.

(D) Deductibles and coinsurance. If the client has other third party coverage, the CSHCN Services Program **[program]** may pay a deductible or coinsurance for the client as long as the total amount paid to the provider does not exceed the maximum allowed for the covered service, and conforms with current CSHCN Services Program **[program]** policies regarding third party resources, deductible, and coinsurance.

(3) Exceptions to the claim receipt or correction and resubmission deadlines. The manager of the department unit having responsibility for oversight of the CSHCN Services Program **[CSHCN Division Director]** or his/her designee(s) will consider a provider's request for an exception to the claim receipt or correction and resubmission deadlines provided in paragraphs (1) and (2) of this section, if the delay in claim receipt or correction and resubmission is due to one of the following reasons:

(A)-(B) (No change.)

(C) delay or error or constraint imposed by the program in the eligibility determination of a client **[recipient]** and/or in claims processing, or delay due to erroneous written information from the program or its designee, or another state agency; or

(D) (No change.)

(4) (No change.)

(5) Other exceptions to claims receipt or correction and resubmission deadlines. The manager of the department unit having responsibility for oversight of the CSHCN Services Program **[CSHCN Division Director]** or his/her designee(s) will consider a provider's request for an exception to claims receipt or correction and resubmission deadlines due to delays caused by entities other than the provider and the program under the following circumstances:

(A)-(D) (No change.)

§38.10

(6) CSHCN Services Program [program] fee schedules. The CSHCN Services Program [program] or its designee shall reimburse claims for covered medical, dental, and other services according to the following fee schedules:

(A)-(D) (No change.)

(E) nutritional products--the lower of the billed amount or the Average Wholesale Price (AWP) per unit according to the prices in the current edition of the Drug Topics Red Book, published by Medical Economics Company, Inc., Montvale, New Jersey 07645-1742, on file with the CSHCN Services Program [program]. For products not listed in the current edition of the Drug Topics Red Book, reimbursement shall be based on the same methodology using the AWP supplied by the manufacturer of the product;

(F) (No change.)

(G) medical foods--the lower of the billed amount, the manufacturer's suggested retail price (MSRP), or the maximum charge allowed by the Texas Medicaid Program up to a maximum of \$200 per client per month;

(H)[(G)] out-patient medications:

(i) medications covered by Medicaid when billed by pharmacies--the same drug costs and dispensing fees allowed by the Texas Medicaid Vendor Drug Program;

(ii) medications not covered by Medicaid when billed by pharmacies--the lower of the billed amount or the drug cost available through the database used by the Texas Medicaid Vendor Drug Program plus the same dispensing fees allowed by the Texas Medicaid Vendor Drug Program;

(iii) medications covered by Medicaid when billed by hospitals--(the lower of the billed amount or the drug cost available through the database used by the Texas Medicaid Vendor Drug Program plus \$2.28) / 0.970; and

(iv) hemophilia blood factor products--the lower of the billed price or the United States Public Health Service (USPHS) price in effect on the date of service plus a dispensing fee of \$.04 per unit of factor;

(I)[(H)] expendable medical supplies--the lower of the billed amount or the maximum amount allowed [allowable by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if available, or] by the Texas Medicaid Program;

(J) durable medical equipment--provided by enrolled home health agencies and durable medical equipment providers, the lower of the billed amount or the maximum allowable fee for durable medical equipment established by the Texas Medicaid Program. If the

§38.10

Texas Medicaid program has not established a maximum fee, then reimbursement will be the least of the following:

(i) the billed amount; or

(ii) the Medicare fee schedule as defined in 25 Texas Administrative Code §29.301; or

(iii) the Manufacturer's Suggested Retail Price (MSRP) minus a discount as established by the Texas Medicaid Program; or if no MSRP exists, the incurred cost to the dealer plus a percentage as determined by the Texas Medicaid Program;

[(I) durable medical equipment:]

[(i) non-customized--the lower of the billed amount or the amount allowable by the CMS, if available, or the Texas Medicaid Program;]

[(ii) customized:]

[(I) customized, non-powered equipment--the lower of the billed amount or the manufacturer's suggested retail price (MSRP) less 18%;]

[(II) power wheelchairs--the lower of the billed amount or the MSRP less 15%; and]

[(III) other--when no MSRP has been published, the lower of the billed amount or the dealer's cost plus 25%; and]

[(IV) delayed delivery penalty--a claim submitted for customized durable medical equipment that was delivered to the client more than 75 days after the authorization date shall be reduced by 10%;]

[(iii) orthotics and prosthetics--the lower of the billed amount or the amount allowed by the CMS, if available, or the Texas Medicaid Program;]

(K) orthotics and prosthetics--the lower of the billed amount or the amount allowed by the Texas Medicaid Program;

(L)[(J)] total parenteral nutrition/hyperalimentation (including equipment, supplies and related services)--the lower of the billed amount or the maximum amount allowed by the Texas Medicaid Program;

(M)[(K)] home health nursing services (provided only through CSHCN Services Program [program] participating home and community support service agencies)--reimbursement for a maximum of 200 hours per client per calendar year, with an additional 200

§38.10

hours per client per calendar year available, if justification of need and cost effectiveness are documented;

(i) services provided by a registered nurse--the lower of the billed amount or \$36 per hour;

(ii) services provided by a licensed vocational nurse--the lower of the billed amount or \$28 per hour; and

(iii) services provided by a home health aide or home health medication aide (including those legally delegated by a supervising registered nurse)--the lower of the billed amount or \$12 per hour;

(N)~~(L)~~ outpatient physical therapy, occupational therapy, speech-language pathology, and respiratory therapy:

(i) services provided by therapists other than physicians--the lower of the billed amount or the amount allowed by the Texas Medicaid Program; and

(ii) services provided by physicians--the lower of the billed amount or the amount allowed by the Texas Medicaid Program;

(O) audiological testing and amplification devices--the lower of the billed amount or the amount allowed by the Program for Amplification for Children of Texas (PACT);[:]

(M) audiological testing and amplification devices:]

[(i) for clients under age 21--payment is made through the Program for Amplification for Children of Texas (PACT); and]

[(ii) for clients ineligible for PACT and those age 21 and over--the lower of the billed amount or the amount allowed by PACT;]

(P)~~(N)~~ insurance premium payment assistance program--the lowest available premium for a plan which covers the client, if cost-effective;

(Q)~~(O)~~ hospital (inpatient and outpatient care) and inpatient psychiatric care--reimbursed at 80% of the rate authorized by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), which is equivalent to the hospital's Medicaid interim rate;

(R)~~(P)~~ inpatient rehabilitation care--reimbursed at 80% of TEFRA rates, for a maximum of 90 inpatient days per calendar year;

(S)~~(Q)~~ hospice services--the lower of the billed amount or the amount allowed by the Texas Medicaid Program;

§38.10

(T)~~(R)~~ care for renal disease--

(i) renal dialysis services--the lower of the billed amount or the amount allowed by the Texas Medicaid Program; and/or

(ii) renal transplant services--renal transplants may be covered if the projected cost for the transplant and follow-up care is less than that of continuing renal dialysis. Negotiated coverage and cost are based on prior authorization documentation of cost effectiveness;

(U)~~(S)~~ freestanding ambulatory surgical centers--the lower of the billed amount or the amount allowed by the Texas Medicaid Program based upon Ambulatory Surgical Code Groupings approved by the Centers for Medicare and Medicaid Services (CMS) ~~[CMS]~~ and the Department of State Health Services ~~[Texas Department of Health]~~;

(V)~~(T)~~ hospital ambulatory surgical centers--the lower of the amount billed or the amount allowed by the Texas Medicaid Program based upon Ambulatory Surgical Code Groupings approved by the CMS and the Department of State Health Services ~~[Texas Department of Health]~~;

(W)~~(U)~~ covered professional services by physicians, podiatrists, advanced practice nurses, psychologists, licensed professional counselors, or other providers that are not otherwise specified--the lower of the billed amount or the amount allowed by the Texas Medicaid Program;

(X)~~(V)~~ independent laboratory--the lower of the billed amount or the maximum amount allowed by the Texas Medicaid Program; [the lowest of the following:]

[(i) the amount allowed by the Texas Medicaid Program state fee schedule;]

[(ii) the amount allowed by the CMS national fee schedule; or]

[(iii) the billed amount;]

(Y)~~(W)~~ radiology services--the lower of the billed amount or the amount allowed by the Texas Medicaid Program ~~[program]~~;

(Z)~~(X)~~ dental services--the lower of the billed amount or the amount allowed by the Texas Medicaid Program ~~[program]~~; and

(AA)~~(Y)~~ vision services--the lower of the billed amount or the amount allowed by the Texas Medicaid Program, except high-powered lenses, which are reimbursed at the manufacturer's suggested retail price less 18%;

§§38.10-38.12

(7) Required documentation. The CSHCN Services Program **[program]** may require documentation of the delivery of goods and services from the provider.

(8) Overpayments.

(A) Overpayments are payments made by the CSHCN Services Program **[program]** due to the following:

(i)-(iii) (No change.)

(iv) services disallowed by the CSHCN Services Program **[program]**;
and

(v) (No change.)

(B) (No change.)

§38.11. Contracts, Written Agreements, and Donations. The CSHCN Services Program **[program]** may contract on a bid basis for treatment, equipment, medications, supplies, program operations and other services in order to conserve funds and administer the program effectively.

(1) The CSHCN Services Program **[program]** may enter into contracts or written agreements with persons or entities for the development and improvement of program standards and services.

(2) The CSHCN Services Program **[program]** may use consultants from any medical or dental specialty or other discipline to address specific issues and problems in relation to the identification, diagnosis and evaluation, rehabilitation, case management, other family support services, and health benefits coverage for clients.

(3) With **[the]** approval **[of the board]** as required by law, the CSHCN Services Program **[program]** may accept gifts and donations.

§38.12. Denial/Modification/Suspension/Termination of Eligibility for Health Care Benefits and/or Health Care Benefits.

(a) Any person applying for or receiving health care benefits from the CSHCN Services Program **[program]** shall be notified in writing if the CSHCN Services Program **[program]** proposes to deny, modify, suspend, or terminate such health care benefits because:

(1)-(7) (No change.)

(8) utilization review indicates inappropriate use of CSHCN Services Program **[program]** services and the client/family fails to adhere to a plan established to direct and/or supervise the use of CSHCN Services Program **[program]** services;

§§38.12-38.13

(9) CSHCN Services Program [program] funds are reduced or curtailed; or

(10) the client is placed on a waiting list for CSHCN Services Program [program] health care benefits.

(b) The CSHCN Services Program [program] will notify the parent/foster parent/guardian/managing conservator or the adult applicant/client in writing of the action, the reasons for the action, and the right of appeal in accordance with §38.13 of this title (relating to Right of Appeal).

§38.13. Right of Appeal.

(a) Appeal procedures for families who request authorization of family support services and/or providers.

(1) Administrative review.

(A) If the CSHCN Services Program [program] intends to deny a family's authorization request for family support services according to §38.4(b)(5) [§38.4(b)(5)(B)(viii)] of this title (relating to Covered Services) and/or a provider's authorization request according to §38.4(d) [§38.4(d)(5)] of this title [(relating to Covered Services)] and/or a provider's claim that has been corrected and resubmitted for reconsideration according to §38.10(1)(B) [§38.10(1)(B)(ii)] of this title (relating to Payment of Services), the program shall give the family or provider written notice of the denial and the right of the family or provider to request an administrative review of the denial within 30 days.

(B) If the CSHCN Services Program [program] intends to deny, modify, suspend, or terminate an individual provider's participation in the CSHCN Services Program [program], the CSHCN Services Program [program] shall give the provider written notice of the proposed action and the provider's right to request an administrative review of the proposed action within 30 days.

(C) If the family or provider does not respond in writing within the 30-day period, the family or provider is presumed to have waived the administrative review as well as access to a fair hearing, and the CSHCN Services Program's [program's] action is final. If the family or provider so requests, the CSHCN Services Program [program] will conduct an administrative review of the circumstances on which the proposed denial of the authorization request/claim and/or the proposed denial, modification, suspension, or termination of provider program participation is based and give the family or provider written notice of the program decision and the supporting reasons within ten days of receipt of the request for administrative review.

(D) The commission [department] establishes provider reimbursement [fee schedules] and the program's budget alignment methodologies [methodology] by rule. Families and/or providers may not request administrative review and may not appeal service authorization decisions and/or provider reimbursement amounts that are

§38.13

in accordance with the reimbursement [fee schedules] and budget alignment methodologies [methodology] as stated in CSHCN Services Program [program] rules.

(2) Fair hearing. If the family and/or provider is dissatisfied with the CSHCN Services Program's [program's] decision and supporting reasons following the administrative review, the family and/or provider may request a fair hearing in writing addressed to the Children with Special Health Care Needs Program, Purchased Health Services Unit, Department of State Health Services [Bureau of Children's Health, Texas Department of Health], 1100 West [W.] 49th Street, Austin, Texas 78756 within 20 days of receipt of the administrative review decision notice. If the family and/or provider fails to request a fair hearing within the 20-day period, the family and/or provider is presumed to have waived the request for a fair hearing, and the CSHCN Services Program [program] may take final action. A fair hearing requested by a family and/or provider shall be conducted in accordance with §§1.51-1.55 of this title (relating to Fair Hearing Procedures).

(b) Appeal procedures for applicants/clients.

(1) Administrative review.

(A) If the CSHCN Services Program [program] intends to deny eligibility to a program applicant, the program shall give the applicant written notice of the denial and the applicant's right to request an administrative review of the denial within 30 days.

(B) If the CSHCN Services Program [program] intends to deny, modify, suspend, or terminate an individual client's eligibility for health care benefits and/or health care benefits (unless such program actions are authorized by §38.16 of this title (relating to Procedures to Address CSHCN Services Program [program] Budget Alignment)), the CSHCN Services Program [program] shall give the client written notice of the proposed action and the client's right to request an administrative review of the proposed action within 30 days.

(C) If the applicant/client does not respond in writing within the 30-day period, the applicant/client is presumed to have waived the administrative review as well as access to a fair hearing, and the CSHCN Services Program's [program's] action is final. If the applicant/client so requests in writing, the CSHCN Services Program [program] shall conduct an administrative review concerning the circumstances on which the denial of the applicant's eligibility or the proposed denial, modification, suspension, or termination of the client's eligibility and/or health care benefits is based within ten days after receiving the request and shall give the client written notice of the decision and the supporting reasons.

(2) Fair hearing. If the applicant/client is dissatisfied with the CSHCN Services Program's [program's] decision and supporting reasons following the administrative review, the applicant/client may request a fair hearing in writing addressed to the Children with Special Health Care Needs Program, Purchased Health Services Unit, Department of State Health Services [Bureau of Children's Health, Texas Department of Health], 1100 West 49th Street, Austin, Texas 78756 within 20 days of receipt of the administrative review decision notice. If the applicant/client fails to request a fair hearing within the 20-day period, the

§§38.13-38.14

applicant/client is presumed to have waived the request for a fair hearing, and the CSHCN Services Program [program] may take final action. A fair hearing requested by the applicant/client shall be conducted in accordance with §§1.51-1.55 of this title (relating to Fair Hearing Procedures).

§38.14. Development and Improvement of Standards and Services. To ensure that cost-effective, quality, appropriate medical and related services are available and delivered to clients, the CSHCN Services Program [program] may establish a system of program evaluation to obtain management information about the CSHCN Services Program's [program's] operation and effectiveness; to establish guidelines and standards for CSHCN Services Program [program] health care services; to monitor compliance with these established standards and guidelines; to identify and analyze patterns and trends in provider billing and service delivery; and to develop systems which promote family-centered, community-based alternatives that nurture and support children with special health care needs.

(1) Quality assurance. The CSHCN Services Program [program] may establish a system of monitoring the quality, medical necessity, and effectiveness of services.

(A) Standards and guidelines. The CSHCN Services Program [program] may develop standards and guidelines for services and providers reimbursed by the CSHCN Services Program [program] to ensure that quality services are available.

(B) Review of services. The CSHCN Services Program [program] may conduct or contract for concurrent and/or retrospective review of client care services reimbursed by the CSHCN Services Program [program].

(C) Provider review. The CSHCN Services Program [program] may conduct periodic quality assurance reviews for provider services.

(D) Survey of clients and families. The CSHCN Services Program [program] shall survey clients periodically to assess the availability, appropriateness, effectiveness, accessibility, and cultural sensitivity of provided services.

(2) Utilization review. Utilization review will assess the appropriateness of services provided to CSHCN Services Program [program] clients by monitoring systems developed or contracted by the CSHCN Services Program [program]. Suspected fraud and abuse cases will be evaluated by the Office of the General Counsel for possible prosecution.

(3) Task forces. The CSHCN Services Program [program] may establish task forces to advise the CSHCN Services Program [program].

(4) Cooperation with other agencies. The department cooperates with public and private agencies and with persons interested in the welfare of children with special health care needs. The CSHCN Services Program [program] will make every effort to establish cooperative agreements with other state agencies to define the responsibilities of each agency in relation to specific programs to avoid duplication of services.

§§38.14, 38.16

(5) Collaboration with stakeholders. The CSHCN Services Program [program] values the participation of all stakeholders who have an interest in children with special health care needs and will make every effort to work collaboratively with stakeholders in the design, development, and implementation of program rules and policies.

(6) Systems development activities. The CSHCN Services Program [program] may conduct population-based systems development activities to improve and support the state's infrastructure for serving all children with special health care needs and their families by program staff or through contractors.

(A) (No change.)

(B) The CSHCN Services Program [program] may establish wellness centers, which are programs and/or physical locations of community-based service organizations which provide specific support services for children with special health care needs and their families.

(i) Community-based service organizations that serve as wellness centers may include, but are not limited to: hospitals, churches, boys/girls organizations, health centers, or school-based centers. Existing community-based service organizations that provide services to children with special health care needs and their families within a community shall receive preference in funding by the CSHCN Services Program [program].

(ii)-(iii) (No change.)

§38.16. Procedures to Address CSHCN Services Program [Program] Budget Alignment.

(a) The department shall analyze actuarial cost projections concerning CSHCN Services Program administrative and client services to estimate the amount of funds needed in the fiscal year by the program to serve CSHCN Services Program clients and shall monitor such program cost projections and funding analyses at least monthly to determine whether the estimated amount of funds needed by the program will:

(1)-(2) (No change.)

(b) When the CSHCN Services Program [program] projects that the estimated amount of funds needed in the fiscal year by the program to serve CSHCN Services Program clients will exceed the program's appropriated funds and other available resources for the fiscal year, the program shall use the following methodology to reduce/ limit the amount of funds to be expended by the program:

(1) (No change.)

(2) take the following actions in the order listed only until the projected amount of funds to be expended by the program approximately equals, but does not exceed, the program's appropriated funds and other available resources:

§38.16

(A) implement administrative efficiencies, while avoiding changes which may jeopardize the quality and integrity of CSHCN Services Program [program] service delivery;

(B) (No change.)

(C) at the same time the waiting list is established:

(i) provide only limited prior authorization for family support services for ongoing clients, as determined by the medical director or other designated medical staff, only in order to continue services already being provided at the time the waiting list is established, and/or when the specific services are required to prevent out-of-home placement of the client (as documented by the CSHCN Services Program [program] regional case management staff/ contractors), and/or when the provision of such services is cost effective for the program;

(ii)-(iii) (No change.)

(D)-(E) (No change.)

(F) place clients who are eligible to receive CSHCN Services Program [program] health care benefits and who currently are not on the waiting list (ongoing clients for health care benefits) on the waiting list. These clients will be ordered on the waiting list according to the original date/time that starts the client's latest uninterrupted sequence of eligibility for program health care benefits, and in the following order of movement to the waiting list:

(i) ongoing clients for health care benefits who have one or more sources of substantial health insurance coverage (such as Medicaid/ CHIP/ or other private health insurance similar in scope) in addition to the CSHCN Services Program [program] (not including those ongoing clients for whom the CSHCN Services Program [program] pays the insurance premiums);

(ii)-(iii) (No change.)

(G) employ additional measures to reduce/ limit the amount of funds to be expended by the program as directed [the board shall direct] by rule.

(c) If the procedures described in subsection (b)(2)(A)-(F) of this section enable the program to project that the estimated amount of funds to be expended by the program in the fiscal year approximately equals, but does not exceed, the program's appropriated funds and other available resources, the program shall take the following additional steps in order to provide health care benefits to as many clients with urgent need for health care benefits as possible who are currently on the waiting list.

(1) generate cost savings by taking the following steps in the order listed:

§38.16

(A)-(B) (No change.)

(C) employ additional measures to generate cost savings as directed [the board shall direct] by rule.

(2) (No change.)

(3) provide health care benefits (which may or may not include coverage [payment] of outstanding bills for health care benefits) for clients with urgent need for health care benefits who are removed from the waiting list;

(A)-(B) (No change.)

(4) provide limited health care benefits and/or payment of outstanding bills for health care benefits for clients with urgent need for health care benefits who are on the waiting list and remain on the waiting list. The program's coverage of such health care benefits may be limited in scope, amount, and duration and is not intended to be sustained over time. If limited health care benefits coverage includes coverage of family support services, the coverage of family support services must be limited according to the parameters set forth in subsection (b)(2)(C)(i) of this section. Clients with urgent need for health care benefits who are on the waiting list will be served in the same order used in paragraph (2) of this subsection to remove clients with urgent need for health care benefits from the waiting list. This coverage may be provided to clients with urgent need on the waiting list prior to or at any point during activities described by paragraphs (2)-(3) of this subsection only:

(A)-(C) (No change.)

(d) When the CSHCN Services Program [program] projects that the estimated amount of funds to be expended by the program in the fiscal year is less than the program's appropriated funds and other available resources due to the cost reduction, limitation, or deferral procedures implemented according to subsections (b) or (c) of this section, or the program's receipt of additional funding, or funding analysis **[as described in subsection (a)(2) of this section,]** resulting in a projected amount of unobligated funds, the program shall increase the amount of funds to be expended by the program.

(1) In an effort to expend unobligated funds (except for unobligated funds resulting from program actions taken according to subsection (c) of this section) the program shall utilize the following steps in the order listed only until the program projects that the estimated amount of unobligated funds will be expended by the program during the fiscal year:

(A) take clients off the waiting list according to the original date/time that starts the client's latest uninterrupted sequence of eligibility for program health care benefits and in the following group order:

(i)-(ii) (No change.)

§38.16

[(iii) clients who are less than 21 years old who do not have an urgent need for health care benefits and who are clients who were placed on the waiting list when they were ongoing clients and who have had no lapse in eligibility while on the waiting list or who are new clients who are re-applicants for health care benefits and who have had a lapse in eligibility for no longer than the 12 months prior to the date/time that starts their latest uninterrupted sequence of eligibility;]

[(iv) clients who are 21 years of age or older who do not have an urgent need for health care benefits and who are clients who were placed on the waiting list when they were ongoing clients and who have had no lapse in eligibility while on the waiting list or who are new clients who are re-applicants for health care benefits and who have had a lapse in eligibility for no longer than the 12 months prior to the date/time that starts their latest uninterrupted sequence of eligibility;]

[(iii)][(v)] all other clients who are less than 21 years old who do not have an urgent need for health care benefits; and

[(iv)][(vi)] all other clients who are 21 years of age or older who do not have an urgent need for health care benefits;[.]

(B) provide health care benefits [(which may include payment of outstanding bills for health care benefits)] for clients taken off the waiting list as long as program unobligated funds are available[:]

[(i) as long as program unobligated funds are available; and]

[(ii) if the outstanding bills for health care benefits are for dates of service that are within the time period that program unobligated funds are available and provided the client was eligible for program health care benefits at the time of the dates of service;]

(C) provide limited health care benefits for clients who are on the waiting list and remain on the waiting list; and/or payment of outstanding bills for health care benefits for clients who are on the waiting list and remain on the waiting list; and/or payment of outstanding bills for health care benefits for clients who have been taken off the waiting list. The program's coverage of such health care benefits may be limited in scope, amount, and duration and is not intended to be sustained over time. If limited health care benefits coverage includes coverage of family support services, the coverage of family support services must be limited according to the parameters set forth in paragraph (b)(2)(C)(i) of this section. [Clients on the waiting list will be served in the same order used in paragraph (1) of this subsection to take clients off the waiting list.] This coverage may be provided **[to clients on the waiting list prior to or] at any point during activities described by subparagraphs (A) and (B) of this paragraph [paragraphs (1)-(2) of this subsection] only:**

(i)-(iii) (No change.)

§38.16

(D) if the CSHCN Services Program **[program]** projects that the amount of funds to be expended by the program in the fiscal year will be less than the program's appropriated funds and other available resources after no clients eligible for CSHCN Services Program **[program]** health care benefits remain on the waiting list, the program may take the following actions in the following order:

(i)-(ii) (No change.)

(iii) remove any of the additional measures taken to reduce/limit the amount of funds to be expended by the program as directed **[by the board]** by rule;

(iv)-(v) (No change.)

(2) In an effort to expend unobligated funds resulting from program actions taken according to subsection (c) of this section (unobligated cost savings funds that remain after all clients with urgent need for health care benefits have been removed from the waiting list and provided health care benefits) the program shall utilize the following steps in the order listed only until the program projects that the estimated amount of unobligated funds will be expended by the program during the fiscal year:

(A) (No change.)

(B) provide health care benefits (which may or may not include coverage **[payment]** of outstanding bills for health care benefits) as stipulated in subsection (d)(1)(B) of this section for these clients taken off the waiting list; **[or]**

(C) provide limited health care benefits for clients identified in subsections (d)(2)(A)(i) and (ii) of this section who are on the waiting list and remain on the waiting list; and/or payment of outstanding bills for health care benefits for clients identified in subsections (d)(2)(A)(i) and (ii) of this section who are on the waiting list and remain on the waiting list; and/or payment of outstanding bills for health care benefits for clients who have been taken off the waiting list. The program's coverage of such health care benefits may be limited in scope, amount, and duration and is not intended to be sustained over time. If limited health care benefits coverage includes coverage of family support services, the coverage of family support services must be limited according to the parameters set forth in paragraph (b)(2)(C)(i) of this section. **[These clients on the waiting list will be served in the same order used in paragraph (2)(A) of this subsection to take these clients off the waiting list.]** This coverage may be provided **[to these clients on the waiting list prior to or]** at any point during activities described by subparagraphs (A) and (B) of this paragraph **[paragraphs (2)(A) and (2)(B) of this subsection]** and only as stipulated in subsections (d)(1)(C)(i)-(iii) of this section;

(D) remove any of the additional measures taken to generate cost savings **[by the board]** by rule according to subsection (c)(1)(C) of this section; and

(E) (No change.)

§38.16

(e) The program shall establish a protocol to be used by the medical director or other designated medical staff to determine whether a client has an "urgent need for health care benefits" by considering criteria including, but not limited to, the following:

(1)-(3) (No change.)

(4) information received from CSHCN Services Program regional case management staff/contractors supports other information gathered and/or indicates that a delay in health care benefits could reasonably be expected to result in an out-of-home placement/institutionalization of the client because the family cannot continue to care for the client; and

(5) (No change.)

(f) The CSHCN Services Program **[program]** central office may establish and administer the waiting list for health care benefits to address a budget shortfall.

(1) In order to facilitate contacting clients on the waiting list, the CSHCN Services Program **[program]** shall collect information including, but not limited to the following:

(A)-(G) (No change.)

(2) (No change.)

(3) The program shall refer clients on the waiting list to other possible sources of services, and shall contact waiting list clients periodically to confirm their continuing need for CSHCN Services Program **[program]** services.

(4) (No change.)